SCHEMA THERAPY FOR ANOREXIA NERVOSA:
AN INTENSIVE SYSTEMATIC INDIVIDUAL CASE STUDY

A thesis submitted in fulfilment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

of

RHODES UNIVERSITY

by

Graham Alexander

December 2020

ACKNOWLEDGEMENTS AND GRATITUDE

To my supervisor, Professor Dave Edwards, my gratitude for not only introducing me to schema therapy, but for his abundant wisdom and sturdy mentorship. Your encouragement, reassurance and guidance throughout this study helped bring it to its finality. Thank you for your friendship and guidance on my journey both within and beyond my professional identity.

My love and gratitude go to my family. Thank you to my wife, Vicky, for her constant loving support; for carrying the extra responsibilities and always believing in my projects. To my daughter, Sophie, for her abundant love, sense of humour, and motivation to always inspire me to be a better person and father. To my parents, Sara and Igor, for their loving support, and never-failing encouragement to achieve my dreams. And, finally, to my brother, David; a lifelong friend, confidant and constant source of limitless support, skills and guidance in all arenas.

To Professor Daniel le Grange, thank you for your friendship and your mentorship into the realm of eating disorders treatment. I am so grateful for your guidance from the early 1990s. My thanks also extend to Doctor Susan Simpson for her advice, guidance and an abundance of material in recent years. I have immense respect for your knowledge in the interface of schema therapy and eating disorders.

To clinical dietician, Elliene Horwitz, for providing me with valuable and ongoing collateral, and to David Alexander, Sara Alexander, Ashleigh Davies, Caitlin Hancocks and Emily Davies for the hours of proofreading and computer assistance.

Finally, to my ten patient-participants, especially Alison (not her real name), for your participation in this study. Thank you for the many hours of written work that made this study possible. My admiration goes out to all of you in never resigning to your hardships and persisting in the therapeutic journey towards the healing of your inner child. Together we have all grown immensely through this process of discovery.

ABSTRACT

Developed more than three decades ago, schema therapy (ST) was born out of a need for a more effective way of working with difficult and challenging cases where patients were clearly unresponsive to the existing short-term cognitive therapies. While anchored in the primary theoretical orientation of cognitive therapy, ST has carefully integrated techniques and principles from attachment and object-relations therapies, as well as humanistic, gestalt and experiential therapies. The mode model emphasises the concept of "multiplicity" in terms of which the self is functionally divided into parts or schema modes. For a little more than a decade there has been growing interest amongst researcher-clinicians in the application of ST for the treatment of eating disorders (EDs) (Waller, et al., 2007; Simpson, 2012; Edwards, 2015; Munro et al., 2016; Simpson, 2016; Munro et al., 2016). While multivariate studies can provide quantifiable evidence for the efficacy of ST for treating EDs, systematic case-based research offers a means of engaging in an intensive analysis and description of the complex and subtle processes that unfold over time in a real-life therapeutic environment (Edwards et al., 2004; Yin, 1994). This research method also provides an opportunity for the refining of the clinical treatment model as well as its testing. Ten participants were assessed and treated with schema therapy. However, because of the large amount of data gathered, a decision was made to write up only one as an intensive systematic individual case study. Alison, an elderly woman with a longstanding history of AN who had been largely unresponsive to considerable previous therapies, received 100 ST sessions over a two-year period and showed a very positive response. The many challenges that arose and the way these were addressed within the ST framework provide an in-depth account of the application of the ST mode model for the treatment of AN. This is presented in a detailed therapy narrative. After results of the quantitative measures are provided, the next three chapters address three interpretative questions pertaining to the Healthy Adult/Vulnerable Child dyadic relationship, the processes of working with the Angry Child mode, and the conceptualising of an AN-specific coping mode. Several conclusions are drawn about the strengths of the schema therapy model and its particular application to AN. Amongst these is the importance of having a comprehensive case conceptualisation that serves as a collaborative "road map" with which to negotiate the unfolding collaborative therapeutic process. Another is the identifying of the "Anorexic Overcontroller" as a stand-alone coping mode that clarifies the functions of AN to hinder schema-based emotional injury, but paradoxically, still denies the individual's basic core needs being met. Such a conceptualisation significantly assisted in the suspension of anorexic behaviour. A further significant observation is how emotion-focused work (especially within the context of chair work and imagery) brought therapy to life and was particularly effective in mobilising the conflict between internal voices. Another outstanding feature is how the building of a strong Healthy Adult mode proved vital in the healing process and the development of patient autonomy. Finally, therapy revealed how central the establishment of a sturdy, warm and loving therapeutic relationship is, and how influential the resonance between the therapist and patient is in the outcome of treatment.

TABLE OF CONTENTS

ACKNOWLEDGEMENTS ... i
ABSTRACT ... ii
LIST OF TABLES ... xi
LIST OF FIGURES ... xii
GLOSSARY OF ABBREVIATIONS ... xiiI

INTRODUCTION ... 1
SETTING THE SCENE ... 1
SYNOPSIS ... 5
Chapter 1 ... 5
Chapter 2 ... 6
Chapter 3 ... 7
Chapter 4 ... 8
Chapter 5 ... 8
Chapter 6 ... 9
Chapter 7 ... 9
Chapter 8 ... 9
Chapter 9 ... 10
Chapter 10 ... 10
Chapter 11 ... 10

CHAPTER 1: SCHEMA THERAPY ... 12
1.1 The Development of Schema Therapy ... 12
1.1.1. The Birth of Schema Therapy ... 12
1.1.2. The Expansion of Schema Therapy ... 14
1.2. Early Maladaptive Schemas ... 15
1.2.1. The Origin of Early Maladaptive Schemas ... 16
1.2.2. The 18 Early Maladaptive Schemas ... 17
(a) Disconnection and Rejection Domain ... 17
(b) Impaired Autonomy and Performance Domain ... 18
(c) Impaired Limits Domain ... 19
(d) Other-Directedness Domain ... 20
(e) Hypervigilance and Inhibition Domain ... 20
1.3. Human Needs ... 21
1.4. Schema Coping ... 23
1.5. The Schema Mode Model ... 24
1.5.1. Case Conceptualisation with the Schema Mode Model ... 28
1.5.2. Treatment Goals for Individual Modes ... 30
1.6. Schema Therapy Treatment Tools and Techniques ... 31
1.6.1. Cognitive Interventions ... 31
1.6.2. Behavioural Interventions ... 32
1.6.3. Metacognitive Interventions ... 34

1.6.4. Emotion-focused Techniques 35
(a) Imagery Exercises 35
(b) Transformational Chair Work 36
1.7. The Therapeutic Relationship 39
1.7.1. Therapy Relationship in the Assessment and Education Phase of Treatment 39
1.7.2. Therapy Relationship in the Change Phase of Treatment 40
1.7.3. Limited Reparenting 40
1.7.4. Empathic Confrontation 42
1.8. Effectiveness and Efficacy of Schema Therapy 43

CHAPTER 2: EATING DISORDERS 46
2.1. Historical Context of Eating Disorders 46
2.2. Definitions and Diagnostic Features of Eating Disorders 46
2.3. Prevalence of Eating Disorders 50
2.4. Medical Complications Associated with Eating Disorders 52
2.5. Psychiatric Conditions Associated with Eating Disorders 54
2.6. Development and Course of Eating Disorders 56
2.7. Causes of Eating Disorders 57
2.7.1. Predisposing Factors 59
(a) Genetic Factors 59
(b) Neurodevelopmental Factors 61
2.7.2. Predisposing and Perpetuating Factors 62
(a) Early Attachment 62
(b) Familial Risk Factors 64
(c) Personality Traits 66
2.7.3. Predisposing, Precipitating and Perpetuating Factors 67
(a) Perfectionism 68
(b) Low Self-Esteem 69
(c) Body Dissatisfaction 71
(d) Trauma and Abuse 72
2.7.4. Precipitating and Perpetuating Factors 74
(a) Biological Factors 74
(b) Stressors, Crises and Developmental Transitions 75
(c) Sociocultural Contributors 77
(d) Dieting 81
2.7.5. Perpetuating Factors 81

CHAPTER 3: TREATING EATING DISORDERS 84
3.1. Introduction 84
3.2. Therapeutic Treatments for Eating Disorders 84
3.2.1. Psychodynamic Therapy 84
3.2.2. Cognitive Behavioural Therapies 93
3.2.3. Family Therapy 99
3.2.4. Experiential Therapies 101
3.3. The Motivation to Change 103

3.3.1. The Transtheoretical Stages of Change Model 104
3.3.2. Motivational Interviewing 105
3.4. Evaluation of Eating Disorders Treatment Models 106
3.4.1. Psychodynamic Therapy Studies 107
3.4.2. Cognitive Behavioural Therapy Studies 110
3.4.3. Family Therapy Studies 112
3.5. Summary on the Treatment of Eating Disorders 112

CHAPTER 4: SCHEMA THERAPY FOR EATING DISORDERS 116
4.1. Negative Core Beliefs and Early Maladaptive Schemas in Eating Disorders 116
4.2. Schema Therapy Models for the Treatment of Eating Disorders 119
4.2.1. Waller's Schema-Focused CBT Model 119
4.2.2. The Emergence of the Mode Model for the Treatment of Eating Disorders 124
(a) Simpson's Schema Therapy Mode Model for the Eating Disorders 125
(b) Edwards' single case study of Linda, an individual with Anorexia Nervosa 134
(c) Munro's Schema Mode Model for the Intensive Treatment of Anorexia Nervosa 135
(d) Group Schema Therapy Mode Model for the Eating Disorders 137
4.3. A Call for Further Research 138

CHAPTER 5: METHODOLOGY 140
5.1. Research Objectives 140
5.2. Distinguishing Research Methodology from Clinical Methodology 140
5.3. Research Paradigms 141
5.3.1. Nomothetic and Ideographic Research Methodology Perspectives 141
5.3.2. Different Qualitative Methodological Approaches to Research 144
5.4. The Systematic Case Study Method 145
5.4.1. Defining Case Study Research 145
5.4.2. The Benefit of Case Study Research to the Practicing Therapist 146
5.4.3. The Coexisting Roles of Therapist, Researcher, and Author 147
5.4.4. McLeod's Typology of Psychotherapy Case Studies 148
5.4.5. Pragmatic Case Study Model 149
5.4.6. Interpretative Phenomenological Analysis as a Methodological Framework 151
5.4.7. Reliability and Rigour in Case Study Research 153
(a) Subjectivity 154
(b) Generalization 156
(c) Causality 158
(d) Analysis of Data 158
(e) Triangulation 159
(f) Concluding Comments on Reliability and Rigour in Case Study Research 160
5.4.8. Ethics and Moral Considerations in Case Study Research Design 160
5.5. Research Sample Selection 161
5.5.1. Inclusion Criteria 161
5.5.2. Recruitment Method 162
5.5.3. Screening Interview 162
5.5.4. Sample of Participants 164

5.5.5. The Selection of the Case of Alison 164
5.6. Clinical Methodology 165
5.6.1. Assessment and Education Phase 165
5.6.2. Case Conceptualisation 165
5.6.3. Treatment or Change Phase 166
5.6.4. Experience and Expertise of the Therapist 166
5.6.5. Ethical Considerations in the Therapy Setting of Case Study Research 168
5.7. Data Collection 168
5.7.1. Audio-Recordings of Sessions 169
5.7.2. Therapy Notes 170
5.7.3. Homework Assignments and Communication outside Sessions 170
5.7.4. Collateral from Professional Colleagues 170
5.7.5. Transcripts from Select Sessions 170
5.7.6. Self-Report Surveys and Questionnaires 171
(a) Clinical Assessment Self-Report 171
(b) Eating Disorders Assessment Survey 171
(c) Eating Disorders Examination – Questionnaire 171
(d) The Body Image Quality of Life Inventory 172
(e) Clinical Impairment Assessment Questionnaire 172
(f) Eating Disorder Quality of Life 172
(g) The Eating Disorder Belief Questionnaire 173
(h) Mood Disorder Questionnaire 173
(i) Depression Anxiety Stress Scale 173
(j) Experience of Shame 173
(k) Clinical Outcomes in Routine Evaluation 174
(l) Personality Belief Questionnaire 174
(m) Young Schema Questionnaire 174
(n) Schema Mode Inventory 174
(o) Young Parent Inventory 175
(p) Session Bridging Form 175
(q) Working Alliance Inventory 176
(r) Agnew Relationship Measure 176
5.7.7. Therapy Evaluation Interview 176
5.8. Data Condensation 177
5.8.1. Session Summaries 177
5.8.2. Summarising of Therapy Evaluation Interview 178
5.8.3. The Therapy Narrative 178
5.8.4. Results of Questionnaires, Inventories, and Surveys 179
5.9. Data Interpretation 179

CHAPTER 6: THE THERAPY NARRATIVE 181
6.1. Alison's Summary Biographical 181
6.2. Diagnosis 185
6.3. Alison's Mode Map 186
6.4. The Therapy Narrative 187

6.4.1. Therapy Session 1 187
6.4.2. Therapy Session 2 189
6.4.3. Therapy Session 3 191
6.4.4. Therapy Sessions 6 and 7 194
6.4.5. Therapy Sessions 8 to 11 195
6.4.6. Therapy Session 12 196
6.4.7. Therapy Sessions 13 to 17 200
6.4.8. Therapy Session 18 200
6.4.9. Therapy Sessions 21 and 22 202
6.4.10. Therapy Sessions 23 to 35 204
6.4.11. Therapy Session 41 212
6.4.12. Therapy Sessions 42 to 46 215
6.4.13. Therapy Sessions 47 and 48 220
6.4.14. Therapy Session 49 223
6.4.15. Therapy Session 51 225
6.4.16. Therapy Session 54 229
6.4.17. Therapy Session 56 232
6.4.18. Therapy Session 59 234
6.4.19. Therapy Session 60 237
6.4.20. Therapy Session 61 240
6.4.21. Therapy Session 62 242
6.4.22. Therapy Session 63 246
6.4.23. Therapy Sessions 86 to 89 248
6.4.24. Brief Summary of Session 90 to 99 251
6.4.25. Therapy Session 100 252

CHAPTER 7: QUANTITATIVE MEASURES 255
7.1. Eating Disorder Measures 255
7.2. Shame 257
7.3. Depression, Anxiety and Stress 257
7.4. Efficacy of Therapy in Resolving Problem Areas 258
7.5. Quality of Therapy Relationship 258
7.5.1. Working Alliance Inventory 259
7.5.2. Agnew Relationship Measure 259
7.6. Schema and Mode Measures 260
7.6.1. Young Schema Questionnaire 260
7.6.2. Schema Mode Inventory 264
7.6.3. Young Parent Inventory 266
7.7. Evaluation of the Therapy Narrative 267

CHAPTER 8: BUILDING THE HEALTHY ADULT/VULNERABLE CHILD DYAD 269
8.1. Session 1 272
8.2. Session 2 276
8.3. Session 3 278
8.4. Session 12 281

8.5. Session 18 283
8.6. Session 22 285
8.7. Session 25 286
8.8. Session 29 288
8.9. Session 41 290
8.10. Session 45 293
8.11. Session 47 295
8.12. Session 49 298
8.13. Session 56 299
8.14. Session 61 301
8.15. Session 63 304
8.16. Session 86 306
8.17. Session 87 308
8.18. Session 88 309
8.19. Session 89 312
8.20. Session 100 313
8.21. Summary 314

CHAPTER 9: ENGAGING THE ANGRY CHILD 318
9.1. Session 1 319
9.2. Session 2 323
9.3. Session 3 324
9.4. Session 8 328
9.5. Session 11 330
9.6. Session 12 331
9.7. Session 18 341
9.8. Session 47 343
9.9. Session 51 346
9.10. Session 53 354
9.11. Session 54 359
9.12. Session 59 362
9.13. Session 60 369
9.14. Session 62 372
9.15. Session 72 382
9.16. Session 93 384
9.17. Session 100 386
9.18. Summary 388

CHAPTER 10: IDENTIFYING AND DISMANTLING THE ANOREXIC OVERCONTROLLER 390
10.1. Functions of Alison's Anorexic Overcontroller 393
10.1.1. Numbing Emotional Pain 393
10.1.2. Insulation from Everyday Pain 394
10.1.3. Comfort and Control 394
10.1.4. Feeling of Power 395
10.1.5. Evading Adult Responsibilities 396

10.1.6. Suppress Sexuality 396
10.1.7. Self-Punishment 397
10.1.8. Attention, Recognition and Identity 399
10.2. A Specific Mode for Anorexia Nervosa 399
10.3. Chronological Account of Tracking and Dismantling the Anorexic Overcontroller 400
10.3.1. Session 2 401
10.3.2. Session 3 403
10.3.3. Session 7 404
10.3.4. Session 12 405
10.3.5. Session 21 407
10.3.6. Session 22 409
10.3.7. Sessions 23 to 35 410
10.3.8. Session 42 412
10.3.9. Session 43 414
10.3.10. Session 45 416
10.3.11. Session 48 418
10.3.12. Session 51 419
10.3.13. Session 54 420
10.3.14. Session 56 421
10.3.15. Session 59 422
10.3.16. Session 60 423
10.3.17. Session 62 426
10.3.18. Sessions 63 to 99 428
10.3.19. Session 100 428
10.4. Summary 429

CHAPTER 11: CONCLUSION – REFLECTINGS AND CLINICAL IMPLICATIONS 432
11.1. A New Treatment Model for Alison 432
11.2. Case Conceptualisation and the Emergence of Modes 433
11.3. Measurable Changes in the Strength of Schemas and Modes 434
11.4. Emotion-focused Work as a Platform for Change 437
11.5. The Importance of Building the Healthy Adult Modes 439
11.6. A Place for Specific Eating Disorder Coping Modes 441
11.7. The Therapeutic Relationship 443
11.8. Alison’s Capacity for Deeper Emotional Connectivity 448
11.9. Participant’s Responses to Post-Study Interview 449
11.9.1. Assessment Phase 450
11.9.2. The Therapeutic Relationship 450
11.9.3. Eating Disorder as a Coping Mode 452
11.9.4. Schema Therapy Techniques 452
11.9.5. Overview 454
11.10. Closing Thoughts 454

REFERENCES 458

APPENDISES 563

Appendix 1: Table 1: The 18 Early Maladaptive Schemas within 5 Schema Domains 564
Appendix 2: Table 2: Personality Disorder Symptom Correlates with Early Maladaptive Schemas and Interpersonal 568
Appendix 3: Table 4: Schema Modes 569
Appendix 4: Figure 1: Schema Therapy Treatment 572
Appendix 5: Figure 2: Schema and Mode Worksheet for Identifying and Breaking Self-Defeating Patterns 573
Appendix 6: Figure 3: Schema Therapy Flash Card Template 575
Appendix 7: Table 5: Limited Reparenting Strategies for each Early Maladaptive Schema 576
Appendix 8: Table 6: Diagnostic Criteria for Anorexia Nervosa in the DSM-5 577
Table 7: Diagnostic Criteria for Bulimia Nervosa from the DSM-5 578
Table 8: Diagnostic Criteria for Binge-Eating Disorder from the DSM-5 579
Appendix 9: Table 9: Potential Risk Factors for Eating Disorders 580
Table 10: Aetiology of Anorexia Nervosa 581
Appendix 10: Figure 11: Body Image Restructuring Exercise 582
Appendix 11: Table 12: Munro's Pathways to Recovery for AN that Parallel the Transtheoretical Stages of Change Model 583
Appendix 12: Form1: Alison's Evaluation of the Therapy Narrative 584
Appendix 13: Form 2: Contractual Agreement Contract between Researcher and Research Participant 591
Form 3: Release Form for the use of Electronic Recordings for Research Purposes 594
Form 4: Consent Form for Research Participants 596
Appendix 14: Form 5: A Client's Guide to Schema Therapy 597
Form 6: Using Schemas and Schema Modes as a basis for Formulation and Treatment Planning in Schema Therapy 607
Appendix 15: Table 13: Summary Details of the Patient-Participants 617
Appendix 16: Form 7: Schema Therapy Case Conceptualisation Form for Alison 618
Appendix 17: Form 8: Research Participant Therapy Review Interview Guide 645
Appendix 18: Figure 22: Therapy Relationship Field 650
Appendix 19: Table 26: Dysfunctional schema modes associated with ambivalence and change 591

LIST OF TABLES

Table 1: The 18 Early Maladaptive Schemas within 5 Schema Domains 564
Table 2: Personality Disorder Symptom Correlates with EMSs and Interpersonal Problems 568
Table 3: The relationship between schema domains and basic human needs 21
Table 4: Schema Modes 569
Table 5: Limited Reparenting Strategies for each Early Maladaptive Schema 576
Table 6: Diagnostic Criteria for Anorexia Nervosa in the DSM-5 577
Table 7: Diagnostic Criteria for Bulimia Nervosa from the DSM-5 578
Table 8: Diagnostic Criteria for Binge-Eating Disorder from the DSM-5 579
Table 9: Potential Risk Factors for Eating Disorders 580
Table 10: Aetiology of Anorexia Nervosa 581
Table 11: The Relationship between EMSs and Eating Disorder profiles 117
Table 12: Munro's Pathways to Recovery for AN that parallel the Transtheoretical Stages of Change Model 583
Table 13: Summary Details of the Patient-Participants 617
Table 14: Pre-and Post-Study Results of the Eating Disorder Examination Questionnaire 256
Table 15: Results of the Eating Disorders Quality of Life 257
Table 16: Results of the DASS 257
Table 17: Pre- and Post-Study and Follow-up Scores on the CORE-OM 258
Table 18: Results of the Working Alliance Inventory 259
Table 19: Results of the Agnew Relationship Measure - Short 260
Table 20: Pre- and Post-Study Scores on the Schema Mode Inventory 266
Table 21: Pre- and Post-Study Scores on the Young Parent Inventory 267
Table 22 Qualities of the Healthy Adult and Their Respective Strengths 271
Table 23: Strengths Associated with Each Quality of Healthy Adult mode 271
Table 24: Harris' List of Values 271
Table 25: Biographical Information for 9 Participants in the Study 449

LIST OF FIGURES

Figure 1: Schema Therapy Treatment 572
Figure 2: Schema and Mode Worksheet for Identifying and Breaking Self-Defeating Patterns 573
Figure 3: Schema Therapy Flash Card Template 575
Figure 4: Anorexia Nervosa as a Multi-determined Disorder 58
Figure 5: Predisposing, Precipitating, and Perpetuating Factors in the Development of AN 58
Figure 6: Tripartite Influence Model of Body Image and Eating Disturbance 78
Figure 7: A Schematic Representation of the Cognitive Behavioural Theory of the Maintenance of BN 94
Figure 8: A Schematic Representation of the Transdiagnostic Theory of the Maintenance of EDs 99
Figure 9: Example of an Individual ST Formulation for a Patient with a Restrictive Eating Pathology 121
Figure 10: Example of an Individual ST Formulation for a Patient with a Bulimic Eating Pathology 122
Figure 11: Body Image Restructuring Exercise 582
Figure 12: Simpson's 13 Mode Schema Therapy Mode Model for the Eating Disorders 130
Figure 13: Origins of the Self-Critical Mode 131
Figure 14: Generic Eating Disorder Case Conceptualisation 133
Figure 15: Munro's Schema Therapy Mode Model for Anorexia Nervosa 136
Figure 16: Professional Activity as Disciplined Inquiry 151
Figure 17: Alison's Mode Map 186
Figure 18: Alison's Body Mass History 256
Figure 19: Pre-Study Results of the YSQ 262
Figure 20: Post-Study Results of the YSQ 263
Figure 21: 5-Year Follow-up Results of the YSQ 263
Figure 22: Therapy Relationship Field 651

GLOSSARY OF ABBREVIATIONS

AASe	Attention and Approval Seeker
AgSu	Aggrieved Surrenderer
AN	Anorexia Nervosa
AN-b/p	Anorexia Nervosa (purging type)
AN-r	Anorexia Nervosa (restrictive type)
AnCh	Angry Child
AnOv	Anorexic Overcontroller
AnPr	Angry Protector
AsPD	Antisocial Personality Disorder
AvPD	Avoidant Personality Disorder
AvPr	Avoidant Protector
BAD	Bipolar Affective Disorder
BED	Binge Eating Disorder
BMI	Body Mass Index
BN	Bulimia Nervosa
BPD	Borderline Personality Disorder
BuaA	Bully and Attack
CBT	Cognitive-Behavioural Therapy
CoAM	Conning and Manipulative
CoSu	Compliant Surrenderer
CrPa	Critical Parent
CT	Cognitive Therapy
DBT	Dialectic Behaviour Therapy
DePa	Demanding Parent Mode
DePr	Detached Protector
DeSS	Detached Self-Soother
DeST	Detached Self-Stimulator
DFST	Dual-Focus Schema Therapy
DPD	Dependent Personality Disorder
DPM	Dysfunctional Parent Mode
ED	Eating Disorder
EDEQ	Eating Disorder Examination Questionnaire
EDNOS	Eating Disorder Not Otherwise Specified
EFT	Emotion-Focused Therapy
EMS	Early Maladaptive Schema
EnCh	Enraged Child
FBT	Family-Based Treatment
FlOv	Flagellating Overcontroller
gi-DPM	guilt-inducing Dysfunctional Parent Mode
GWR	Goal Weight Range
HaCh	Happy and Contented Child
HeAd	Healthy Adult
HiPD	Histrionic Personality Disorder
ImCh	Impulsive Child
IPA	Interpretative phenomenological analysis
IPT	Interpersonal psychotherapy

IR	Imagery Rescripting
ISST	International Society of Schema Therapy
LoCh	Lonely Child
MBT	Mentalisation-Based Therapy
MET	Motivational Enhancement Therapy
MI	Motivational Interviewing
NPD	Narcissistic Personality Disorder
ObOv	Obsessive Overcontroller
OCD	Obsessive Compulsive Disorder
OCPD	Obsessive Compulsive Personality Disorder
OSFED	Otherwise Specified Feeding or Eating Disorder
PaOv	Paranoid Overcontroller
PaPD	Paranoid Personality Disorder
PD	Personality Disorder
PDT	Psychodynamic Psychotherapy
PeOv	Perfectionistic Overcontroller
PPP	Positive Parenting Patterns
PrCh	Protector Child
Pred	Predator
PTSD	Post-Traumatic Stress Disorder
PuPa	Punitive Parent
RaOv	Rationalising Overcontroller
RCT	Randomised Controlled Trial
ReCh	Rebellious Child
sAN	severe Anorexia Nervosa
ScOv	Scolding Overcontroller
Se-Cr	Self-Critical Mode
SeAg	Self-Aggrandiser
SFCBT	Schema-Focused Cognitive Behaviour Therapy
SMI	Schema Mode Inventory
SPVi	Self-Pity/Victim
ST	Schema Therapy
StSS	Stimulating Self-Soother
SuOv	Suspicious Overcontroller
TA	Transactional Analysis
TAU	Treatment As Usual
TFT	Transference-Focused Therapy
TSCM	Transtheoretical Stages of Change Model
UnCh	Undisciplined Child
VuCh	Vulnerable Child
WoOv	Worrying Overcontroller
YAI	Young-Rygh Avoidance Inventory
YCI	Young Compensation Inventory
YSQ	Young Schema Questionnaire

INTRODUCTION

This brief introduction provides an overview for the specific motivations underlying the present study through a synthesis of the chapters that constitute this thesis.

SETTING THE SCENE

Numerous studies indicate that anorexia nervosa (AN) has the highest mortality rate of any psychiatric condition (Smink, van Hoeken, & Hoek, 2012). However, the estimated rate of 20% (Birmingham, Su, Hlynsky, Goldner, & Gao, 2005; Smink, van Hoeken, & Hoek, 2012) decreases almost tenfold when the condition is professionally addressed (Tamburrino & McGinnis, 2002). Despite significant progress having been made over the past few decades in the development of evidence-based psychological treatments for AN (Wilson, Grilo, & Vitousek, 2007), the most efficacious of these still fail to help a significant portion of sufferers. There is thus an increasing appreciation amongst clinicians and researchers that the complexity of AN, with its multifactorial aetiology and biopsychosocial nature, requires a treatment that is highly integrated, especially in light of the need to explore, confront and resolve the numerous complex psychological factors that lie at the epicentre of this difficult-to-treat condition.

Schema Therapy (ST) was developed more than three decades ago, emerging from a trend towards the development of more integrative therapies. The reason for this proliferation of integrative therapies was due to the vast majority of therapists having been trained in predominantly one of either cognitive-behavioural therapy (CBT), psychodynamic, humanistic or the experiential therapeutic frameworks, and thus being limited in their capacity to treat a broader range of patients and the complexity of problems they encountered in clinical practice (Dattilio, Edwards & Fishman, 2010; Edwards & Arntz, 2012). Jeffrey Young's development of ST was driven by his interest in cultivating a more effective way of working with difficult and challenging cases in which patients were clearly unresponsive to the existing short-term cognitive therapies. Anchored in an adaption of cognitive therapy, he carefully integrated techniques and principles from other well-established frameworks such as attachment-based and object-relations therapies, as well as Gestalt and experiential therapies. Initial publications on ST from the early 1990s largely focused on patients with personality pathology (Young, 1990) until a decade later when Young and his colleagues published the first comprehensive ST manual (Young, Klosko, & Weishaar, 2003). Central to the ST model was the identifying of early maladaptive schemas (EMSs); self-defeating emotional and cognitive patterns that result from early developmental damage that provoke maladaptive behavioural responses that are repeated throughout life if not interrupted (Walburg & Chiaramello, 2015). In difficult cases, especially those involving patients with complex personality problems, many different EMSs would present alongside a diversity of ways of coping with them. To resolve this challenge, Young blended a number of these EMSs and coping strategies, narrowing down a number of new and more manageable units of analysis called "schema modes"; the

instantaneous, continuously changing, but dominant states of mind patients find themselves in (Young et al., 2003). There are four broad groups of schema modes, namely: child modes, dysfunctional parent modes, coping modes and healthy modes, the latter of which includes the Healthy Adult (HeAd) mode and the Contented/Happy Child (HaCh) mode. The coping modes, which serve to protect the individual from core pain, are an important focus of this thesis. Seldom operating in isolation, any individual inevitably has a constellation of maladaptive modes, where one will be active in the foreground at any one time that determines their current behaviour. An active mode will eventually be suspended for another mode in the constellation to become the dominant or active mode, thus accounting for the rapid changes in thoughts, feelings and behaviour. This ST mode model strongly emphasised the concept of multiplicity in terms of which the self is functionally divided into parts that are in conflict with one other (Edwards & Arntz, 2012).

Whether by way of a single case series (Nordahl & Nysæter, 2005) or randomised controlled trial (RCT) studies (Bamelis, Evers, Spinhoven, and Arntz, 2014; Farrell, Shaw, and Webber, 2009; Giesen-Bloo et al., 2006; Nadort et al., 2009; Zorn, Roder, Muller, Tschacher, & Thommen, 2007), there is evidence that patients with severe personality pathology have responded favourably to ST. Studies demonstrating the application of ST for individuals with mood disorders (Morrison, 2000; Ball, Mitchell, Malhi, Skillecorn, & Smith, 2003; Ball, Mitchell, Corry, Skillecorn, Smith, & Malhi, 2006), anxiety conditions (Cockram, Drummond, and Lee, 2010) and even addiction have also shown ST to be a promising alternative model of treatment and at least as effective as other more recognised treatment designs. More recently, ST has caught the interest of clinicians and researchers in the eating disorders (EDs) field seeking more effective treatment than those currently most recognised and practiced. After all, numerous studies have confirmed that patients across the diagnostic domain of EDs have elevated negative core beliefs and EMSs when compared with controls (Cooper, Rose & Turner, 2006; Damiano, Reece, Reid, Atkins, & Patton, 2015; Hughes et al., 2006; Leung & Price, 2007; Leung et al., 1999; Luck, Waller, Meyer, Ussher, & Lacey, 2005; Unoka, Tölgyes, & Czobor, 2007; Vitousek & Hollon, 1990; Waller, Ohanian, Meyer, & Osman, 2000). Likewise, preliminary research reflects that maladaptive modes are more pronounced amongst patients with EDs compared with controls whilst, conversely, the healthy modes are significantly under-developed for the same group (Nesci, J., Redston, S., Snell, M, Kaplan, A, Newton, R, & Cleeve, S., 2014, June). The challenge is to develop a comprehensive treatment model that will address the eating and personality pathology as well as other presenting problems in an intensive, integrated, and focused manner for the purpose of enhancing treatment efficacy and achieving sustained remission (Bruce & Steiger, 2006; Munro, Thomson, Corr, Randell, Davies, Gittoes, Honeyman, & Freeman, 2014; Hinrichsen & Waller, 2006; Leung, et al., 1999, McIntosh et al., 2016).

The only RCT study to have been completed that investigated the efficacy of ST for the treatment for the EDs demonstrates it to be as effective as the more recognised existing treatments (McIntosh et al., 2016). Other

studies have involved group ST (Simpson, Morrow, van Vreeswijk, & Reid, 2010), but it is individual case studies that have allowed for the exploration of the subtle details of the therapeutic process and the overall response to ST. Yet, there still remains paucity in the investigation of the efficacy of ST for EDs, despite many of the techniques and therapeutic strategies integrated into the ST model having been demonstrated to be very effective in addressing EDs. In light of the many personality, interpersonal and other adjunct psychological problems experienced amongst patient with EDs, it is Simpson (2012) who has been the most active clinician-researcher in developing a ST mode model for this psychiatric population. Amongst other researchers, she has observed the most common EMSs and schema modes evident within this psychiatric population; observing the interplay and sequences of child, adult and select coping modes, and appreciating the centrality of the therapeutic relationship to facilitate change. Both Edwards' (2015, 2020) case of Linda, and Simpson's (2020) most recently updated ST mode model for EDs identify AN as a stand-alone overcompensatory coping mode. While Simpson's (2020) "Overcontroller" mode outlines the many ED-related rules and functions of this coping mode, my preference has been to adopt Edwards' "Anorexic Overcontroller" (AnOv). In his case study of Linda, he describes a highly specialised and composite overcompensatory coping mode that evolved out of existing Perfectionistic Overcontroller (PeOv) coping that fulfils multiple functions to avoid broad EMS activation. A core feature of the ST mode model is the conceptual understanding that coping modes serve as survival strategies that, although "functional" in childhood, deny the fulfilment of emotional needs as an individual matures into adulthood. As such, the ST mode model of treatment facilitates the identification and confrontation of the ED as a coping mode with a specific "identity", which can only be made redundant once the DPMs have been banished and the HeAd sufficiently established to provide the Child with the guardianship to foster authentic and spontaneous development. While CBT techniques often help patients gain an intellectual understanding of their EDs and unmet childhood needs, it is with the rich array of techniques and tools available to schema therapists that patients can ultimately engage at a deeper emotional level in order to identify and heal EMSs and thus liberate the Child within.

There is value in Pugh's (2015) call for RCTs to provide robust quantifiable evidence for the efficacy of ST for treating EDs. However, it is no less imperative that systematic case studies contribute to an accumulating knowledge base, because, as Hilliard (1993) explains, only this method of research allows a spotlight to be cast upon the delicate therapeutic process that unfolds in therapy. While the individual cases outlined above by Edwards (2015; 2020) and Simpson (2020) have already demonstrated to be invaluable building blocks towards a foundation of clinical theory, the intensive systematic individual case study that forms the basis for this thesis aims to contribute further evidence for the meaningful role that this relatively new model of therapy can make towards treating AN and the broader spectrum of EDs.

Nine of the ten participants across a broad spectrum of EDs who were recruited for and completed this study made meaningful progress and provided valuable insight in the application of the ST mode model for their

respective EDs. However, it was only due to the length limitations for this thesis that Alison was eventually identified and presented as an intensive systematic individual case study. She was a woman in her mid-sixties when the study began, and she had a longstanding history of restrictive anorexia nervosa (AN-r) that started in her twenties. She was written up because the treatment well-illustrated many valuable aspects of ST, whether with favourable response or challenges that needed to be addressed. The case study analyses the 100 ST sessions that she received over an approximately two-year period. A brief description of the therapy narrative, the three chapters that address the three broad reading questions, and the final chapter that addresses the significant observations of the therapy is outlined next.

SYNOPSIS

CHAPTER 1: SCHEMA THERAPY

The first of four chapters that review the existing literature focuses on the development and basic theory by which schema therapy has evolved. This chapter is divided into eight sections, of which the first addresses the development of ST. It describes how Schema Therapy (ST) emerged some decades ago as an assimilative integration primarily anchored in cognitive-behavioural therapy (CBT), but drawing on influences in attachment and object-relations therapies, as well as Gestalt and experiential therapies. Its developer, Jeffrey Young, sought a treatment model for patients who were unresponsive to the existing treatments. With a strong emphasis on case conceptualisation, this model incorporated relational perspectives and experiential techniques, and strongly emphasised the concept of multiplicity in terms of which the self is functionally divided into parts that are in conflict with one another. ST expanded globally, especially into Europe, with a growing body of research cementing its credibility. The next section outlines Young's development of early maladaptive schemas (EMSs) as a central component of ST development, and a means by which to explain psychological conditions, especially personality pathology, being sourced in painful early childhood emotional experiences, trauma, lack of limits and unmet core needs. The 18 EMSs across five distinct domains are described in detail. The next section focuses on the deprivation of human needs and how this results in the formation of EMSs. The next section addresses schema coping, which has often been compared with Freud's psychoanalytic concept of defence mechanisms. With examples, this brief section outlines the three different categories of maladaptive coping styles by which an individual might respond to the threat of EMS activation. The next section outlines the rationale behind the more recent development of the schema mode model that can better manage difficult cases where there is multiple and, sometimes, simultaneous EMS activation. This is typically the case for patients with complex personality pathology like narcissistic and borderline personality disorders. With an abundance of research and the model becoming increasingly adopted amongst therapists, so its organic nature has revealed an expanding number of modes being recognised across the four main categories of modes, namely child modes, dysfunctional parent modes, coping modes and healthy modes. These are described as well as the nature of mode interaction. The mode model's emphasis on a thorough assessment, the identification of treatment goals and the building of a case conceptualisation is also outlined in this section. ST Treatment Tools and Techniques forms the next section, outlining how ST draws on a combination of cognitive, behavioural, emotion-focused and relational interventions. While the many tools and techniques used in CBT are invaluable to schema therapists, the hallmark of ST is the emphasis placed on gaining deep access to the patient's emotional world. This is where emotion-focused techniques, especially imagery, and transformational chair work are central to ST. Many of the cognitive and behavioural tools are outlined, including the influence of the "third wave" of CBT, where mindfulness techniques are being increasingly utilised by schema therapists. The penultimate section addresses the importance of the

therapeutic relationship in ST, outlining how it lies at the heart of both the assessment and change phases of ST treatment. The importance of therapist empathy, warmth, kindness and authenticity are emphasised, while the cornerstones of limited reparenting and empathic confrontation are outlined as central to the therapy relationship fostering change. The final section of this chapter addresses the Effectiveness and Efficacy of ST, outlining where research has bolstered credibility in the arenas of personality pathology and select Axis I disorders. Not only have single case studies provided detailed accounts of the ST model at work, but an increasing number of randomised control studies on personality disorder populations has provided more substantial empirical evidence for the efficacy of ST.

CHAPTER 2: EATING DISORDERS

This chapter familiarises the reader with the diagnostic category of eating disorders (EDs). While the broader spectrum of EDs is discussed, this chapter predominantly focusses on AN, due to the analysis being the focus of one intensive case study; that of a woman with restrictive Anorexia Nervosa (AN-r). The chapter includes seven sections, the first of which views the historic context of EDs. This short section describes the historic emergence of AN as a psychiatric diagnostic entity in the late nineteenth century and also describes the concept of "Holy Anorexia" in the Middle Ages. Such fasting by nuns is described by some psychiatric historians as resembling the diagnostic entity coined some centuries later, while others view it as an analogous phenomenon. It is relevant in light of the case study presented and the religious influences of her upbringing. The next section looks at the definition and diagnostic features of EDs, outlining the DSM-5 (APA, 2013) definitions and diagnostic criteria for the three main Feeding and Eating Disorders category diagnostic entities, namely AN, Bulimia Nervosa (BN) and Binge Eating Disorder (BED); AN receiving the primary focus. The many co-morbid conditions that accompany AN are also outlined. Finally, the issue of diagnostic fluidity is explored with the transdiagnostic notion of a continuum of related ED conditions having already been repeatedly proposed and debated. The next section cites the major EDs prevalence rate studies, especially for AN, while the limited number of South African prevalence studies are also cited. The next section discusses the medical complications associated with EDs. For patients with AN, serious medical complications are common, with many of the physical signs and symptoms being secondary to the starvation state. The myriad of signs and symptoms are outlined. Special attention is given to the effects of amenorrhea and the cognitive fall-off associated with significant weight loss. Mortality rates are also outlined. The next section outlines the many psychiatric and psychological conditions that are co-morbid to EDs, especially AN. Besides Axis I conditions like depression, the focus is predominantly on co-morbid personality pathology on Axis II. The section also challenges the existing psychiatric model of viewing a conglomeration of distinct diagnostic labels in an individual, but rather to consider the value of the ST model's concept of identifying an individual's EMSs and modes as a preferable means of comprehensively understanding that individual's psychological problems. The next short section outlines the development and typical course of EDs, including the

rates of remission. While this thesis provides one intensive case study of AN, the other EDs are briefly outlined due to the fluid manner in which individuals can shift between diagnostic entities. This further points to the caution of viewing EDs as isolated, and rather viewing them transdiagnostically. The causes of EDs are the subject of the next and final section of the chapter, comprehensively outlining the plethora of research on the causes of EDs. The biopsychosocial model is central to understanding the broad causes of AN, and it is this integrative conceptualisation of AN that has remained the most widely recognised model since the 1980s. Fifteen distinct predisposing, precipitating and perpetuating factors that account for the development and maintenance of AN are thoroughly discussed.

CHAPTER 3: TREATING EATING DISORDERS

Despite the most effective current interventions still failing to help a significant portion of patients across the EDs diagnostic spectrum, it is acknowledged that significant progress has been made over the past few decades in the development of evidence-based psychological treatments for EDs. This chapter reviews the most historically significant, relevant and efficacious treatments for EDs developed to date. Starting with the psychodynamic models, early explanations of AN were purely interpretative and viewed through the lens of hysteria. Towards the middle of the 20th century, however, more interventive models were developed that drew on attachment theory and the emphasis on internal object relations, thus bringing the struggle for autonomy into focus. Where these theoretical frameworks are well integrated into ST, it is considered as a relevant treatment model for EDs. Interpersonal Psychotherapy (IPT) further demonstrated the important role that interpersonal relationships play in the aetiology and maintenance of EDs. It was IPT that significantly influenced Fairburn's development of cognitive-behaviour therapy (CBT) for the treatment of EDs. This most efficacious model is comprehensively outlined and demonstrates the shift from interpretative models to more manualised interventions to disrupt dysfunctional eating behaviour, the irrational thoughts that govern abnormal eating behaviour, and irrational thought patterns around food, weight and body shape. Dialectic behaviour therapy (DBT) for EDs demonstrated the valuable shift towards affect-regulated models. Breaking from viewing EDs as distinct diagnostic entities, Fairburn's transdiagnostic model for the treatment of EDs receives special attention because it acknowledges themes that are pertinent to ST, like perfectionism, low self-esteem and dysregulated mood. The chapter goes on to review the important role of family therapy and the importance of addressing relational issues and parental support. Finally, the experiential therapies are reviewed, where emotion-focused therapy (EFT) addressed the ED sufferer's intense fear of emotion and the evasion thereof. EFT also emphasises the importance of the therapeutic relationship, where the therapist's empathy is central to recovery. Motivation for change theory is briefly discussed, where the transtheoretical stages of change model and motivational interviewing for EDs are outlined. The final section of the chapter reflects on the evaluations performed on these numerous ED treatment

frameworks and models, with enhanced CBT (CBT—E) demonstrated to be the most efficacious treatment model to date.

CHAPTER FOUR: SCHEMA THERAPY FOR EATING DISORDERS

The fourth and final chapter that reviews the existing literature reflects on the efforts that have been made in the application of ST for the treatment of EDs. It begins by reviewing the numerous studies that explore which negative core beliefs and EMSs are typically carried by different ED patient groups. The next section outlines all the existing ST models for EDs, starting with Waller's schema-focused CBT model. More recently, the mode model has been adapted to treating EDs, where Simpson's 5-phase mode model has been comprehensively outlined. Edward's (2015) intensive case study of Linda is then discussed, where the "Anorexic Overcontroller" as a specialised and composite coping mode first appeared in the literature. Munro's mode model for the intensive treatment of AN is the third ST mode model to be included for discussion in this section. The pilot study for a group ST model for EDs developed by Simpson and her team is then outlined. The final section of the chapter outlines the call for further research; the motivation for this study.

CHAPTER 5: METHODOLOGY

The methodology chapter begins with outlining the research project objectives and a reasoning for the thesis focussing on one intensive case instead of the ten cases that were analysed. The next section deals with making a distinction between research and clinical methodology. The chapter then goes on to draw the distinction between nomothetic and idiographic research methodologies, the latter of which is typified by the focus on qualitatively rich patterns of human transactions in particular cases. Different qualitative methodological approaches to research are then outlined that finally brings the systematic case study method into focus. It is defined, after which the benefits of the case study method to practicing therapists are explained. It was also important to address the challenges of my coexisting roles of therapist, researcher and author. Thereafter, the pragmatic case study model is outlined, after which the interpretative phenomenological analysis (IPA) as a methodological framework is discussed to demonstrate how one case is widely accepted as a legitimate study in itself, with Smith (2004) pointing to the fact that a detailed analysis of a single case may well be justified if rich and meaningful data has been collected. For a patient undergoing psychotherapy, the IPA researcher would, thus, seek to understand the entire therapy experience from the patient's perspective and, through interpretative activity, make sense of the patient's entire experience. The importance of reliability and rigour in case study research is thoroughly address in the next section, after which ethical and moral considerations in the case study method are discussed. The focus then turns to the sample that I selected for this study, where inclusion criteria, the recruitment method and the screening interview are explained. The sample for the study is described, after which the clinical methodology of the use of the schema mode model in my intensive case study of Alison is explained. I outline the

assessment phase, diagnosis, case conceptualisation and the treatment phase. I go on to describe my own experience and expertise as a clinical psychologist. The chapter then describes the ethical considerations in this particular case study. Thereafter, I describe my numerous sources of data collection, including a description of each of the 18 questionnaires and surveys that were used during the study to gather important information and clinical data. I describe the details of a therapy evaluation interview that was conducted by an independent third-party psychologist with each of the research participants that completed the study. The penultimate section describes the data condensation phase before the final section outlines data interpretation.

CHAPTER 6: THE THERAPY NARRATIVE

This chapter was divided into four sections, the first of which provides a 5-page biographical summary of Alison to orientate the reader with Alison's childhood and home life, the circumstances behind the onset of her AN, the treatment she received and the remainder of her adult life, during which she married and had a son. The second section provides a DSM-5 diagnosis, after which Alison's mode map is illustrated. The final section involves a detailed therapy narrative, where most of the 100 sessions that defined the study period are described in chronological order. Each session or group of sessions outlined culminates with a short interpretative discussion.

CHAPTER 7: RESULTS

This chapter provides the results of all the pertinent measures that were used in the study, whether as part of the assessment and to gather baseline scores, or at the completion of the study, or at the 5-year follow-up, for comparison. Results are assigned to sections according to a theme, beginning with EDs measures. This includes a body mass graph of Alison's weight preceding the CBT-E until the end of the study, as well as a comparison of scores for ED measures pre- and post-study and at the 5-year follow-up period. Other sections include measures of shame; depression, anxiety and stress; efficacy of therapy; the quality of the therapeutic relationship; and, finally, all ST questionnaires and inventories. Tables and graphs are extensively used to provide a good visual summary of results.

CHAPTER 8: BUILDING THE HEALTHY ADULT/VULNERABLE CHILD DYAD

This is the first of three chapters that address three key reading questions. In this chapter, I explore the processes by which Alison developed her Healthy Adult (HeAd) mode; its primary purpose being that of fostering a secure dyadic relationship with the VuCh. I start by outlining the early definition as well as the functions and qualities of the HeAd mode. While this is a schema mode that was largely absent from the literature, there has been a more recent and deserving proliferation of publications to help us better understand this important mode. I give special attention to Bernstein's (2020) recent efforts in outlining the many qualities of the HeAd as well as the strengths that it possesses. The bulk of the chapter is a chronological account of the processes and challenges that were

faced in the developing of Alison's HeAd mode and the manner in which it served to bring healing to the Vulnerable Child (VuCh). Selected extracts are provided to bring this process to life. A summary discussion follows each section that outlines an important development in the HeAd/VuCh dyad.

CHAPTER 9: ENGAGING THE ANGRY CHILD

This chapter addresses the second of three key reading questions. It explores what hindered Alison's access to the Angry Child (AnCh) and by what processes she ultimately gained access to this severely suppressed mode. While the majority of the 100 sessions that were analysed for the purpose of this research showed evidence of anger in some form, only selected extracts from those sessions that most significantly highlighted the process by which anger was therapeutically addressed and encouraged into full and healthy expression are included in this chapter. Seventeen sections highlight either a specific session or a group of sessions, and all include extracts and close with a brief summary discussion. The chapter closes with a broad summary.

CHAPTER 10: IDENTIFYING AND DISMANTLING THE ANOREXIC OVERCONTROLLER

This is the feature chapter of the thesis and explores the reading question that asks whether there is a legitimate place in ST case conceptualisation for a specific stand-alone coping mode for AN sufferers; the Anorexic Overcontroller. The chapter begins with a historic review of researchers and clinicians who have already identified anorexia as having a distinct voice and associated functions. Beginning with Bruch's description of an internal critical voice in the late 1970s, I go on to outline a growing number of schema therapists that have more recently provided labels for the voice of anorexia. The emergence of Alison's ED is outlined in the context of her EMSs and then briefly described to familiarise the reader with her particular struggle with anorexia over the decades. The next section outlines eight distinct functions of Alison's AnOv. First coined by Edwards (2017b) in his case study of Linda, he describes his AnOv as a distinct, highly specialised and composite overcompensatory coping mode that evolved out of exiting modes like the Perfectionistic Overcontroller. This chapter supports the existence of this coping mode, demonstrating its value to both Alison and me as we worked to dismantle it through ST. The last section of this chapter is a chronological account of the ST sessions that effectively illustrated the process of identifying, confronting and dismantling this highly specialised coping mode that had wreaked havoc on Alison's life for more than four decades.

CHAPTER 11: CONCLUSION - REFLECTIONS AND CLINICAL IMPLICATIONS

This, the final and concluding chapter of the thesis, highlights the outstanding elements of the study and outlines the clinical implications of introducing the Anorexic Overcontroller into ST for individuals suffering with AN. Divided into sections and often drawing on information that was gleaned from the post-study interview, this chapter begins with a description of how Alison was a suitable candidate for the study and made the transition

from CBT-E to ST in light of her inadequate response to the former treatment model. Having treated her in both models, I was well-positioned to compare her response to both CBT-E and ST. The next section highlights and illustrates the importance of case conceptualisation and the significance it played in not only preparing Alison for ST, but how it served as a valuable road map around which the therapeutic process could unfold. The next section reflects on the measurable changes in the strength of schemas and schema modes, also demonstrating how modes cannot be viewed in isolation, but how there is always a complex interplay between them, whether child modes, parent modes, coping modes or the HeAd. The next section highlights the importance that emotion-focused work played in bringing Alison's modes to life. I reflect on how chair work and imagery enabled Alison to engage powerfully with her modes. The next section reflects upon the findings of chapter 8 that makes the establishment of a sturdy HeAd mode a significant foundation for therapy and a central component in ultimately dismantling the AnOv coping mode. The next section reflects on chapter 10 that demonstrated the significant value to be derived from assigning a stand-alone coping mode to AN. By creating a specific mode for this Axis I condition, it is shown how Alison benefitted from bringing to a single point everything that related to her drive for starvation. Bringing the AnOv onto Alison's mode map facilitated Alison's understanding of the functions her ED served, and how this helped her to more clearly see the illusory benefits that this complex coping mode served. This case study provides a strong argument for more schema therapists working within the ED field to conceptualise their patients' EDs as a coping mode. The next section reflects upon the benefits of the nature of the therapeutic relationship in ST. The section not only outlines Alison's thoughts about the relationship that she expressed in the post-study interview, but also my own experiences of how this therapy relationship differed markedly from the therapy relationship when we were using the CBT-E model. I describe how the therapeutic alliance was built and reflect upon how my own experiences of greater self-disclosure enhanced the resonance of our therapy relationship. The next section is included to emphasise the manner in which ST engendered a capacity for deep emotional connectivity. Reflecting upon her ST experience, Alison expressed how ST brought her into closer contact with her suppressed emotion, whether positive or negative. This demonstrates the centrality of emotional connection in ST and how such emotional engagement is critically important in the healing process. The penultimate section reflects on the views of the patient participants' views in the post-study interview conducted by an independent psychologist, while the final section reflects my closing thoughts.

CHAPTER 1: SCHEMA THERAPY

1.1. The Development of Schema Therapy

1.1.1. The Birth of Schema Therapy

Schema Therapy (ST) emerged from a trend more than three decades ago towards the development of more integrative therapies. This was attributed to the fact that clinicians were trained in predominantly one of either cognitive behavioural therapy (CBT), psychodynamic, humanistic or the experiential therapeutic frameworks, and thereby limiting their capacity to treat a broader range of patients and the complexity of problems they encountered in clinical practice (Dattilio, Edwards & Fishman, 2010; Edwards & Arntz, 2012). ST emerged as an adaption of cognitive therapy (CT), drawing also on the well-established frameworks of attachment and object-relations therapies, as well as Gestalt and experiential therapies. It belongs in the category of "assimilative integration"; anchored in a primary theoretical orientation while carefully integrating techniques and principles from other orientations (Castonguay, Eubanks, Goldfried, Muran & Lutz, 2015). It was developed predominantly by Jeffrey Young from the mid-1980s due to his interest in cultivating a more effective way of working with difficult and challenging cases that were clearly unresponsive to the existing short-term cognitive therapies. The initial publications on ST from the early 1990s largely focused on patients with personality pathology (Young, 1990) until, a decade later, Young and his colleagues published the first ST manual (Young, Klosko, & Weishaar, 2003). Adding to his existing cognitive and behavioural training, Young incorporated relational perspectives, experiential techniques, and strongly emphasised the concept of multiplicity in terms of which the self is functionally divided into parts that are in conflict with one other (Edwards & Arntz, 2012).

Although Beck's CT is associated with therapy that is brief, manualised, and highly technical, his practical approach to working with patients never entirely relinquished the influence of his psychoanalytic training. In particular, the centrality of case conceptualisation as a basis for treatment planning has always been a hallmark of Beck's approach. Furthermore, CT was already essentially an integrative therapy through Beck's exposure to and influence from client-centred therapy and transactional analysis (TA), as well as his access to the phenomenological and existential writers. Beck's CT also integrated the practical aspects of behaviour therapy that had been expanding since the 1970s, and it was the integration of behavioural and cognitive components that led to the emergence of the term "cognitive-behavioural therapy" (CBT), which was first referenced in 1969 by Albert Ellis.

The second important aspect of ST is its focus on interpersonal and relational aspects of therapy. While CBT has never relinquished the importance of developmental analysis in case conceptualisation, the central focus of CBT is on the careful analysis of the immediate maintaining factors of a patient's problems (Edwards & Arntz, 2012). It was Beck's exposure to Carl Rogers' notion of a therapeutic relationship, characterised by unconditional positive

regard, empathy and authenticity, that influenced Young to make the nature of the therapeutic relationship one of the hallmarks of ST. This is evident in two central features of the therapeutic relationship in ST, both of which are discussed in more detail later, namely, the therapist's provision of "limited reparenting" and a style of "empathic confrontation" that best ensure that the patient feels securely guided and challenged in the therapeutic healing process. The work by Guidano and Liotti (1983) was particularly influential on Young. These authors integrated the developmental concepts of Piaget with Beck's CT and Bowlby's attachment theory to address problematic cases, including cases of EDs (Edwards & Arntz, 2012). Edwards and Arntz (2012) point to the central influence that other relational therapies have had on the development of ST, whether it be Sullivan's (1950) interpersonal theory or the work of object-relations theorists like Klein, Kernberg, Mahler and Kohut (Cashdan, 1988). The subsequent research and clinical theory that explored the relationship between disturbed attachment and PDs (Brennan & Shaver, 1998; Perris, 1999; Liotti, Pasquini, & Cirrincione, 2000) became central to the development of case conceptualisation in ST. All these theorists shared the view of the significance of interpersonal or relationship schemas that determine representations of self and other in relationships and influence interpersonal behaviour. They maintained that the healthy and adaptive development of such relationship schemas required a safe social environment and, most importantly, a healthy quality of relationship cultivated by primary caretakers. Conversely, such relationship schemas would become dysfunctional if the primary caretakers were emotionally depriving, inconsistent or abusive. The consequence would be that individuals would struggle with affect regulation, while their interpersonal schemas would impact negatively on interpersonal relationships, including the therapeutic relationship.

A third important component of ST is the incorporation of experiential techniques. These play a central role in promoting change at a deep emotional level. This is particularly important, given that Greenberg and Safran (1984) demonstrated the independence of rational, language-based cognitive systems from systems associated with emotion. Teasdale (1993) incorporated this into his "Interacting Cognitive Subsystems" model and argued for a distinction between a rational, "propositional" encoding of meaning, and what he called "implicational encoding of meaning" in the emotional systems. He argued that often meaningful change could not be achieved without accessing the implicational system by means of experiential techniques. In fact, Beck (1985) acknowledged much earlier that verbal introspection and rational analysis was insufficient to access schemas built from early childhood experiences, and he realised the value of imagery in modifying and guiding fantasies to promote therapeutic change (Beck, 1970). Young's own consultations with a gestalt therapist in the mid-1980s led to his realising the immediate and substantial impact of imagery techniques. Incorporating these in a systematic and structured way into ST, he now had a vital component with which to help the many patients who had been unresponsive to standard CT interventions. Also, at this time, Edwards (1989, 1990a), Layden (Layden, Newman, Freeman, & Morse, 1993) and Smucker (Smucker, Dancu, Foa, & Niederee, 1995) were successfully incorporating these techniques into CT to treat various conditions. Lazarus (1985) also integrated gestalt methods, such as the empty

chair technique, into multimodal therapy, while Greenberg and Safran (1987) further developed imagery/dialogue methods as a central aspect of emotion-focused therapy (EFT). Arntz and Weertman (1999) drew together many of these developments in describing the use of imagery rescripting and psychodrama techniques for patients with personality pathology associated with emotionally entrenched early childhood memories.

While many of the early publications on ST profiled difficult cases of patients with significant personality pathology (Stein & Young, 1992) and "characterological problems" (Bricker, Young, & Flanagan, 1993; Young & Lindemann, 1992), conceptualisations were subsequently developed to address more specific conditions such as narcissistic PD (NPD; Young & Flanagan, 1998), addiction (Ball, 1998; Ball, 2007; Ball, Cobb-Richardson, Connolly, Bujosa, & O'Neall, 2005; Ball & Young, 2000; Pauwels et al., 2013), BPD (Farrell, Shaw, & Webber, 2009; Giesen-Bloo et al., 2006; Kellogg & Young, 2006; Nordahl & Nysæter, 2005) and EDs (Luck, Waller, Meyer, Ussher, & Lacey, 2005; Waller, Kennerley, & Ohanian, 2007). By the late 1990s, ST had its own distinct identity, whereby interventions in the treatment were based on an understanding of the patient's distinct EMSs, their dysfunctional schema coping methods, the developmental factors that led to their formation, and how behaviour impacted on the core arenas of the individual's life, including their influence on the therapeutic relationship.

1.1.2. The Expansion of Schema Therapy

The ST model grew into Europe through the collaborative work of Arntz and Young, where the former was determined to develop new methods with which to help patients with borderline personality disorder (BPD), a personality pathology profile considered by many to be untreatable. Encouraged by the work of Edwards (1990a, 1990b), Arntz incorporated experiential techniques into his expanded form of CT for BPD to hold the view that such individuals should be seen as experiencing the world as through "little frightened children who felt abandoned in a dangerous world where nobody could be trusted" (Edwards & Arntz, 2012, p.16). Realising the similarity of their models for the treatment of BPD, Arntz collaborated with Young in the running of a three-year randomised controlled trial (RCT) conducted in the Netherlands. In this study, ST was compared to transference-focused therapy (TFT). The results of the study demonstrated ST to be twice as effective as TFT, more cost-effective and having a lower drop-out rate (Giesen-Bloo et al., 2006). ST thus grew in stature as an evidence-based treatment within the clinical and scientific community. While the RCT and state funding led to numerous clinicians in the Netherlands being trained in the ST model, the torch spread through Europe, most notably in Germany and the UK, while an increasing number of clinicians in Asia and Australasia became familiar with the treatment model. In due course, ST research cast its net over a wider range of psychological conditions, including patients with Cluster C and other Cluster B PDs, while Bernstein and colleagues explored ST treatments for individuals within the forensic setting (Bernstein, Arntz, & de Vos, 2007). The International Society of Schema Therapy (ISST) was established in 2008 to provide clinicians and researchers with training, workshops, research, certification and the opportunity to network through and beyond a biennial international conference.

The following year saw Farrell and Shaw publish the findings of their RCT to demonstrate ground-breaking success in the provision of ST to patients with BPD within a group therapy setting (Farrell, Shaw, & Webber, 2009). Their respective training in experiential therapies provided a forum within which to explore ways of directly addressing the failed attachment styles and early emotional learning deficits among patients with BPD. Their approach, which they were already developing from the late 1980s, resulted in an integrated model of group therapy for the treatment of BPD, with a strong emphasis on limited reparenting. The model incorporated emotional awareness training, distress reduction training, the instilling of emotional regulation skills, and the identifying and challenging of early maladaptive cognitive schemas (Farrell & Shaw, 1994). When they eventually met Young in 2004, they realised that they had developed a group version of ST in which they, as therapists, were fulfilling the limited reparenting role (Farrell & Shaw, 2010). They had identified that the therapeutic factors of group therapy outlined by Yalom (1995), namely universality, cohesiveness and the forum for the corrective recapitulation of the primary family experience, all impact directly on the main schemas associated with patients with BPD. The design required two therapists to facilitate such groups, with each having a distinct task of ensuring that all group members maintain emotional connectivity, are interrupted of the influence of maladaptive modes, and each helped to gain access to the Child modes and consciously develop the HeAd mode (Edwards & Arntz, 2012).

1.2. Early Maladaptive Schemas

The concept of a "schema" is utilised in a number of disciplines, where it is broadly seen as a structure, framework or outline. It has a rich history in philosophy and psychology, being found in Kant (1724-1804) and Adler (1870-1937). However, it is particularly associated with Piaget (1952), who described schemas at various stages of childhood cognitive development. From a Piagetian stance, and within cognitive psychology more broadly, a schema is understood to be an abstractive memory structure that organises the interpretation of information and subsequent action. Within the literature of CT (Beck, 1967) and psychotherapy it is generally defined as any broad organising principle for making sense of the individual's life experience, or "a pattern imposed on reality or experience to help individuals explain it, to mediate perception, and to guide their responses" (Young et al., 2003, p.6). Whether positive or negative, it's an abstract representation of the distinctive characteristics of an event; a blueprint of its most salient elements.

Young (1994) maintained that some of these schemas, particularly those that result from toxic childhood experiences, lie at the core of PDs as well as milder characterological problems and a host of Axis I disorders. As such, he defined a subset of schemas that he termed "Early Maladaptive Schemas" (EMSs). He defined these as "a broad, pervasive theme or pattern comprised of memories, emotions, cognitions, and bodily sensations regarding oneself and one's relationship with others, developed during childhood or adolescence, elaborated throughout one's lifetime, and dysfunctional to a significant degree" (Young et al., 2003, p.7). These self-defeating emotional and cognitive patterns that result from early developmental damage provoke maladaptive behavioural responses

that are repeated throughout life if not interrupted (Walburg & Chiaramello, 2015). Whether perceived as positive or negative, adaptive or maladaptive, cultivated early or later in life, EMSs serve as a reality-based representation of the individual's environment, and reflect the tendency for "cognitive consistency" in maintaining a stable and consistent view of self, the world and others, however inaccurate or distorted it might be. In essence, they fight for survival, as the comfort and familiarity of their adaptive role in childhood overrides the suffering, dysfunction and limitations they might impose on individuals during adulthood. They largely govern how individuals think, feel, act and relate to others. Paradoxically, they inadvertently lend to the individual recreating in their adulthood an inevitably accurate reflection of the childhood circumstances that were most harmful to them. Young and colleagues remind us that this is what makes them so hard to change. EMSs are also dimensional; in that they are variable in their severity and pervasiveness. The more severe the EMS, the greater the number of circumstances that will trigger it, the more intense the negative affect, and the more enduring the triggered experience is likely to be (Young et al., 2003).

1.2.1. The Origin of Early Maladaptive Schemas

EMSs are the consequence of a child's core emotional needs not being adequately met. Young et al. (2003) consider such needs universal and maintain that a psychologically healthy individual is one who can adaptively meet five core emotional needs. The first and most vital core emotional need is for a secure attachment to others. The second is for autonomy, competence and a sense of identity. The third is for the freedom to express one's appropriate needs and emotions. The fourth highlights the importance of spontaneity and play. The final core emotional need is an appreciation for realistic limits and to exercise self-control. The goal of ST is to help patients transcend the frustration that is derived from a combination of the individual's innate temperament and early environmental experiences towards developing and securing adaptive ways to meet their core emotional needs. Toxic childhood experiences, especially within the domain of the nuclear family, are the principal source of EMSs, while other influences later in life might include peers, school, groups in the community and the surrounding culture.

There are four types of early life experiences that lend to the development of EMSs. The first of these is the toxic frustration of needs, where a young child experiences a deficit of what is good for him or her, like stability, understanding and love. This can result in the development of the Emotional Deprivation or Abandonment EMSs. The second is traumatisation or victimisation, where the child is harmed or victimised. The resultant EMSs could include Mistrust/Abuse, Defectiveness/Shame or Vulnerability to Harm. The third is when the child receives in excess of what is good for him or her due to the parents' failure to maintain healthy moderation. Although the child is rarely mistreated as such, overindulgence or overprotection can interrupt the healthy development of autonomy or limit-setting. As a result, EMSs such as Dependency/Incompetence or Entitlement/Grandiosity might develop. The final type of early life experiences involves the selective internalization or identification with

significant others in which the child selectively identifies with and internalises the thoughts, feelings, experiences and/or behaviours of, most often, a parent. The child's innate temperament is a strong determinant in this respect. A good example would be of a son fighting back at his abusive father; his more aggressive temperament exacerbating his propensity to internalise his father's thoughts, feelings and actions, and eventually becomes abusive himself (Young et al., 2003).

1.2.2. The 18 Early Maladaptive Schemas

Table 1 in Appendix 1 provides a full description of the 18 EMSs, grouped into five categories of unmet emotional needs called "schema domains" (Young et al., 2003), each of which is outlined below. The definitions of these EMSs are mainly derived from clinical observation and consideration, and have been further confirmed in various research studies (Arntz & Jacob, 2013; Schmidt, Joiner, Young, & Teich, 1995). Although we all have schemas of variable intensity, EMSs are considered pathological when associated with pathological emotional experiences and symptoms, or the impairment in social functioning. Patients with PDs invariably score highly on many of the EMSs in the Young Schema Questionnaire (YSQ; Schmidt, Joiner, Young, & Teich, 1995), while individuals leading a more functional life and not fulfilling the criteria for a PD will typically only score high on one or two EMSs. Table 2 in Appendix 2 outlines how the various PDs correlate with the various EMSs and interpersonal problems.

(a) Disconnection and Rejection Domain

EMSs in the "disconnection and rejection" domain are characterised by attachment difficulties and all are associated with a lack of safety and reliability in interpersonal relationships. While an unstable family profile will likely lend to the Abandonment/Instability EMS, abusive home environments are frequently associated with the Mistrust/Abuse EMS. Cold and rejecting families of origin are associated with the Emotional Deprivation and Defectiveness/Shame EMSs respectively, while families isolated from the outside world or individuals ostracised within a school peer environment create susceptibility to the Social Isolation/Alienation EMS. Patients scoring high in this domain are associated with severe damage and have inevitably experienced a highly traumatic childhood. They either avoid intimate relationships or repeatedly experience highly disruptive and dysfunctional intimate relationships (Arntz & Jacob, 2013; Young et al., 2003).

Individuals who suffer with the Abandonment/Instability[1] EMS perpetually anticipate and worry about being abandoned by significant others in their lives. It is common for them to have experienced a significant loss in their childhood, whether a death or parental divorce that results in a parent leaving and ceasing to appear to care about them. They are susceptible to entering into intimate relationships with others who are unreliable and perpetuate

[1] This EMS has recently been reclassified into the Impaired Autonomy domain. This can be considered a blind following of factor analysis rather than psychological analysis. After all, one can see how abandonment/instability can create impaired autonomy, but it is not the result of it.

the schema pattern. Even if the individual is in a stable relationship, an innocuous event (e.g., a partner arriving home slightly later than usual or needing to cancel an arrangement due to an emergency) will likely precipitate powerful, albeit unjustified, feelings of loss or abandonment. Patients with the Mistrust/Abuse EMS frequently feel anxious and threatened and remain suspicious and vigilant to the notion that others will exploit, abuse, hurt, humiliate, manipulate or deceive them. Such individuals often have a childhood abuse history, whether it is psychological, verbal, physical or sexual in nature. Individuals with the Emotional Deprivation EMS seldom feel this schema with much intensity, and often describe their childhood in a neutral light. In fact, it is often their partner who is more alert to the presence of this schema when they struggle to foster an intimate connection with such an individual. They inevitably experienced a childhood devoid of the necessary warmth and loving care to feel safe and comforted. Deprivation is experienced in three distinct ways, namely a deprivation of nurturance due to the absence of affection and care, the deprivation of empathy if ignored or never listened to, or the deprivation of protection due to a lack of guidance and direction from others. The Defectiveness/Shame EMS reflects an individual who frequently feels flawed, inferior, worthless or bad as a result of a childhood filled with intense devaluation and humiliation. Such individuals' feelings of inadequacy inevitably evoke shame and have them believing that they are unlovable or unwanted. This EMS is common among patients with BPD and is often flanked by the Mistrust/Abuse EMS. The final EMS within this domain is Social Isolation/Alienation. Individuals with this EMS feel alienated from others and struggle to feel a sense of belonging with anyone. They feel different to others in the community around them. Many such individuals experienced interruptions in their early socialisation due to living in a foreign language community or being denied access to social settings in which to safely integrate themselves (Arntz & Jacob, 2013; Young et al., 2003).

(b) Impaired Autonomy and Performance Domain

This domain addresses problems related to autonomy and achievement potential. Individuals within this domain feel dependent, insecure and struggle in their self-determination. They are wary that exercising their autonomy will jeopardise important relationships, and they anticipate failure in demanding situations. These EMSs are often acquired by social learning through modelling, most commonly from a family member. Parents that hold too low or too high expectations of their child create a susceptibility to these EMSs, with both extremes leading to problems in the autonomy realm (Arntz & Jacob, 2013; Young et al., 2003).

Individuals with the Dependency/Incompetency EMS perpetually feel helpless and believe they need the support of others to manage their daily lives. This EMS is closely associated with the Dependent PD. While some individuals develop this EMS as a result of being severely neglected and, hence, are always relying on the help of others, other individuals develop it as a result of being confronted with harsh and overly challenging demands in their childhood. This interrupts their ability to develop a sense of competency and the healthy means by which to face tasks. Parents that err to the other extreme, by being overly protective and providing in excess, prevent the

child from confidently cultivating autonomy. Such individuals inevitably remain dependent and reliant upon others. Therapists should consider this EMS when they experience patients who are overly cooperative, friendly and/or enthusiastic, but actually make little progress in therapy. The Vulnerability to Harm and Illness EMS is characterised by an exaggerated anxiety about imminent and sudden catastrophes, tragic events or illnesses. It is no surprise that this schema is inflated amongst those with the diagnoses of hypochondriasis and Generalized Anxiety Disorder. Many such individuals report of a parent or family member who was overly cautious, worried excessively, or frequently warned them of illness or danger. It is also an EMS associated with individuals who have experienced trauma or post-traumatic stress disorder (PTSD). Individuals who suffer from the Enmeshment/Undeveloped Self EMS have a weak sense of their own identity and are very cautious in making decisions without the assistance and reassurance of others. Their enmeshed relationships are experienced as very close and very emotional, and largely viewed as functional by the one with this EMS. Individuals with the Failure EMS feel totally inadequate and believe that they will inevitably fail to achieve anything. They often view themselves as unintelligent, inept, untalented or unsuccessful. Most of these individuals have distinct childhood memories of being devalued, while those who engaged from a young age in perfectionistic and achievement-orientated activities (e.g., playing a classical music instrument or participating in competitive sport) are more prone to developing this EMS. Avoiding demanding situations in order to avoid feeling like a failure keeps such individuals ill-prepared and, ironically, lends to a vicious cycle in which failure is perpetuated (Arntz & Jacob, 2013; Young et al., 2003).

(c) Impaired Limits Domain

Individuals with EMSs in this domain struggle to accept normal limits. Accepting the rights of others, cooperating, maintaining commitments and fulfilling personal goals can be difficult for them. They often present as selfish, over-indulged, irresponsible, reckless or narcissistic. Such EMSs are often learned by direct modelling and social learning. It is common for such individuals to have been overindulged in their childhood, but can also manifest as a defiant rebellion to a very strict upbringing.

Individuals with the Entitlement/Grandiosity EMS view themselves in a special light, have little regard for normal rules and conventions, and loath to be restricted or given limits. This EMS is typically associated with Narcissistic Personality Disorder (NPD). These individuals are often competitive and strive for power and control. Individuals with the Lack of Self-Control/Self-Discipline EMS struggle with self-control and frustration tolerance, and have difficulty regulating their emotional expression and impulses. They have difficulty with tasks that require discipline and perseverance (Arntz & Jacob, 2013; Young et al., 2003).

(d) Other-Directedness Domain

Individuals with EMSs in this domain usually place the needs, wishes and perceived desires of others before their own. While their efforts to meet the needs of others are motivated by the necessity for approval, to maintain emotional connectivity or to avoid retaliation, they lose sight of their own mounting anger and personal preferences. While in childhood they were cautious in following their natural inclination, as adults their needs are directed externally in following the desires of others. The culture within the family of origin is often based on conditional acceptance. These EMSs are often secondary, whereby they are activated in order to cope with the EMSs activated within the Disconnection and Rejection domain. For example, a son who frequently watches his alcoholic father become aggressive while intoxicated will develop the Mistrust/Abuse EMS. However, he chooses to be submissive to his father in order to avoid a possible conflictual scenario (Arntz & Jacob, 2013; Young et al., 2003).

Individuals with the Subjugation EMS typically prioritise the needs and wants of their partner above their own needs, due to feeling coerced. The function of subjugation is usually to avoid conflict, retaliation or abandonment. A distinction is made between the subjugation of needs in which one's preferences and desires are suppressed, and the subjugation of emotions, especially anger. This build-up of anger can then manifest in maladaptive symptoms like passive-aggressive behaviour or uncontrolled rage outbursts, or it can result in psychosomatic symptoms. Individuals with the Self-Sacrifice EMS, on the other hand, actively seek out the needs of others. They do this in order to spare the other individual pain, to avoid guilt, gain self-esteem or maintain an emotional link with someone that they perceive as needy. This EMS often develops in individuals who, when young, learnt to focus on the suffering of others as the only means of maintaining a connection with them. Individuals with the Approval-Seeking/Recognition-Seeking EMS seek approval and recognition from others above developing their own genuine sense of self. Their self-esteem is gauged by the approval or recognition elicited from others. Such individuals often lack authenticity and, instead of listening to their own internal needs and desires, are more preoccupied with social status, physical appearance, wealth or success if it is going to elicit approval and recognition from others (Arntz & Jacob, 2013; Young et al., 2003).

(e) Hypervigilance and Inhibition Domain

Individuals with EMSs in this domain suppress their spontaneous feelings and impulses. At the expense of their happiness and contentedness, self-expression, close relationships and optimal health, such individuals will rather strive to meet highly rigid internalised rules about their own performance. Many such individuals would have experienced a very authoritarian and strict upbringing in which self-control and self-denial would predominate over spontaneity and pleasure. These EMSs are often acquired through reinforcement and social modelling, especially where parents were very preoccupied with their children's achievement and success at the expense of them cultivating important aspects in life, like fun and spontaneity (Arntz & Jacob, 2013; Young et al., 2003).

Individuals with the Negativity/Pessimism EMS are consistently preoccupied with the negative or problematic side of any situation and anxiously anticipate problems everywhere. This schema is often modelled by parents or other significant figures with a pessimistic outlook on life. Others often find such individuals difficult to tolerate due to their worrisome, apprehensive, hypervigilant, complaining and indecisive disposition. Individuals with the Emotional Inhibition EMS are very averse to showing spontaneous feelings, which they eventually dismiss as unimportant and unnecessary. Either their strong emotional expression during childhood was not tolerated or they were exposed to uncontained familial conflict that left them feeling threatened and overwhelmed. It is important to discern whether the individual with this schema perceived emotions as either ridiculous or as threatening. Individuals with the Unrelenting Standards EMS feel perpetually under pressure to meet their highly ambitious goals in order to avoid the threat of feeling shameful or being disapproved of. Denying themselves fun and spontaneity, such individuals find it difficult to engage in any activity that is not achievement-based. They constantly strive to do better in anything they set out to do. Often perfectionistic, highly rigid and preoccupied with time and efficiency, such individuals do not compromise on the high standards they set for themselves, even if such standards are clearly unrealistic. The Punitiveness EMS describes individuals who believe that mistakes, whether made by themselves or others, deserve punishment. This attitude is often learned from others in their childhood (Arntz & Jacob, 2013; Young et al., 2003).

1.3. Human Needs

Lockwood and Samson (2020) and Arntz and Jacob (2013) point to the centrality of the concept of human needs in the theory on which ST is based. They highlight how needs, or the omission thereof, is the main factor in explaining the development of psychological problems, and that EMSs develop as a consequence of needs not being adequately met. This notion is supported by the wealth of research that confirms the correlation between traumatic and stressful childhood experiences and the manifestation of subsequent psychopathology. In fact, Young et al. (2003) identified five broad groups of basic human needs, each of which is accurately mirrored through the five domains of EMSs described above. These are outlined in Table 3 below.

Table 3: The relationship between schema domains and basic human needs (Young et al., 2003)

Schema Domain	Related basic needs
Disconnection and Rejection	Safe attachment, acceptance, care
Impaired Autonomy and Performance	Autonomy, competence, sense of identity
Impaired Limits	Realistic limits, self-control
Other-directedness	Free expression of needs and emotions
Hypervigilance and Inhibition	Spontaneity, playfulness

Recent research by Lockwood and his colleagues on the concept of Positive Parenting Patterns (PPP) has endeavoured to expand on the importance that good-enough parenting plays to ensure that a child's core emotional needs are met. A PPP is defined as a broad, pervasive theme or pattern comprising behaviours, tone, emotions, attitude, beliefs and values as recalled by an adult's memories of his or her interaction with the parents or caretakers that leads to the fulfilment of core emotional needs and the development of a secure attachment, adaptive schemas and adaptive behavioural dispositions (Lockwood & Samson, 2020, p77).

Louis and his colleagues identified seven patterns whereby PPPs are thought to meet core needs and foster positive mental health, namely (i) emotional nurturance and unconditional love, (ii) playfulness and emotional openness, (iii) the support for autonomy, (iv) the granting of such autonomy through the freedom to be the author of one's own life, (v) dependability through being reliably present, and providing guidance and support, (vi) instilling intrinsic worth towards the pursuit of meaningful life goals while being true to oneself as well as being fair and respectful to others and, finally, (vii) instilling confidence and competence by example as parents (Louis, Wood & Lockwood, 2020). These seven PPPs can be seen to form the basis of the process of limited reparenting to provide corrective emotional experiences.

A central goal of ST, as is the case in other humanistic therapies, is to help patients identify their realistic needs, including the need for limits, and to develop the means by which such needs can be met more adequately and appropriately. Equally important is the emotional processing required in order to be able to accept, in adulthood, the needs that were not met during childhood or adolescence. While, to some degree, every model of therapy addresses the patient's needs, ST addresses needs in a very direct fashion via the tools and techniques associated with the many ST interventions. For example, imagery rescripting (see Section 1.6.2a) ensures that basic needs are inserted in the corrective imaginal experience, while dialogues in chair work (see Section 1.6.2b) is an effective means by which to defend and/or consolidate the needs and rights of the patient (Arntz and Jacob, 2013). Psychoeducation is another valuable element of ST in which therapists can discuss with their patients how their unmet childhood needs laid the basis for their subsequent psychological problems, and how the EMSs that they developed for protective purposes during early life actually perpetuate the deprivation of such needs in later life. This is where directive interventions, including homework tasks or behavioural pattern-breaking strategies, can help individuals to appropriately experience their needs being met (Arntz and Jacob, 2013).

What is central to ST, therefore, is the importance of interrupting the perpetuation of EMSs and promoting the healing of such EMSs. They are perpetuated through the primary mechanisms of cognitive distortions and self-defeating life patterns or schema coping styles. Through cognitive distortions, situations are misperceived in such ways that the schema is protected or even strengthened through accentuating information confirming the schema and minimisation or denial of information that contradicts it. Self-defeating behaviour is described by Scher and Baumeister (1988) as an individual's intentional behaviour that will either definitely or likely have a negative

outcome for him or her. They outline three conceptual models of self-defeating behaviour that are distinguished on the basis of intentionality (desiring and foreseeing harm). In primary self-destruction, the individual foresees and desires harm, while in trade-offs, the harm is foreseen, but not desired. In counterproductive strategies, the harm is neither foreseen nor desired (Scher & Baumeister, 1988). The third mechanism, schema coping styles, deserves elaboration.

1.4. Schema Coping

The concept of schema coping has often been compared with Freud's psychoanalytic concept of defence mechanisms (Walburg & Chiaramello, 2015). The latter is described as unconscious mental processes that serve to protect the individual from intra-psychic conflict and their disruptive affects. Bond, Gardner, & Christian (1983) have classified defence mechanisms along a continuum ranging from those considered the most mature to those most immature and distorting. Such defences can change across adulthood and thus may be changed through the process of psychotherapy. The ST concept of maladaptive coping styles describes the manner in which individuals respond to the threat of one or more EMS being activated. Young et al. (2003) have described three distinct categories of coping styles, namely surrender, avoidance and overcompensation. In the first category, surrender, the individual experiences very intense schema-associated feelings and surrenders to the messages of the schema, essentially accepting them. The individual behaves as though the schema was true and that there is no alternative but to tolerate the harsh treatment of others. A typical example of this coping style is the phenomenon by which individuals who experienced severe childhood abuse later tolerate such abuse in their subsequent intimate relationships. Within the therapeutic relationship, patients using the surrender coping style might demonstrate significant dependency or come across as submissive to the therapist instead of focusing on their own needs. Avoidant schema coping is evident when individuals avoid the activation of their EMSs by various means and thus elude the painful emotions associated with such activation as a means of self-protection. Typical examples would include social withdrawal and the emotional avoidance of others. Avoidance may also be sought through the abuse of substances or through self-injurious behaviour in order to becoming emotionally disengaged from the uncomfortable feelings activated by EMSs. Yet another means by which to avoid EMS activation is to remain continuously occupied or stimulated in order to emotionally evade the feelings associated with the threatening schema. Good examples of this would include excessive computer gaming, internet surfing, television viewing or by individuals overworking or overeating. These activities often serve the purpose of reducing anxiety. Within the therapeutic relationship, a good clue that this coping style has been activated is when the therapist struggles to experience an authentic connection with his or her patient. The coping style of overcompensation is very similar to the psychoanalytic defence mechanism of reaction formation (German: *Reaktionbildung*), where emotions or impulses that elicit anxiety, or are perceived to be unacceptable, are mastered by exaggeration or hypertrophy of the directly opposing tendency. So, too, with overcompensation the individual behaves as if the opposite of the

schema is true. Someone with a failure schema, for example, might demonstrate arrogance and boast of real or fictitious achievements. Another example would involve someone with a Mistrust/Abuse schema either behaving in an overly controlled and aggressive manner, or even abusing others in order to avoid being personally threatened or abused. Within the therapeutic relationship, a patient actively using this coping style might dominate or devalue the therapist, leaving the latter feeling controlled, manipulated or undermined (Arntz & Jacob, 2013; van Genderen, Rijkeboer, & Arntz, 2012).

1.5. The Schema Mode Model

In difficult cases, especially those involving patients with complex personality problems, many different EMSs may present alongside a diversity of coping styles. In extreme cases of patients with BPD, for instance, as many as 15 EMSs can be simultaneously active, lending to the rapid changes in mood and behaviour that creates significant emotional instability. This makes it extremely difficult to pinpoint and pursue discrete therapeutic goals (Lobbestael, van Vreeswijk, & Arntz, 2007). It was also noted that certain EMSs and coping strategies were being simultaneously activated. Young blended a number of these EMSs and coping strategies, narrowing down a number of new and more manageable units of analysis called "schema modes" (Young et al., 2003). Eleven such modes formed the basis of the initial schema mode model, developed primarily for treatment-resistant and lower-functioning patients, specifically those with BPD and NPD (Young et al., 2003). Lobbestael et al. (2007) extended the model to include 22 modes, 14 of which are measured by the Schema Mode Inventory (SMI; Young et al., 2008). These modes are based on clinical observations that have emerged from experiential interventions in case-based examples.

Although many of these modes are firmly established in ST theory and used in clinical practice, Edwards (2015) points to the significant variation that exists in both the names and definitions of modes. He cites, for example, that while both Young et al. (2003) and Lobbestael et al. (2007) acknowledge two DPMs, namely the PuPa and DePa, the former describe a "critical" quality residing in the PuPa, while the latter describe the "critical" aspect being associated with the DePa. More recently, Jacob, van Genderen, and Seebauer (2014) describe the "Guilt-Inducing Parent modes" in which the child mode is triggered to feel guilty for not behaving in a manner that adequately meets the needs and expectations of others. Children who experience parentification, especially in adopting adult social and emotional roles too early in life, are very prone to this parent mode. While Bernstein, de Vos, and van den Broek (2009) prefer to use the term "Playful Child" for the Happy Child (HaCh) mode, Edwards (2012) speaks of the "Authentic Child" that describes an integrated child that is not only happy, but also creative, spontaneous and playful. This is akin to Winnicott's concept of the "True Self", which I elaborated on in section 3.2.1. While I have retained the widely used term "HaCh" throughout this thesis, I have increasingly adopted Edwards' description of this integrated child in my daily clinical practice.

Young et al. (2003) describe schema modes as the instantaneous, continuously changing, but dominant states of mind patients find themselves in. Whereas EMSs are stable or "traits" that represent a one-dimensional theme (e.g., Defectiveness/Shame), modes describe a discreet situation or "state" that reflects a constellation of EMSs and coping styles that are simultaneously active. For example, the Lonely Child (LoCh) might comprise the Defectiveness/Shame and Emotional Deprivation EMSs (Lobbestael, et al., 2007). It should be noted that while individuals with PDs might have a large and complex constellation of modes, even healthy individuals engage in coping mode behaviour to some degree. However, a healthy individual will be able to better tolerate an unpleasant situation by holding and integrating concurrent feelings of sadness and anger and would more likely remain adaptive in their behaviour instead of succumbing reflexively to maladaptive coping behaviour (Arntz & Jacob, 2013).

Schema modes seldom operate in isolation. Individuals inevitably have a constellation of maladaptive modes, where one will be active in the foreground at any one time, thus determining their current behaviour. An active mode will eventually be suspended for another mode in the constellation to become the dominant, active mode. This altering of modes can be sudden and abrupt and is referred to as mode "switching" or "flipping" (Lobbestael, et al., 2007; van Genderen et al., 2012). This phenomenon accounts for the rapid changes in thoughts, feelings and behaviour. Edwards (2015) describes the less dramatic flipping between modes in a natural progression through triggering and coping as a "mode sequence." Identifying and targeting a patient's frequent mode sequences provides a systematic means of interrupting the maintenance cycles of dysfunctional behaviour. Mode flipping and mode sequences are analogous to a theatre stage setting upon which stands an individual's constellation of modes. While at any time only one member of the cast is performing under the spotlight, the remainder of the cast is temporarily dormant backstage, but each singularly taking turns to perform under the spotlight. Stiles (1999, p.3) also describes this multiplicity of self in an eloquent manner, explaining how "an emerging understanding considers people not as separate, unitary individuals, but rather as mosaics or communities of different voices". ST provides an ideal platform upon which the discrete voices of this complex mosaic can be distinctly identified and drawn into dialogue, such that the Child can be rescued and be drawn under the safe guardianship of the HeAd.

The list of 22 schema modes that have been identified by Lobbestael et al. (2007) are each described in Table 4 in Appendix 3. These can be grouped into four main categories. The first of these is the Child modes. They are innate and universal, in that all children are born with the potential to develop such modes (Young et al., 2003). When a child's needs are adequately met, such an individual will develop a happy, contented and authentically safe mode, namely the HaCh. They will feel loved, fulfilled, protected, acknowledged, confident, competent, appropriately autonomous, in control, and have the capacity for spontaneity and playful expression. The maladaptive variants of Child modes develop when certain core needs, as already discussed in 1.3., are not met in

childhood. These centre around themes of vulnerability (Vulnerable Child mode), anger (Angry Child mode) and the lack of adequate discipline (Impulsive Child).

The second group, dysfunctional coping modes, corresponds directly with the coping styles of "surrender", "avoidance" and "overcompensation". Patients seldom enter therapy feeling safe enough at the outset to openly express and bring into focus their core pain. It is for this reason that coping modes are the first to enter the therapy room; this is the aspect that serves to protect the core pain. As such, an early goal of therapy is to bring attention to these coping modes, embrace them without judgment and condemnation, but expose them in an empathetic way for the paradoxical role that they play in actually hindering the growth of the Child. Surrendering coping modes submit to core schemas. Surrender is an adaptive strategy in the face of circumstances that are unavoidable or insurmountable. We accept and give into things we cannot change. The most notable of these in the ST literature is the Compliant Surrenderer (CoSu; Van den Broek, Keulen-de Vos & Bernstain, 2011), whereby the patient surrenders by appeasing the needs of others ahead of their own to feel accepted or to avoid criticism, condemnation and conflict situations. The patient essentially surrenders to the EMSs of Emotional Deprivation, Self-Sacrifice and Subjugation. Pessimism (Pessimistic Predictor) and hopelessness (Hopeless Protector) also fall within this category that reflect surrendering to worst-case scenarios; protecting the individual from disappointment. There is a surrendering to the EMSs of Failure, Defectiveness and Pessimism to make their lives more predictable and prepared for what will be inevitable (Heath & Startup, 2020). Edwards (2015) has identified another surrender mode, the Self-Pity/Victim (SPVi), which is akin to Simpson's (2020) Hopeless Surrenderer[2] or Bernstein's (2009) Complaining Protector. This mode complains about insufficient help around patients, who thus canvass for attention around them instead of digging into their internal resources. Avoidant coping modes, on the other hand, aim to steer clear of schema-driven threats to avoid pain. They protect the individual by steering away from powerful emotions (Detached Protector; DePr), challenging situations (Avoidant Protector; AvPr), interpersonal threat (Angry Protector; AnPr), or by creating distractions to soothe (Detached Self-Soother; DeSS) or stimulate (Detached Self-Stimulator; DeST). Overcompensatory coping modes, on the contrary, strive for dominance or control at the expense of other needs. They take the opposite stance in relation to the individual's underlying vulnerability. It might involve needing to feel more important (Self-Aggrandiser, SeAg), powerful (Bully and Attack; BuaA), attended to (Attention and Approval Seeking (AASe) or to feel in control, of which there are a number of overcontroller modes that have entered the literature beyond the list compiled by Lobbestael, et al. (2007). Some of these are the Perfectionistic Overcontroller (PeOv), Paranoid Overcontroller (PaOv), Suspicious Overcontroller (SuOv), Worrying Overcontroller (WoOv), Rationalising Overcontroller (RaOv) and the Scolding Overcontroller (ScOv), amongst others. This list grows as clinicians and researchers propose more such overcontroller modes as distinct stand-alone coping modes. Essentially, all coping modes encompass a broad

[2] Simpson (2016b) previously used the term "Aggrieved Surrenderer" before changing this to the Hopeless Surrenderer in her most recent case conceptualisation for AN.

range of human capacities that have just gone too far; taken to the point where the individual's awareness has become lost and they have resorted to an automatic reflex with the coping mode providing a "solution" that is inevitably a poor fit for the situation. The memory of emotional injury residing in coping modes speak to the VuCh's needs for schema healing. However, they do not bring about lasting or authentic healing, but merely the immediate evasion of such early pain and injury. It is for this reason that therapists should have a validating discussion with their patients about the self-protective developmental function and motives of the coping modes (Heath & Startup, 2020).

The DPMs form the third group and echo the harmful internalised behaviour of the parents or key authorities experienced by the individual during childhood. These introjections of the key adults in a person's life become an integral part of the self. While three distinct dysfunctional parent modes have been recognised – the punitive, critical and demanding parent modes – many clinicians prefer to also specify a distinct guilt-inducing quality in each of these parent modes to give them a distinct identity. Conversely, the preference of some clinicians and researchers has been to amalgamate these three distinct parent modes into one dysfunctional parent mode or, as Simpson (2020) prefers to call it, the "Inner Critic".

The Healthy Adult (HeAd) stands alone in the last group. This mode performs appropriate adult functions, takes responsibility for their choices and actions, and is committed to intentions. In a balanced way, such an adult pursues activities that are likely to be fulfilling in work, intimate and social relationships, and in sporting, cultural and service-related activities. Carl Rogers (1951, 2012) conceptualised this as the "fully functioning person" who, in addition to the abovementioned qualities, also has a capacity for mindfulness, reflective thought, emotional engagement, empathy, compassion and a care for self and others. Cruzat-Mandich, et al. (2015) described this as "authentic selfhood". Such authenticity is also associated with the "Authentic Child" (Edwards, 2012) outlined earlier.

As mentioned earlier, the schema mode model was initially developed for individuals with BPD. These patients are typically characterised by four prominent schema modes. The first of these is the Abandoned and Abused Child (AaAC), a subset of the Vulnerable Child mode (VuCh) given the high prevalence of childhood abuse amongst such individuals. The AnCh is also very prominent, given the centrality of excess and misplaced anger reflected in the criteria for BPD in the DSM-5 (APA, 2013). The strongly featured Punitive Parent (PuPa) is accounted to the harshly dysfunctional family environment in which punishment and rejection were frequent. However, such individuals can spend considerable time in the Detached Protector (DePr) coping mode, which serves a temporary respite from the negative emotions evoked by the other prominent dysfunctional modes (Young et al., 2013). Mode switching is frequently observed amongst such patients as they respond to changes in environmental or internal cues (Lobbestael, et al., 2007). Quantitative studies have verified the prominence of these particular modes amongst individuals with this PD (Arntz, Klokman, & Sieswerda, 2005; Lobbestael, Arntz, & Sieswerda, 2005).

A very similar mode conceptualisation has been created for patients with Antisocial PD (AsPD), but with one additional prominent overcompensatory coping mode, namely the BuaA mode. Bernstein and Arntz (2007) have also identified the AnPr, Conning and Manipulative (CoMa), and the Predator (Pred) coping modes all playing a central role in patients with AsPD. The NPD has also been conceptualised with regards to schema modes. Behind the flamboyant representation of the SeAg coping mode there lies the vulnerability of the LoCh mode who often resorts to DeSS coping behaviours in order to evade loneliness (Young et al., 2003). Arntz and Bögels (2000, cited in Lobbestael et al., 2007) expanded on this model by adding an addition mode, the Enraged Child (EnCh), who will lash out at others as a defence when the inferiority of the LoCh swells. Mode models have been developed for many other PDs, including the Avoidant PD (AvPD), where it is hypothesised that the prominent modes are the Avoidant Protector (AvPr), the CoSu, the LoCh, and the Critical Parent (CrPa).

1.5.1. Case Conceptualisation with the Schema Mode Model

A case conceptualisation is developed at the outset of treatment. This starts with the patient's problems and symptoms, their interpersonal patterns, emotional difficulties and related biographical information. Self-rating inventories like the Young Schema Questionnaire (YSQ; Young & Brown, 1994) and the Schema Mode Inventory (SMI; Lobbestael, van Vreeswijk, Spinhoven, Schouten, & Arntz, 2010), whilst only tapping into a limited number of schema modes, serve as a valuable source of information and an adjunct to the more qualitative information about EMSs and modes that is gathered in sessions during the assessment phase of treatment. Problems and symptoms should be reflected in the mode model, which can be diagrammatically displayed as a "mode map". Enquiring about the goals of therapy is a crucial part of the assessment phase, and often highlights were the EMSs and modes are located. For instance, depressive or anxious feelings typically manifest in the VuCh, while binge-eating and vomiting would most likely be identified as the DeSS coping mode that numbs these difficult feelings residing in the Child. Some symptoms relate to one particular mode. For example, alcohol abuse, excessive exercise or excessive computer gaming would all fall within the ambit of avoidant coping mode behaviour. Sometimes a particular symptom would be assigned to different modes in two individuals or, indeed, even in the same individual. Self-cutting, which is often reported amongst BPD patients, serves as a good example. In one instance it might be a means of manifesting self-punishment, hence, reflecting the PuPa. Alternatively, self-cutting might be used to disconnect from negative emotions, in which case it reflects the actions of the DePr coping mode. The self-cutting might even serve as a Stimulating Self-Soother (StSS) to countering the uncomfortable numbing effect of the DePr. Binge-eating serves as another good example of the way in which a symptom might be operating under different labels. While someone's binge-eating reflects a self-imposed punishment for feeling defective, it is emanating from the PuPa. In another scenario, an individual might binge-eat in order to numb the loneliness or sadness residing in the VuCh, in which case it is the workings of the DeSS coping mode. Arntz and Jacob (2013) have suggested that the patient's affect is often a good clue to ascertain which mode is being

activated. For example, when the anger being displayed seems rather uncontrolled and child-like, and it is clearly being triggered by a situation that is in keeping with a child's protest of their needs not being met, it is likely the AnCh or EnCh. The patient will feel like a child or adolescent while the mode is active. Unlike the AnCh or EnCh, the angry coping modes (AnPr, ScOv and BuaA) do not reflect authentic anger. Instead, the angry expression has a strategic quality in protecting the Child from real or perceived threat. It is thus a secondary rather than primary emotion; an emotional reaction to another emotion, which is a concept described by Greenberg (2006). It is important that the therapist and patient recognise the quality of the affect and the motive for the behaviour in a discrete moment in order to correctly identify which mode is active.

Biographical information gathered during the assessment phase is also valuable in the effort towards building the mode model. Here it is important for the therapist to explore the link between current symptoms and their biography. It is valuable to explore the genesis of a particular schema mode. For instance, is the patient's DePa the direct consequence of overly pressurising parents or teachers, or is it something that was modelled from the parent's own extreme ambition? As such, it is important that the therapist builds hypotheses based on the biographical information volunteered and to explore with the patient in a collaborative fashion whether the expected modes have evolved directly as a result of actions imposed on the child or via observations. In addition to self-report tools and open discussion, diagnostic imagery is another effective means by which to better understand the biographical origins of current emotional and behavioural problems. This is done by asking the patient to imagine a pertinent current problematic situation and then to allow associated memories and images from earlier experiences in their lives to surface. The therapist's role is facilitative rather than directive, with the patient providing as much sensory detail as possible to enrich the connection to the memory (Arntz & Jacob, 2013; Hoffart, 2012). The experience of the memory and in particular the emotions, beliefs and attitudes of the child provide valuable information relevant to identifying EMSs. Another diagnostic focus is on the patient's behaviour within the therapeutic relationship. Arntz and Jacob (2013) maintain that the therapist should assume that the interpersonal patterns of modes displayed in the therapeutic relationship are likely to reflect the patient's broader interpersonal dynamics. The therapist should directly address this in therapy, exploring the extent to which this is consistent with their interactions with others.

As is the case in CBT, ST requires the provision of psychoeducation in order to familiarise a patient with the treatment model. Thereafter, the therapist would be able to engage their patient in a more informed discussion of their most pertinent modes and the implications for treatment. The therapist might provide their patient with a personalised and provisional mode map prepared in advance of the session. However, I prefer an approach in which my patient and I collaboratively construct the mode map on a whiteboard using laminated and magnetised mode labels. Where I reserve a selection from the full collection of mode labels, this collaborative process not only serves to consolidate the psychoeducation process, but also provides an opportunity to discern which of the

modes the patient is confident to acknowledge and which ones they are reluctant to include. It is advisable to first discuss the VuCh modes, followed by the DPMs, as this sequence best ensures that the patient's negative emotions are being validated. This also makes it easier for both the patient and the therapist to then address the coping modes; even though these are often perceived by the patient as threatening or even a criticism being imposed by the therapist, given that these modes are seldom viewed in a positive or functional light. It is advisable to reserve discussion of the HeAd last as it closes the discussion of the mode model on a validating note, confirming that the patient does, indeed, possess a functional element. It is important that the therapist highlights all the important modes in this discussion and does not force the mode model on the patient. This best assures that the discussion remains open and honest for both parties. Where the patient is reluctant to acknowledge their coping modes, it is best for the therapist to find a consensus and to agree to hold a difference of opinion until they address them later in the treatment (Arntz & Jacob, 2013). When addressing the DPMs, patients are quite often reluctant to acknowledge their parents as the source of these modes. They might feel guilty or a sense of disloyalty describing their parents in a negative light and as the source of their emotional pain. This is especially the case where the parent either suffered a mood disorder or substance abuse problem. Here it is helpful to explain to the patient that their DPMs are not a carbon copy of their parents, but that the DPMs merely capture the introjections of early painful experiences at the hands of their parents or other key individuals in their lives.

It is important that the mode model be discussed openly, and that the therapist is attentive to the patient's view for the purpose of preserving the collaborative quality of the therapeutic relationship. The more the patient cognitively identifies with the mode model, the more constructive its purpose serves in not only identifying the goals for treatment, but also instilling hope for the patient and ensuring the best possible alliance in the therapeutic relationship. Once all problems have been identified, it is advisable for the therapist to integrate the problems so that the connection between the various problems can be explored. Again, in a collaborative fashion, the therapist and patient should make the distinction between which problems are primary, which are secondary, and whether maintaining relationships exist between the various problems (Hoffart, 2012).

1.5.2. Treatment Goals for Individual Modes

Once the mode model has been discussed with the patient and they have a good appreciation of the mode concept, each mode should then be linked with the mutually identified treatment goals. This treatment overview is graphically displayed in Figure 1 in Appendix 4. The fundamental goal of ST pertaining to VuCh modes is to help patients to better attend to their own needs. In developing a stronger focus on such needs, care should be taken to establish and strengthen the activities that fulfil important emotional and social requirements. It is important for the therapist to validate, soothe and facilitate the processing of abuse and other negative experiences in the VuCh. The therapist thus provides a model for the caring and nurturing of the VuCh modes. The Angry Child (AnCh) and Enraged Child (EnCh) modes need to be expressed in therapy. Patients should be encouraged to

experience and articulate their anger, something that emerges when their needs are not being met. While such needs should be validated and accepted by the therapist, it is their role to teach patients more functional and appropriate ways of communicating their needs. The general needs of the Impulsive Child (ImCh) and Undisciplined Child (UnCh) should also be validated and accepted. Where patients express these in an exaggerated manner, it is important for the therapist to set realistic limits for these child modes and help patients recognise more realistic expectations regarding their needs. Skills development in discipline and frustration tolerance is valuable in this regard. The main goal with respect to DPMs is to weaken them. They should be vigilantly interrogated and forcefully limited. The therapist must help the patient wane the exceptionally high standards and self-depreciation associated with the DePa and PuPa respectively. Coping modes should initially be confronted with empathy due to the perceived and possibly very real assistance such modes played in helping them tread the turbulent waters during childhood. The influence of these modes needs to be diluted in order for the patient to be able to respond in a more flexible and functional manner in a stressful scenario. The functional modes, namely the HeAd and the HaCh, should be encouraged to thrive in therapy, with their intensity and regularity of activation increased over time (Arntz & Jacob, 2013). Broadly summarised, the fundamental goals of the ST mode model of treatment outlined in the treatment manual by Young et al. (2003) involves the building of the HeAd, the healing of the VuCh, the banishment of the dysfunctional parent modes, and the dismantling or neutralizing of the coping modes.

1.6. Schema Therapy Treatment Tools and Techniques

ST draws on a combination of cognitive, behavioural, metacognitive and emotion-focused interventions. These are now discussed.

1.6.1. Cognitive Interventions

Cognitive interventions largely make use of a wide array of CBT methods, such as reframing, debate around errors of reasoning, and the use of cost and benefit lists in order to test the validity or legitimacy of EMSs and modes. Such cognitive testing aims at helping the patient gain insight into and appreciate a more functional perspective on something that may have been distorted through the lens of a particular schema. For example, a therapist can challenge a schema-congruent error in reasoning when patients with AN are convinced that their lives are more "in control" as a result of their emaciation and weight-reducing behaviour. The VuCh might be absolutely convinced that the coping mode(s) maintaining their starvation state accounts for their lives feeling more stable and in control. In surveying the evidence of their current life circumstances and the true impact of their eating pathology, there is inevitably overwhelming evidence that, despite the deliberate weight control, their lives are far less manageable as a direct result of the effects of starvation. While other patients with AN are particularly anxious in the VuCh, they may feel compelled to frequently weigh themselves, a ritual associated with EDs-related

overcontroller behaviour, to ensure constant control over their weight. While patients may believe this to be beneficial, a cost-and-benefit debate will invariably reveal an intellectual appreciation of the numerous disadvantages and risks associated with this action, and that seldom, if ever, will they experience legitimate value from weighing themselves, especially in reducing anxiety levels. Psychoeducation can also be invaluable. For example, informing a patient with Anorexia Nervosa (purging type) (AN-b/p) about the physiological dangers associated with purging (e.g., oesophageal tearing, prolapsed rectum, oedema), the biochemical dangers of electrolyte depletion (hyponatraemia, hypokalaemia) on the cardiac system, and the deceptively small quantity of food binged upon that is actually evacuated through purging is both helpful and an ethical responsibility of the therapist to outline. In a broader context, it is valuable to educate patients about the normal needs of children, normal emotions and behaviour patterns, and the contrast between a normal and healthily adjusted childhood development and their own. This is due to many patients, especially those with severe PDs, having no clear perspective of how they should have been treated when they were younger (Arntz & Jacob, 2013).

With regards to DPMs, cognitive interventions can be very helpful in addressing issues pertaining to guilt and inadequate parenting. Many patients automatically assume that the abusive or neglectful parenting they received as children was either their own fault or as a result of their own defectiveness. Such misconceptions need to be reattributed using cognitive treatment techniques. For instance, creating external perspectives for patients to re-evaluate their childhood experiences where viewing the same treatment being imposed on another child or their own offspring might create dissonance to their distorted personal perspective. When patients justify their abused childhood to their difficult temperament, whether this is true or not, they need to be educated about the wrongfulness of any parent being negligent or neglectful for this or any other reason. Cognitive methods are helpful in challenging DPMs by, for example, normalising the notion of making mistakes, or explaining the necessity for making mistakes in the process of mastering a skill. While it is important to validate the protective function that coping modes served during a difficult childhood, such pros and cons during the childhood years should be re-evaluated for their current and adult life circumstances in order to expose their obsolete and widely destructive impact. It is imperative that the therapist appreciate the patient's personal experiences, opinions and feelings associated with a particular coping mode in order for the pro-and-con list to be personally relevant to him or her. It is recommended that the pros are discussed first, so that there is always something to validate as a perceived advantage. Of course, the therapist needs to make reference to this list repeatedly throughout therapy, as the dysfunctional nature of the mode is often deeply entrenched and well-disguised through decades of reinforcement (Arntz & Jacob, 2013).

1.6.2. Behavioural Interventions

In the treatment of symptoms and behaviour pattern-breaking, essentially all behavioural therapy techniques can be used. This includes role-plays, homework assignments, exposure techniques, skills training and relaxation

exercises/mindfulness training. Such interventions can be used in conjunction with specific ST tools, such as schema flash cards or logbooks for specific EMSs and schema mode analysis in order to connect a symptom or a specific behavioural problem with the related schema mode(s). CBT treatment techniques such as social skills, assertiveness training and healthy lifestyle practices are frequently employed. Social skills training is useful for the child modes in fostering healthy and supportive interpersonal relationships. DPMs should be fought on a behavioural level by, for example, reducing perfectionism, embracing the normality of making mistakes or failing and engaging in activities that lend to experiencing personal success. Behavioural interventions aim at dismantling patients' temptations to habitually hold onto their coping modes and cultivate more prominence through the guiding influence of their HeAd.

While role-play during the assessment phase can assist in gaining deeper insight into the patient's coping behaviour (Weertman, 2012), it is also a useful teaching aid by which therapists can guide their patients towards more healthy and functional ways of addressing challenging situations in both their current or future circumstances. Homework assignments largely, but not exclusively associated with CBT, hold great value in ST. They provide patients with an accountability to maintain the momentum of attending to tasks assigned to them in their everyday environment outside of the therapy consultation room. They also ensure that progress can be monitored through the provision of concrete records. An example of such a record is the "Schema and Mode Worksheet for Identifying and Breaking Self-defeating Patterns" (see Figure 2 in Appendix 5) adapted by Edwards from Perris & Young (2007). In recent years, a growing number of self-help books and manual guides for clinicians have been published, providing a wealth of worksheets and resources for readers to identify, explore the nature of, and modify their various EMSs and schema modes (Farrell, Reiss, & Shaw, 2014; Farrell & Shaw, 2012; Jacob et al., 2015; Treadwell, Dartnell, Travaglini, Staats, & Devinney, 2016).

As is used extensively in classical CBT, so schema diaries, schema flash cards and other written material is frequently used in ST for the purpose of implementing change in everyday life. The schema diary can provide a conscious alertness to, and recording of, positive or difficult events. The schema flashcard is a very useful tool by which a patient can summarise a typical everyday experience with regards to a particular destructive mode and the particular cognitive and emotional implications. The flashcard then provides an alternative perspective and reparative guidance from the HeAd stance. A standard schema flashcard should open with a typical scenario in which negative thoughts and feelings are evoked in the child mode. The frequently automatic coping response to the triggering of the Child should be written down as validation. Thereafter, a reality-testing towards a healthier and more appropriate interpretation should be constructed. Finally, options or suggestions for a more functional way of coping with the difficult scenario (e.g., emotion-regulation skills, contacting a support, resumption of a prescribed meal plan) are written down for implementation (Arntz & Jacob, 2013). While most patients will write their flash cards on a piece of paper or cardboard to keep close at hand, storing the flashcard on a smartphone or

even making an audio flashcard to listen to on a mobile phone is a useful way of utilising an everyday (and usually very accessible) device. See Figure 3 in Appendix 6 for a standardised template flash card developed by Young (2003).

Reflecting on my own clinical practice of the past two decades, the provision of both psychoeducation and the wide array of cognitive exercises have undoubtedly proven helpful in providing my patients with EDs with valuable insight. However, this very often does not create enough traction to precipitate the necessary motivation to willingly shift away from their extremely dysfunctional and self-deprecating behaviour. As such, it appears necessary for psychotherapy to engage such resistant patients at a deeper EMS level in order for them to consider relinquishing the perceived value of their ED behaviour for an alternative mode of existence. It would thus seem imperative that such patients require therapeutic interventions that would engage their needs at an emotional level that is both safe and tolerable. It is for this reason that ST draws on a myriad of emotionally-based techniques.

1.6.3. Metacognitive Interventions

Metacognitive therapy (MCT), developed by Wells (2008) involves strategies that target the specific psychological processes that control thinking, thus enabling the patient to free themselves from ruminations and worry. Relaxation exercises, for instance, can be brought into the therapy at different times. It is particularly pertinent to introduce when the patient is feeling especially stressed or worried, and less accessible to their HeAd and HaCh. In recent years, ST has expanded to incorporate mindfulness-based techniques to teach patients to view their thoughts, behaviour, emotions and physical experiences without automatically responding to the activation of EMSs and modes. The patient is taught to observe such experiences with renewed interest, as though seeing it for the first time and not attaching a value judgment to it. In this way the patient does not develop tunnel vision but sees several options of how to respond to the given situation (van Vreeswijk, Broersen, Bloo, & Haeyen, 2012). Associated with the "third wave" of CBT, mindfulness counters the powerful impact of schema activation and provides an opportunity to enhance the HeAd influence by switching to a more distanced, self-reflective level of functioning (Roediger, 2012). Bricker and Labin (2012) caution that mindfulness meditation not be taught as a stand-alone technique but be integrated into the fuller and more richly diverse therapeutic experience. Therapists should, however, be wary of the possible danger of patients using mindfulness meditation as a means of avoidance coping mode behaviour. As an example of this, van Vreeswijk and Broersen (2012) caution how the DePr can become heightened through schema mindfulness practices. Segal, Williams, and Teasdale (2002) have also cited potential problems in teaching meditation techniques to psychotherapy patients. For instance, patients are often resistant to such homework and may have a negative or prejudiced attitude to meditation if, for example, viewed as a spiritual practice that is incompatible with their own spiritual/religious belief system. Some patients also have great difficulty coping with the heightened negative emotions that arise from meditation practice. I make use of

two workbooks by Leahy (2003) and Schmidt, Startup and Treasure (2018) that make significant use of metacognitive strategies, the latter of which has specifically been written for AN suffers. *Emotional Alchemy* by Tara Goleman (2003) is another helpful self-help text that integrates ST concepts and mindfulness.

1.6.4. Emotion-focused Interventions

Emotion-focused interventions provide patients with an opportunity to experience and process powerful emotion in order to more intensely focus on their particular needs and goals. For the VuCh, the intention is to assist them towards realising their true value and engage with life with more confidence and positivity. Problematic emotions can also be actively changed through the use of emotion-focused techniques, where schema therapists emphasise the use of imagery exercises (including imagery rescripting) and chair work.

(a) Imagery

Imagery has served as a means of healing for many millennia (Edwards, 2011), and was acknowledged by Beck from the outset of CT to fulfil a crucial role in gaining an understanding of the meanings we attach to personal experiences (Beck, 2004). However, its value has become increasingly recognised, making it one of the most exciting and more recent frontiers in CT. According to Hackmann, Bennett-Levy, and Holmes (2011), it is an exciting and rich domain that holds much promise for both therapists and researchers. Not only has the literature on the topic become increasingly accessible to a wider audience of interested parties, but systematic research has provided evidence-based practice for an array of imagery-based interventions and techniques (Edwards, 2011). While Young and colleagues (Bricker, Young, & Flanagan, 1993; Edwards, 1990; Layden, Newman, Freeman, & Morse, 1993; McGinn, Young, & Sanderson, 1995; Smucker & Dancu, 1999; Stein & Young, 1992; Young, 1990; Young, 1999; Young & Lindemann, 1992) were developing the ST model from the late 1980s and into the 1990s, they provided rich and comprehensive descriptions in the application of imagery-based techniques within the CT framework. These imagery techniques allow for the underlying schemas to be activated, thus intensifying current emotions and linking them with biographical memories. For traumatic childhood memories, imagery rescripting (IR) is the most recognised of these interventions that involves a three-step protocol (Simpson & Arntz, 2019). First, the patient recalls a childhood memory linked to their EMS and describes this in detail from the childhood perspective. In the second step, the relived traumatic or difficult situations are interrupted with a licence to be pliable with the existing sequence of events at an imaginary level so as to correct the traumatic scenario and ensure that the Child's needs are fulfilled. The patient experiences this through the lens of a healthy adult. It is comparative to splicing a film reel, editing the traumatic material and replacing it with new and corrective footage as a means of erasing the originally traumatic event. Ideally, the patient will suggest bringing someone real or imaginary, perhaps even the therapist, into the scene to participate in the corrective imagery. For example, a loving father would be deployed to physically overpower a violent or sexually abusive perpetrator, remove the child from the toxic environment, and provide them with the love and reassurance of safety that he or she needs.

The third step of the protocol now requires the rescripted experience to be viewed through the lens of the Child; experiencing the contrast by which he or she is protected and nurtured by an adult figure. IR should conclude with a pronounced validation of the patient's efforts and ensuring that there is a regulating of the patient's emotional state for him or her to safely leave the session to further integrate this corrective experience into his or her make-up. This protocol has proven effective in transforming trauma images experienced in both childhood (Weertman & Arntz, 2007) and adulthood (Arntz, Tiesema & Kindt, 2007; Arntz, Sofi & van Breukelen, 2013; Raabe, Ehring, Marquenie, Arntz & Kindt, 2018). Such research has demonstrated the strength of IR in reducing trauma through changing the meaning encoded in traumatic memories, whether self-blame, a sense of being wrong or powerlessness.

Imagery exercises are not restricted to the corrective treatment of childhood traumatic events, but can also be used to rescript a neglected or abused infancy, where Simeone-DiFrancesco, Roediger, and Stevens (2015) speak of the manner in which "infant modes" have encoded pre-verbal material, which is experienced physically in the body (Layden, Newman, Freeman & Byers-Morse, 1993). Imagery exercises can also assist in later-life traumas, or even prepare the patient for a forthcoming and anxiety-provoking situation, where rehearsal for achieving desired goals can be refined and tested (Maurer & Rafaeli, 2020).

Another valuable strategy for many patients is the "safe place" imagery (Young et al, 2003), for which the goal is to provide the patient with a place of comfort, support, and relaxation to frequent when feeling unduly anxious, threatened, or stressed. It may be an imagined place, although Arntz (2011) suggests the advantage of using real places and people that are already associations with warmth and safety. The therapist's task is to assist in the construction of this rich and deeply sensual image.

(b) Transformational Chair work

For the purpose of psychological change and transformation, chair work is a powerful, effective and very creative intervention. It is a powerful strategy with which to delineate and "map out" mode relationships and bring the formulation to life. It lends to significant neurobiological activation and, therefore, opens up the potential for lasting change (Kellogg, 2012). Originally developed by Moreno in the 1950s as a technique in psychodrama, it is probably most associated with the Gestalt Therapy work that Frederick "Fritz" Perls developed at the Esalen Institute in California in the 1960s (Perls, 1973). However, chair work as a technique has been drawn into an increasing number of therapeutic models, including Process-Experiential/Emotion-Focused Therapy (Greenberg, Rice, & Elliott, 1993), Redecision Therapy (Goulding & Goulding, 1997), Multimodal Therapy (Lazarus & Messer, 1991), while Edwards (1989) and Pugh (2019) have explored ways of integrating it into CBT. Edwards (1989) holds the view that chair work, like imagery rescripting, serves as a form of cognitive restructuring, while Goldfried (1988) speaks about the way in which chair work can evoke "hot cognitions" or "hot emotions"; in other words, early schema activation. It is thus not surprising that Young made it a central component of ST (Young et al, 2003).

Most of the early chair work involved "external" dialogues in which patients interacted with a person or object outside of themselves, thus allowing them to move from talking about, to talking to. Kellogg (2012) identifies various areas in which external dialogues are particularly useful. For grief, Tobin (1971) laid out the classic gestalt structure of "saying goodbye" in grieving the other in the "empty chair". In the case of trauma or abuse, chair work functions as a kind of "psychotherapeutic theatre". Goulding and Goulding (1997), for instance, developed a structure by which the visualised perpetrator is seated in the opposite chair and confronted by the patient/victim, who shares what he or she experienced, how it affected him or her, and the impact that it has had on his or her life. The goal is for the patient to make a "re-decision" by consciously emerging from the shadow of mistreatment to live in defiance of the abuse. This is very similar to the manner in which EMSs and their origins are fought (Kellogg, 2012). With regards to emotional abuse, patients have the opportunity to place their imagined abuser (alive or deceased) in the opposite chair and confront him or her in a manner that was not possible when younger. This also provides patients with a new sense of authority in expressing their anger. Behavioural rehearsal and assertiveness training have their origin in the behavioural tradition, where Wolpe (1973) originally called this way of working "behaviouristic psychodrama". Assertiveness training helps patients to find and claim their voice, access power and protect themselves within a safe environment.

A primary goal of chair work in ST is to drive schema and behaviour change by shifting emotional responses between different parts of the self for the purpose of meeting the individual's core needs in a healthy way. This is where chair work dialogues are mostly "internal" or intrapersonal, where the interaction is conducted between different schema modes or between an EMS and a healthy and functional side of the patient (Kellogg, 2004). Roediger, Stevens and Brockman (2018) explain how multiple chairs allows the patient to voice conflicting modes, which is conceptually similar to different personalities engaging with each other. With a set of physical chairs, each representing a specific mode, the patient is provided with an opportunity to fully embrace the essence of each distinctive mode that contributes to a mounting dialogue that reflects the multiplicity of the inner conflict. For instance, the therapist supports the patient in gaining access to their sadness and anger by having him or her occupy the separate chairs that represent his or her VuCh and AnCh respectively. Similarly, the therapist guides the patient, while personally occupying their HeAd chair, in confronting, reprimanding and eventually banishing the PuPa that speaks in a highly critical way to the patient's VuCh. The patient might subsequently occupy the VuCh chair to reflect on the guardianship role that his or her HeAd provided. Chair work dialogues are particularly useful in situations when a patient experiences ambivalence, or when an inner conflict needs to be clarified and resolved. It is an ideal forum in which to strengthen the healthy modes and weaken or dismantle the dysfunctional modes at the cognitive, emotional and "felt meaning" levels. Besides clarifying emotional ambivalence and conflict between modes, the goals of ST chair work, which are in line with the general goals of ST, are to validate the Child and, more specifically, comfort the VuCh, allowing the AnCh and EnCh to ventilate and set limits for the ImCh and UnCh modes. Chair work is also a convenient forum within which to question and set limits on the DePa

and confront or banish the PuPa. Similarly, such a forum provides an excellent space in which to reflect upon the pros and cons of, and ultimately diminish, the coping modes (Arntz & Jacob, 2013). Chair work provides an ideal forum in which to confront such dilemmas. Mode dialogues in chair work can assist patients to overcome the damaging impact of their coping modes and draw attention to the core needs that the coping modes were ineptly trying to fulfil.

Although a simple two-chair dialogue can effectively address ambivalence residing between the HeAd and a dysfunctional mode, the schema mode model allows for a broader combination of modes in chair dialogue. Flanagan, Atkinson and Young (2020) provide a beautiful metaphor of the HeAd acting as the conductor of an orchestra, emphasising the inherent strengths of each mode, ensuring that no mode compromises the opportunity for the Child's needs being met. While the dialogue ideally commences with a debate between the DPM and the HeAd, feelings from the various child modes soon emerge, with a distinct chair being added to the circle for each of these perspectives. It is not uncommon for a patient to replace the PuPa chair with the imagined specific person who was central in the development of the DPM during their childhood. In such circumstances the therapist facilitates a dialogue between the patient and this specific historic figure with whom he or she exists, as Perls (1969) and Greenberg (Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995) described it, "unfinished business". Another typical scenario for multiple chair dialogues involves the HeAd challenging and, ultimately, aiming to reduce the influence of a coping mode on the VuCh, the latter of which would reflect how it feels to observe the HeAd disarming the coping mode. While each chair in such exercises represents a distinct mode, it is not always necessary or indicated that the patient literally occupies each chair as that particular mode emerges. In fact, the longer a patient remains seated in a particular chair, the stronger that mode is generally activated. Conversely, the less time a patient occupies a particular chair, the less that mode is likely activated (Arntz & Jacob, 2013). Not only is it important that therapists protect patients from becoming too emotionally overwhelmed in chair work, especially by the effect of the PuPa mode, but it is also important that they ensure that chair work concludes with a healthy mode in the ascendency (Rafaeli et al., 2011). Therapists are encouraged to actively participate in ST chair work, whether participating in the dialogue, playing different modes or debating between the modes. The therapist might, for instance, disrupt the influence of the DePa by turning its chair around to mute its ongoing influence, or even remove the chair or other object representing the PuPa from the room as a symbolic gesture of banishing it from the Child's presence. A valuable task of the therapist is to serve as a positive role model for the HeAd mode, validating and comforting the VuCh in its chair. As the sessions progress, so the therapist might have his or her patient physically occupy the HeAd chair and coach or guide him or her on how to engage with the unoccupied VuCh chair with loving compassion. While the patient occupies the HeAd chair, the therapist might have an excellent opportunity in which to coach his or her patient with instructions on how to confront and possibly banish the PuPa (Arntz & Jacob, 2013).

The research being conducted by Doidge (2015) in the arena of neuroplasticity provides an exciting arena with scientific evidence to explain how conscious habits and actions created through experiential techniques, like the ones described above, lend to being able to repossess those portions of the brain that have been contaminated by DPMs and coping modes that threaten the well-being of the Child (Simpson, 2012).

1.7. The Therapeutic Relationship

The therapeutic relationship lies at the heart of both the assessment and change phases of ST treatment. From the outset, the therapist assesses and treats EMSs, coping styles and schema modes as they arise within the dynamics of the therapeutic relationship. The therapist's engagement with the patient essentially serves as a partial antidote to his or her patient's EMSs. As such, it is the therapist's aim for their patients to internalise themselves as the HeAd, whether imparting to them deliberately or vicariously the language, attitudes and behaviour of a loving parent holding guardianship over their child. Although there is no predetermined or distinct boundary between the different phases of ST, there is merit in viewing the nature and quality of the therapeutic relationship through the different stages of treatment.

1.7.1. Therapy Relationship in the Assessment and Education Phase of Treatment

During the initial treatment phase, the quality of the therapeutic relationship may, in itself, lend to the identification of EMSs and schema modes. In this phase, the therapist looks to establish rapport, formulate the case conceptualisation, assess the style of limited reparenting that is best suited to their patient, and determine whether his or her own EMSs might interfere with, or interrupt, the therapeutic process. With regards to rapport, the therapist should strive to embody the empathy, warmth, kindness and authenticity identified by Rogers (2012) as the nonspecific factors of an effective therapy culture. The therapist needs to create a therapeutic environment that is both safe and accepting, within which both the patient and therapist can form an increasingly trusting emotional bond. A schema therapist needs to be "present as a person" rather than detached, and let their natural personality infuse the room. With the therapist's aim of objectivity and compassion, self-disclosure and a transparency of their own emotional responses is necessary if it is deemed valuable and appropriate to the therapeutic process. While not tolerating abuse, the schema therapist should encourage honest feedback from the patient and not be hesitant to acknowledge his or her own mistakes with appropriate apology. The central role of the therapist is to help empower the patient in the cultivation of a strong alliance with the patient's healthy modes and to challenge his or her EMSs and dysfunctional modes. The case conceptualisation may, in fact, reflect EMSs and modes that are activated within the therapy relationship. As such, these need to be explored and analysed, and ultimately linked to parallel experiences in the patient's life outside of the therapy setting. Such activation of EMSs within the therapy setting is comparable with Freud's (1912) concept of "transference," but rather than tacitly working through the patient's "transference neurosis", the schema therapist openly and directly

discusses the EMSs and modes with the patient. In ascertaining the patient's reparenting needs, the therapist needs to collect a childhood history, provide questionnaires, explore current interpersonal difficulties and make use of experiential exercises to illuminate EMSs and modes. A schema therapist needs to be flexible in order to individualise treatment to meet the patient's specific emotional needs. In cultivating trust, providing stability, being emotionally nurturing, demonstrating forgiveness and encouraging autonomy, the therapist needs to be able to provide whatever is a partial antidote to the patient's core EMSs. As Young and colleagues point out, the therapist would seek, within the confines of the therapeutic relationship, to meet the patient's basic emotional needs of secure attachment, autonomy and competence, authentic self-expression of needs and emotions, spontaneity and play, and realistic limits (Young et al., 2003). Successful therapy will see patients strongly internalising a HeAd mode modelled by the therapist and be capable of challenging their EMSs in order to inspire a fuller and healthy life. Finally, therapists need to be familiar with their own EMSs and modes and ensure that the activations of these with particular patients do not jeopardise the therapy relationship and the progress that needs to be accomplished (Young et al., 2003). In fact, a schema therapist being cognisant of the activation of his or her own EMSs and modes often provides vital clues to the process unfolding within the therapy setting.

1.7.2. Therapy Relationship in the Change Phase of Treatment

During the change phase of treatment, the therapist continues to confront the patient's EMSs and modes within the context of the therapy relationship. Limited reparenting and empathic confrontation are the cornerstones by which the therapy relationship fosters change. These will be discussed separately.

1.7.3. Limited Reparenting

Limited reparenting involves the therapist providing, within the appropriate boundaries of a therapeutic relationship, the fulfilment of the patient's needs that were not met by their guardians or significant caretakers during their childhood and/or adolescence. The therapist is thus required to fulfil the role of a caring parent figure, ensuring that his or her actions are genuine. As outlined in an earlier section (see section 1.3.), Lockwood and Samson's (2020) outlining of the seven patterns of Positive Parenting Patterns provides an excellent blueprint by which limited reparenting can ensure that the therapist's provision of corrective emotional experiences meets his or her patient's previously unmet core needs. Limited reparenting is particularly amplified when compared with the typically more neutral therapeutic relationship stance of the earlier psychoanalytic models and the relationship model of the cognitive therapist in which the therapist plays a more Socratic role (Arntz & Jacob, 2013). However, the empathic stance of unconditional positive regard developed by Carl Rogers is one example of the way in which cognitive therapists have been influenced towards displaying the warmth and care that typifies a schema therapist. In fact, the quality of a therapy relationship in which the therapist provides the patient with "corrective experiences" for the childhood needs that were not adequately met, is not a new concept. As early as the 1920s, Ferenczi (1930) described the importance of therapists providing a parenting relationship in

psychoanalysis. Engaging with the child states through an "infantile conversation", he was describing what he called "the advantages of a normal nursery". From the mid-1940s, Franz Alexander further developed Ferenczi's view in advocating that therapists provide their patients with an emotionally corrective parenting experience that countered the influence of the pathologically critical and punitive parenting experience when younger (Wallerstein, 1995). As the work of object relations therapies grew in influence so, too, the therapeutic relationship increasingly emphasised the importance of patients experiencing security and care within the evolving therapy setting. Transactional analysis (TA) therapists explicitly experimented with the principles laid out by Ferenczi and were the first to use the term "reparenting". In fact, the term "self-reparenting" in TA describes the process by which individuals who received inadequate parenting learned to become healthier parents themselves (Wissink, 1994). In ST, this would describe an aspect of the building of the HeAd, rather than being conceptualised as reparenting, as it does not include both the activation and rebuilding of childhood EMSs.

Limited reparenting is especially relevant for patients who have EMSs in the Disconnection and Rejection domain; EMSs that reflect abuse, abandonment, emotional deprivation and rejection in their childhood. The more severe and frequent the traumatic experiences, the more relevant are the reparenting aspect of the therapy. However, patients who possess EMSs from the other four domains can still experience significant benefit from limited reparenting, where the focus might be on issues of autonomy, realistic limits, self-expression, reciprocity, and spontaneity and play (Young et al., 2003). For a summary of specific limited reparenting strategies for each specific EMS, see Table 5 in Appendix 7. It should be noted that reparenting is "limited" to the extent that the therapist provides an approximation of the patient's unmet emotional needs within the confines of a professional therapy relationship. Limited reparenting described a form of deep emotional engagement from the therapist with his or her patients that is conducive to the safe healing of their EMSs and the cultivation of a more prominent HaCh. Individualising the reparenting style to each patient requires cognisance of their developmental stage where, for instance, a patient with BPD will have more child-like needs, such as stability, safety and trustworthiness. It should be noted that the therapist's task is not to avoid activating the patient's EMSs and modes, but to utilise such instances as significant opportunities for the patient to heal by providing him or her with corrective experiences. Where patients with BPD often struggle for object constancy, they might require more frequent appointments or telephone/email contact outside of sessions that are agreeable to the therapist's professional boundaries. Limited reparenting also includes authentic self-disclosure on the part of the therapist, where responses should be forthright, sincere and honest. Experiential exercises provide valuable opportunities for limited reparenting. It can be woven into guided imagery work, for instance, where the therapist might enter the corrective imagery scene to serve as a healthy figure and meet the needs expressed by the patient. As the patient makes progress through therapy, so the imagery would ideally have their HeAd replacing the therapist's role in providing the needs of the child (Young et al., 2003). Chair work provides another experiential forum within which the therapist can reparent the VuCh until such time that the HeAd is able to fulfil this vital role. Setting

appropriate limits is also an essential aspect of limited reparenting, especially where child modes in which spoiled, undisciplined or other inadequate behaviour patterns are evident.

1.7.4. Empathic Confrontation

Empathic confrontation requires the therapist to engage with an empathic and compassionate understanding for the child residing behind the coping behaviour. In a non-judgmental way, the therapist is required to convey an explanation as to why patients perpetuate their schema-driven behaviours, while simultaneously clearly confronting their self-defeating impact. In clearly identifying the dysfunctional means by which patients attempt to meet their needs, the therapist provides the necessary guidance to help them meet their needs in a healthier way. Empathic confrontation is not a technique, but more a stance taken by the therapist towards the patient that demonstrates a genuinely true emotional bond. While the therapist reflects an understanding of the source of the patient's EMSs and reflects how hard it is to change, it is imperative that the therapist simultaneously acknowledges the importance of change by striving to meet an optimal balance between empathy and confrontation to best facilitate change. It is important that the therapist confronts coping behaviour whenever it emerges within the context of the therapy relationships. Without judgment, the therapist should seek the patient's "truth" by enquiring about their thoughts and feelings, making conscious their bodily sensations, exploring their urges and seeking where the identified EMS activation in the therapy context reflects similar experiences in their earlier life. Validating the patient's experience is vital so as to give it a normalised context. Only then should the therapist begin reality-testing by confronting flaws in the patient's viewpoint through gently evoking cognitive dissonance with Socratic questioning or drawing the patient's attention to their self-defeating behaviour. The therapist can then offer an alternative interpretation to the unfolding scenario that may involve self-disclosure if this provides a valuable illustration of the patient's actions. When the patient frequently flips into coping mode behaviour, empathic confrontation is necessary in order to ensure a comfortable balance between validating the urgency for coping mode behaviour and setting limits in a kind and compassionate manner (Arntz & Jacob, 2013). While the need for empathy when confronting a patient is not a new concept, and has been widely written about across a number of psychotherapeutic traditions (Adler & Myerson, 1991; Cashdan, 1988; Leaman, 1978; Kottler, 1992; Miller, Benefield, & Tonigan, 1993; Moyers, Miller, & Hendrickson, 2005; Tamminen & Smaby, 1981; White & Miller, 2007), the term "empathic confrontation" has received renewed prominence since it has featured in the ST literature (Edwards & Arntz, 2012).

1.8. Effectiveness and Efficacy of Schema Therapy

Studies have primarily focused on the two arenas of personality pathology and Axis I disorders. While initial studies on ST focused on the treatment methodology of specific modes associated with BPD (Young, 2005; Kellogg & Young, 2006), the first measure of the effectiveness of ST came from the single-case series published by Nordahl and Nysæter (2005). Analysis demonstrated a strong reduction in the strength of EMSs and improvements in secondary outcome measures, as well as continued progress on follow-up. While methodological issues denied concrete evidence, this study indicated ST as a valid evidence-based treatment method. The RCT conducted by Giesen-Bloo et al. (2006), however, provided more substantial empirical evidence for the efficacy of ST in the treatment of BPD. 86 participants were randomly assigned to one of either transference-focused psychotherapy (TFP) or ST for two weekly sessions over a three-year period. While both treatments led to significant reduction in BPD symptoms, ST was superior to TFP on all outcome measures. Compared to TFP, it also demonstrated a lower risk of drop-out and required less intensive ongoing therapy beyond the study period. Notable observations of ST included the level of transparency of the model for participants, the ease with which techniques were implemented, and the highly rated quality of the therapeutic relationship for both participants and therapists (Giesen-Bloo et al., 2006). Further evidence for the efficacy of ST was demonstrated in the randomised two-group design conducted by Nadort et al. (2009), where more than half of the 62 participants no longer met the criteria for BPD after 18 months of ST. The RCT conducted by Farrell, Shaw, and Webber (2009) compared combined group ST with Treatment as Usual (TAU) to TAU alone in a group of 32 women with BPD. The group receiving the 30 sessions of group-ST adjunct to their TAU demonstrated significantly lower severity of BPD symptoms and higher global functioning than the control group, even at six-month follow-up. Also significant is that none of the participants dropped out of the combined treatment group, compared to a quarter that dropped out of the TAU alone condition. A more recent pilot case-series study by Dickhaut and Arntz (2014) provided two small cohorts of BPD patients with a combination of weekly group-ST and individual ST for two years. With no significant differences between cohorts, BPD manifestation reduced significantly, and there was a 77% full remission from BPD at 30 months. The study suggests that combined group-individual ST might accelerate recovery compared with individual ST alone, although the drop-out rate in the former cohort may be higher, possibly due to the group therapy triggering more EMSs.

There has been an expansion of studies to other PDs. In a RCT conducted by Bamelis, Evers, Spinhoven, and Arntz (2014), a sample of 323 patients with Cluster C paranoid PD (PaPD), histrionic PD (HPD) and narcissistic PD (NPD) were randomly assigned to one of three groups to receive 50 sessions of ST, TAU or clarification-oriented psychotherapy, the latter of which emphasises the importance of clarification process. At three years, the recovery of patients receiving ST, as assessed by blinded interviewers, was significantly better than for the other groups, while the results for secondary measures, including drop-out rate, depression and anxiety disorders, in

addition to general and social functioning, were superior for the ST group compared with the two other cohorts. Interestingly, the findings did not vary between the specific PD diagnoses. The preliminary findings of a Dutch multi-centre RCT being conducted by Bernstein, Nijman, Karos, Keulen-de Vos, de Vogel, and Lucker (2012) to measure the efficacy of ST for hospitalised forensic patients with Antisocial PD (AsPD), BPD, NPD, or PaPD appears promising. Although the preliminary findings are not yet statistically significant, results for the first 30 of 102 patients to complete the three-year study have demonstrated ST to be superior to the control group receiving TAU and has yielded better outcomes with respect to reducing recidivism risk and promoting successful reintegration into the community. This suggests that ST might be superior to the existing treatments for this patient population that has relied on psychoeducation and social skills training. Another RCT involving 93 subjects with a Cluster B or C diagnosis demonstrated schema-focused group therapy to be more effective than classic social skills training to improve interpersonal behaviour, improve emotional coping and reduce symptoms (Zorn, Roder, Muller, Tschacher, & Thommen, 2007). Other studies have also extracted promising results. Hahusseau and Pélissolo's (2006) naturalistic study that explored the response of 14 patients with mainly Cluster B and C PDs receiving, on average, 26 sessions of ST demonstrated improvements in social adaption as the primary outcome measurement, as well as improvements in anxiety, depression and general psychopathology as secondary measures. With the focus on experiential techniques, the study by Weertman and Arntz (2007) demonstrated that historic role-play and imagery rescripting that focused on past traumas was as beneficial as the use of techniques that focus on the present.

While the optimistic outcomes for ST in addressing Axis II problems inevitably led to an inquiry of its effectiveness for Axis I pathology, there remains a scarcity of high-quality research in this arena. Providing a variation of ST, Ball and colleagues conducted a number of studies using Dual Focus ST (DFST) for substance abusers with adjunct personality pathology. An initial case study that provided ten such subjects with 24 sessions of DFST reported a reduction of substance abuse, psychiatric symptoms and negative affect (Ball & Young, 2000). Two small-scale RCTs (Ball, 2007; Ball, et al., 2005) provided further integrity to the application of ST for substance abusers with PDs. While results demonstrated DFST to be more effective than standard group or individual counselling in reducing substance abuse, it also demonstrated a stronger therapeutic alliance, something that is particularly important given the high drop-out rate of this psychiatric population. However, the traditional 12-step Minnesota model treatment did prove more effective in reducing dysphoria in one study (Ball, 2007), while subjects with more severe PDs benefitted more from counselling in another study (Ball, et al., 2005). However, an RCT that provided treatments to 105 adolescents and adults with substance abuse and criminal problems produced mixed findings. Although both the DFST and individual counselling groups experienced reduced symptoms, the latter group dominated with regards to the sustained reduction of psychiatric symptoms and dysphoric effect, suggesting that patients with significant affect instability, impulsivity and avoidance might derive more benefits

from addiction-focused counselling than insight- and change-oriented therapies (Ball, Maccarelli, LaPaglia, & Ostrowski, 2011).

Numerous studies have demonstrated the effectiveness of ST for mood and anxiety disorders. Morrison's (2000) single-case study for a patient suffering from severe depression and anxieties illustrated how ST helped to curtail the activation of EMSs and bring the subject into full remission. Ball and colleagues modified ST for the specific treatment of bipolar affective disorder (BAD). While a preliminary study proposed a ST model for BAD (Ball, Mitchell, Malhi, Skillecorn, & Smith, 2003), the RCT (Ball, Mitchell, Corry, Skillecorn, Smith, & Malhi, 2006) that followed demonstrated ST to be more efficacious than TAU, with benefits being extended on follow-up.

Cockram, Drummond, and Lee (2010) demonstrated the superiority of ST over CBT in the treatment of war veterans suffering from post-traumatic stress disorder (PTSD). In this historic comparison, the subjects receiving ST experienced a stronger reduction of anxiety and depression measures, PTSD symptoms and a significant weakening of EMSs. Promising outcomes have also emerged from individual case studies utilizing ST for the treatment of psychoses (Jakes & Rhodes, 2003) and complicated mourning (De Keijser, 2004). While studies in the application of ST for EDs is outlined later in Chapter 4, reviews of the existing literature for the effectiveness and efficacy of ST (Bamelis, Bloo, Bernstein, & Arntz, 2012; Taylor, Bee, & Haddock, 2016) reflect optimism across a number of psychological conditions. However, there remains an opportunity for strong methodological studies in the future to confirm ST as an efficacious outcomes-based model of treatment.

CHAPTER TWO: EATING DISORDERS

2.1. Historical Context of Eating Disorders

Only after the two renowned physicians, Sir William Gull and Charles Lasègue, were jointly credited with their simultaneous description of Anorexia Nervosa (AN) in 1873, did interest in the so-called "mysterious" afflictions gradually increase (Vanderreycken & van Deth, 1991). Yet the history of morbid self-starvation as a distinct clinical entity began centuries earlier, where extended food refusal, uncommon fasting and peculiar hunger strikes led to speculations about holiness and miracles (Keel & Klump, 2003). This provoked much debate about the similarity between modern AN and the fasting saints of the late Middle Ages, where "Holy Anorexia" (Bell, 2014) comprehensively explores both the religious and pathological dimension of self-starvation amongst many European women during such times (Bell, 1985). Catherine of Siena is the most documented case of "anorexia mirabilis". In the face of many tragic familial circumstances, this 13th century saint went into a rapid psychological decline. She ventured deep into starvation and religiosity and frequently self-flagellated in imitation of Christ's passion. After a life of sacrifice and a devotion to feel closer to God, she died at the age of 32 years. Many of the 261 cases documented by Bell (1985) consciously took Catherine of Siena as their model, turning against the accepted social female role and seeking a sense of superiority in their sanctity and the belief of belonging to God's elect. Although these Medieval fasting cases displayed some resemblance to AN, numerous authors like Van Deth and Vandereycken (1991) have cautioned against attributing any significance to their similarity. They deem it unwise to pathologize or medicalise a particular lifestyle as a psychiatric disorder, given the temporal, geographical and cultural contexts within which these individuals lived, especially with regards to their motive for personal deprivation. Yet the debate continues, with Bell (1985) vehemently maintaining that there is a psychological (rather than bio-medical) continuity across the centuries and arguing that "anorexia mirabilis" and AN are psychologically analogous states in Medieval and modern women respectively, in which both groups sought and seek female liberation from a consistently patriarchal society.

2.2. Definitions and Diagnostic Features of Eating Disorders

While the term "anorexia nervosa" has been used for almost 150 years (Gull, 1874), its designation has been criticised as a misnomer due to the syndrome not necessarily involving a lack of appetite. Perhaps Bruch's (1973) suggestion of the German term "Magersucht" (an "addiction to extreme thinness") or Palazzoli's (1974) description of "a drive towards emaciation" more aptly describes the distinctive psychopathological issue of this complex phenomenon.

Despite the value of having a definition for EDs, very few have been proposed that deviate in any significant way from that in the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5; American Psychiatric Association, 2013). Conditions in the 'Feeding and Eating Disorders' category are characterised by "a

persistent disturbance of eating or eating-related behaviour that results in the altered consumption or absorption of food, and that significantly impairs physical health or psychosocial functioning" (APA, 2013, p. 329). The disorders relevant to this study include AN, Bulimia Nervosa (BN), Binge Eating Disorder (BED), and Other Specified Feeding or Eating Disorder (OSFED), previously referred to as Eating Disorders Not Otherwise Specified (EDNOS) in the preceding edition, the DSM –IV-R (APA, 2000). AN and BN are united by a distinctive core psychopathology in which patients over-evaluate their shape and weight, and judge their self-worth largely, if not exclusively, in terms of their shape and weight and their ability to control them (Fairburn & Harrison, 2003).

There are three essential features in diagnosing AN. The first of these is persistent energy intake restriction in which the individual maintains a body weight that is below the minimal normal level for age, sex, developmental trajectory and physical health. The second feature describes the intense fear of gaining weight or of becoming fat. Nevertheless, clinical data suggests that approximately 20% of adults and an even higher proportion of adolescents with AN deny or significantly minimise their fear of becoming fat (Eddy, Doyle, Hoste, Herzog, & Le Grange, 2008; Eddy et al., 2010; Thomas, Hartmann, & Killgore, 2013). Despite there being numerous reasons for such concealment, there is the possibility that such patients intentionally conceal symptoms due to the ego syntonic nature of the condition (Thomas et al., 2013). The final feature involves a disturbance in self-perceived weight or shape. While some individuals with AN feel globally overweight, others may recognise that they are thin, but remain obsessively and ritualistically preoccupied with certain body parts, particularly the abdomen, buttocks and thighs. The self-esteem of these individuals is highly dependent on their perception of their body shape and weight. Weight loss is invariably viewed as an impressive achievement and indicative of extraordinary self-discipline. Conversely, weight gain is inevitably perceived as an unacceptable breach of self-control.

In addition to the myriad of serious life-threatening medical complications facing individuals with this disorder, many also experience depressive symptomatology by way of a depressed mood, social withdrawal, irritability, insomnia and diminished libido. While these depressive features may be secondary to the physiological consequences of semi-starvation, they can be sufficiently severe to warrant an adjunct diagnosis of major depressive disorder. Obsessive-compulsive features that are both related and unrelated to food, weight and body shape are often prominent. Other common features associated with individuals with AN include a wariness about eating in public, feelings of ineffectiveness, a strong drive to control one's environment, inflexible thinking, restricted social spontaneity and inhibition of the outward expression of emotion. In contrast to individuals with AN of the restrictive type (AN-r), those with AN of the binge-eating/purging type (AN-b/p) present with higher rates of impulsivity and are more prone to substance abuse. A subgroup of individuals with AN also engage in excessive physical activity. While this often precedes the onset of the disorder, it significantly hampers weight restoration when it continues during the course of the disorder. Some individuals with AN will even manipulate

their prescribed medication if the side-effects may serve to facilitate weight loss (APA, 2013). The full DSM-5 (APA, 2013) diagnostic criteria for AN, including the severity specifiers, are set out in Table 6 in Appendix 8.

While not the focus of this dissertation, the other diagnostically recognised EDs require a brief description to make it evident that EDs fit across a spectrum. BN also has three essential features. The first of these is recurrent episodes of binge-eating that is accompanied by a sense of lack of control. An "episode of binge-eating" is defined as "eating, in a discreet period of time, an amount of food that is definitely larger than most people would eat in a similar period of time under similar circumstances" (APA, 2013, p.345). Such individuals are typically ashamed of their abnormal eating behaviour and eat in secrecy or as inconspicuously as possible in an attempt to conceal their humiliating symptoms. The most common antecedent of binge-eating is negative affect (e.g., anxiety, anger, loneliness, boredom), while other factors such as dietary restraint and hormonal fluctuation (Edler, Lipson, & Keel, 2007: Klump, Keel, Culbert, & Edler, 2008) also exacerbate the likelihood of binge-eating. While binge-eating may temporarily alleviate the antecedent stressors in the short-term, negative self-evaluation and dysphoria are inevitably experienced. The second feature involves recurrent inappropriate compensatory behaviours to prevent weight gain. Patients will either purge by way of vomiting or laxative/diuretic abuse (BN-b/p), but some such patients merely use exercise as a compensatory behaviour (BN-e). Vomiting, which is the most common inappropriate compensatory behaviour to follow binge-eating, usually provides physical relief and a tempering of the fear of gaining weight. Sometimes it becomes the goal in itself, as it may serve to "evacuate" or relieve suppressed emotion. Exercise is considered an inappropriate compensatory behaviour when it is contraindicated on physiological grounds or motivated as a means to dampen negative emotion (Ackard, Brehm, & Steffen, 2002; Mond & Calogero, 2009). The third feature of BN, as outlined in the DSM-5 (APA, 2013), involves a self-evaluation that is unduly influenced by weight and body shape. Individuals with BN typically fall within the normal weight or overweight range (viz., a body mass index (BMI) between 18.5 and 30 for adults), and are seldom obese. Medical complications are mostly associated with purging behaviour (APA, 2013). The full DSM-5 (APA, 2013) diagnostic criteria for BN are set out in Table 7 in Appendix 8.

BED was only recognised as a stand-alone nosological category alongside AN and BN for the first time in the DSM-5 (APA, 2013). The essential feature of this disorder is recurrent episodes of binge-eating that must occur, on average, at least once weekly for three months. The binge-eating must be accompanied by a sense of a loss of control, either in an inability to refrain from eating or to stop eating once it has started. Some individuals describe a dissociated quality during and often following the binge-eating episodes. The profile of individuals with BED is similar to those who suffer BN with regards to shame, secrecy and the negative affect preceding binge-eating episodes. BED occurs in normal weight, overweight and obese individuals, where individuals in the latter two groups are more likely to seek treatment due to the increased risk for morbidity and mortality in such weight groups (Flegal, Graubard, Williamson, & Gail, 2005). Besides individuals with BED often suffering high levels of ED

psychopathology, they also often experience other psychological distress like, for example, low self-esteem and impulsivity. Medical complications, including metabolic syndrome, diabetes mellitus (Type II diabetes), hypertension, sleep apnoea and dyslipidaemia are also more prevalent amongst individuals with this ED that exceed the normal weight range (Johnson, Spitzer, & Williamson, 2001; Grilo, Masheb, & Wilson, 2001; Grilo, Masheb, & Wilson, 2005; Grilo, White, Barnes, & Masheb, 2013; Hudson et al., 2010). Medical team management, including bariatric surgery, needs to be considered where such conditions pose morbidity and mortality risks. The full DSM-5 (APA, 2013) diagnostic criteria for BED are set out in Table 8 in Appendix 8.

The OSFED category applies to presentations in which symptoms of feeding and eating disorders that cause clinically significant distress or impairment in social, vocational or other important areas of functioning predominate, but do not meet the full criteria for any of the disorders in the feeding and EDs diagnostic class. The status of sub-threshold disorders has been highly debated, with several studies showing that they may cause as much, if not more, impairment as threshold disorders, while others report how sub-threshold disorders frequently progress into full diagnostic EDs (Preti, et al., 2009).

Fairburn and Cooper (2011) have criticised the classification of EDs in the DSM–IV-R (APA, 2000) as a poor reflection of clinical reality. While in adults it recognised AN and BN, these are just two presentations amongst many for which the diagnostic criteria are merely fine-tuned with each subsequent edition of the diagnostics manual. The addition of BED as a third adult category in the DSM-5 (APA, 2013) has partially succeeded in reducing the enormity of cases that fall into the "non-specified" category. Furthermore, the partial relaxing of the diagnostic criteria for AN and BN in the DSM-5 (APA, 2013) has also helped reduce the large number of cases that would have otherwise become assigned to the residual OSFED category, which has both a prognostic and therapeutic implication. For instance, the DSM-5 (APA, 2013) criteria for AN only require a weight that is less than minimally normal and expected for adults (BMI<18.5) and adolescents/children, while preceding editions of the DSM required a weight of at least 15% below normal or expected levels. Furthermore, the medical criterion of amenorrhea for at least three consecutive months has been dropped from the DSM-5 (APA, 2013). The argument is that this specific medical symptom of AN should not be singled out when there are a number of common medical complications associated with this condition. One adjustment made to the diagnostic criteria for BN from the DSM-IV-TR (APA, 2000) to the DSM-5 (APA, 2013) has been the reducing, by half, the minimum number of binge-eating episodes over a three-month period.

As much as researchers continue to rework the categorisation of EDs, it is evident that EDs are not stable. Fairburn & Cooper (2011) explain that the different ED diagnoses are "snapshots" in the course of an individual's single, evolving condition over time. Alternative systems have been proposed, with Gordon, Holm-Denoma, Smith, Fink, & Joiner (2007) suggesting a dimensional classification system to improve construct validity, whereby varying levels of pathology in a diagnostic continuum may better describe the clinical picture and provide more favourable

treatment options. Fairburn & Cooper (2007) have also challenged the existing diagnostic framework in favour of a continuum of related ED phenomena. They propose the collection of transdiagnostic data on treatment response and outcome in an attempt to better equip clinicians to make sensible treatment plans across a comprehensive spectrum of EDs. Turner, Bryant-Waugh, & Peveler (2010), on the other hand, propose grouping patients with EDs on the basis of personality traits in order to address the poor fit between diagnosis and treatment outcome. They suggest three personality-based clusters both within and between ED diagnoses. The first represents a group of patients that appear to function relatively well. Individuals in this "mild" group, with respect to personality pathology, have some anxiety and low self-esteem issues, and represent a mix of individuals with AN and BN presentations. The remaining two groups are characterised by more severe psychopathology; one by avoidant, compulsive, rigid and over-controlling traits (Cluster C); and the other by emotional deregulation, impulsivity and chronic dysphoria (Cluster B). Their model demonstrates good external validity, with clusters being differentiated on a number of cognitive and behavioural features on the basis of information relating to attachment and coping, as well as aspects of the wider clinical picture relating to vitality, social functioning, mood, mental health and functional impairment.

The fervent debate amongst clinicians and researchers surrounding the criteria for the ED diagnostic entities in each newly published diagnostic manual will likely continue. As such, there appears to be a good argument that it is inherently erroneous to try and define EDs (or any psychiatric phenomena for that matter) by discreet and precise criteria. It seems that while seeking alternative ways of classifying this clinical population, it is vital to assess how effectively alternative systems compare in performance with the existing systems. Clinton and Norring (2005), for instance, urge that one needs to assess the extent to which the comparative systems are able to account for the variation in symptom presentation and evaluate the extent to which the sub-groups within each system are clinically distinct. However, there seems to be consistent agreement that the nosological debate is less important than the prognostic and therapeutic implications of the system utilised (Hebebrand & Bulik, 2011). The models in which boundaries are forcibly created between diagnostic entities to create tidy pigeonholes might pose more problems than solutions when compared to the fluidity of a transdiagnostic model that is less preoccupied with artificial divides, and more invested in identifying appropriate treatment regimens. This is consistent with the ST perspective, where the distinct diagnostic EDs entities are less relevant than building a comprehensive case conceptualisation and identifying pathological behaviour through the interplay of an individualised constellation of modes.

2.3. Prevalence of Eating Disorders

The National Co-morbidity Survey Replication (NCS-R), which was completed in the USA in 2003, is one of a very few prevalence studies done on EDs in a general population. Large sample size studies like this one appear to be the most accurate and effective way of countering the main methodological problems specific to the ED

population. The problems are the particularly low prevalence rate and the challenge to identify a population that has a significant tendency to conceal their illness and evade professional help (Hoek & van Hoeken, 2003). The NCS-R, with its large sample size (n=9282), reflected lifetime prevalence estimates to be 0.9%, 1.5% and 3.5% amongst women for DSM-IV-TR (APA, 2000) AN, BN and BED respectively, while the same figures for men were 0.3%, 0.5% and 2.0% (Hudson, Hipiri, Pope, & Kessler, 2007). In a summary compiled by Hoek & van Hoeken (2003) of 14 prevalence studies conducted for AN in young females between 1981 and 2003, the results of two-stage surveys reflected prevalence rates of between 0.2% and 0.9%, which seem consistent with the NCS-R findings, given the high-risk population group they measured and the strictly-defined AN criteria.

With a cohort of Dutch adolescents, Smink, van Hoeken, Oldehinkel, and Hoek (2014) carried out a prevalence study using the new DSM-5 (APA, 2013) diagnostic entities and criteria. One of the motivations for the study was to measure the effect of the partially relaxed diagnostic criteria for AN and BN (see section 2.2) and the inclusion of BED as a stand-alone diagnostic entity. A lifetime diagnosis of any DSM-5 ED was established in 5.7% of the female and 1.2% of the male adolescents. The female adolescents were most commonly diagnosed with AN and BN, while BED was the most common ED within the male group. While the lifetime prevalence of any ED increased under the application of the less stringent DSM-5 (APA, 2013) criteria, it appeared to have successfully reduced the considerable size of the DSM-IV-TR (APA, 2000) residual category, namely Eating Disorder Not Otherwise Specified (EDNOS; Smink et al., 2014). The lifetime prevalence of 1.7% for DSM-5 AN female adolescents in this sample is higher than in the studies using the DSM-IV-TR (APA, 2000) criteria and closely matches the rates of 2% and 4% for AN found in previous studies amongst adult women when the broader DSM-5 (APA, 2013) criteria are utilised for the purpose of making the comparison (Bulik et al., 2006; Eddy et al., 2008; Keski-Rahkonen et al., 2007).

There is a paucity of epidemiological studies of eating pathology on the South African population. Even fewer such studies exist on the nation's adolescent and young adult population across all ethnic groups. Studies by Szabo & Hollands (1997) and Le Grange, Telch, & Tibbs (1998) both demonstrated that ED pathology is at least as common amongst Black African females as it is amongst Caucasian females. Black African university students reported significantly more ED pathology (Le Grange et al., 1998) and a significantly higher drive for thinness (Wassenaar, Le Grange, Winship, & Lachenicht, 2000) than their Caucasian counterparts in South Africa, suggesting that Black African students in South Africa might be exposed to substantial cultural pressure to be thin. Szabo & Le Grange (2001) have postulated that post-apartheid socio-political changes in the "New" South Africa have challenged traditional gender roles, leaving Black African women unprepared for their "new roles", and consequently more vulnerable to the development of EDs symptomatology. Similarly, there is a dearth of epidemiological studies of EDs in Africa, where the very low levels of AN concurs with the low prevalence rates of AN in Latin Americans and African Americans in the USA, using the DSM-5 (APA, 2013) criteria. The prevalence rate of BN in women in Africa,

however, is comparative with Western populations, as well as with Latin Americans and African Americans (van Hoeken, Burns, & Hoek, 2016).

The recent literature suggests that the overall global incidence rate of AN has remained stable in recent decades, with the only exception being an increase of AN to the high-risk group of 15 to 19-year-old adolescent females. However, it is unclear whether the increase in this group reflects earlier detection due to broader service provision. The occurrence of BN, however, might have decreased since the early 1990s (Smink, van Hoeken, & Hoek, 2012).

2.4. Medical Complications Associated with Eating Disorders

Patients with EDs provide particular challenges to clinicians in the face of common physical signs and symptoms related to their condition. They often develop significant medical complications that require careful evaluation and management (Comerci, 1990). A medical assessment should be conducted at the outset of treatment for all patients with AN, as well as all other ED diagnoses deemed moderate to severe (Birmingham, Su, Hlynsky, Goldner, & Gao, 2005). For patients with AN, serious medical complications are common, with many of the physical signs and symptoms being secondary to the starvation state. Garner and Garfinkel (1997) have noted that one of the most striking observations when interviewing AN patients is the relative lack of reported physical complaints, despite their emaciated state. Yet, upon closer examination, the findings are often more revealing of such evidence of physical harm.

Despite the more relaxed weight criterion for AN in the DSM-5 (APA, 2013), the majority of patients with AN are still significantly underweight by the time they enter treatment. Physical symptoms include heightened sensitivity to cold; gastrointestinal symptoms (constipation, fullness after eating, and bloating); dizziness; amenorrhoea; loss of libido; infertility and poor sleeping patterns. Physical signs, other than the emaciation appearance, include dry skin and hypercarotenaemia; lanugo hair on the back, forearms and side of face; swelling of parotid and submandibular glands (from vomiting) and the erosion of teeth enamel (from vomiting). They also suffer cold hands and feet and hypothermia, bradycardia, orthostatic hypotension, cardiac arrhythmias, dependent oedema and weakened proximal muscle. Upon further physical examination, additional abnormalities are detectible within the endocrine, cardiovascular, gastrointestinal and haematological systems. Other metabolic abnormalities include hypercholesterolaemia, raised serum carotene, hypophosphatemia, dehydration and electrolyte disturbances (where vomiting results in metabolic alkalosis and hypokalaemia, while laxative misuse results in metabolic acidosis, hyponatraemia and hypokalaemia) (Fairburn & Harrison, 2003). Two clinical problems deserve special mention. The first, osteopenia and osteoporosis, is common in longstanding and severe cases of AN, and is associated with a significantly increased risk of stress fracturing. The pathophysiology remains poorly understood and there is uncertainty over its management. This makes the natural increase of oestrogen through increased fat

tissue and hence the resumption of natural menstruation a priority in treatment intervention (Wolfert, 2002). Longstanding amenorrhoea also poses a risk for infertility. The second problem concerns pregnancy. While EDs generally improve during pregnancy, there is an elevated risk of abnormally low birth weight and potential complications during infancy (Patel, Wheatcroft, Park, & Stein, 2002).

It is interesting to note that a longitudinal study that measured general cognition on the Wechsler Adult Intelligence Scale – Revised (WIAS-R; Wechsler, 1981) of a normal weight sample who had been diagnosed with AN ten years prior to the study showed no significant neuropsychological deficits compared to a normal control group with no prior history of being underweight (Gillberg, Råstam, Wentz, & Gillberg, 2007). Yet, in another study, also using the WAIS-R (Wechsler, 1981), the neurocognitive deficits in a sample of 51 patients with teenage-onset AN were significantly higher than in the controls as much as 18 years after the onset of the AN (Gillberg, Billstedt, Wentz, Anckarsäter, Råstam, & Gillberg, 2010). Despite these inconsistent results, it should be considered that patients with AN face a range of neuropsychological problems not only during the illness, but even in the decades following remission.

The medical complications associated with AN place as many as 20% of such individuals at risk of mortality if the condition goes untreated. However, adequate professional intervention lowers that rate to 2 to 3% (Tamburrino & McGinnis, 2002). However, numerous studies still indicate that AN has the highest mortality rate of any psychiatric condition (Smink, van Hoeken, & Hoek, 2012), although a significant portion of mortalities is as a result of suicide (Birmingham, et al., 2005; Smink, van Hoeken, & Hoek, 2012). A review of the literature reflects the mortality rate of BN is considerably lower than that of AN, despite the many physiological complications associated with purging. However, approximately a quarter of such deaths are due to suicide (Crow et al., 2009). BED has been described as the most relevant ED for overweight and obese individuals, with an estimated 20 to 30% of overweight individuals seeking help at weight loss programmes being classified as binge-eaters (Spitzer, et al., 1993). Obesity, as a risk factor for non-communicable diseases, is a global public health concern, while being overweight is listed by the World Health Organization (WHO) as one of the ten leading risk factors for high mortality in developing and developed countries (WHO, 2002). South Africa is no exception with increased levels of obesity across all economic levels and age groups (Popkin, 1994). In a study amongst 554 economically active South African adults, more than half the men were overweight or obese. Almost 75% of black women in the study were overweight or obese, while the figure for white women stood at 42.2% (Senekal, Steyn, & Nel, 2003). Co-morbid medical complications associated with obesity include glucose intolerance and diabetes mellitus, hypertension, coronary heart disease and obstructive sleep apnoea.

2.5. Psychiatric Conditions Associated with Eating Disorders

There is considerable literature demonstrating the presence of additional Axis I disorders amongst patients with ED (Blinder, Cumella, & Sanathara, 2006; Milos, Baur, Muehlebach, & Spindler, 2013). Studies confirm that major depression is associated with body weight instability and abnormal food intake (Hasler, et al., 2005), and that anxiety disorders are very common amongst patients with EDs (Kaye, Bulik, Thornton, Barbarich, & Masters, 2004; Wildman, Lilenfeld, & Marcus, 2004). The presence of obsessive compulsive disorder (OCD) and rigidity (as OCD or as a personality trait) is significantly associated with the longer duration and increased severity of EDs (Milos, et al., 2013; Spindler & Milos, 2007).

There is also substantial evidence in the literature to confirm the particularly high rate of PDs within the ED population. This is particularly pertinent in an investigation of the effectiveness of ST for treating EDs, given that this model of treatment was initially developed for patients with PDs that are particularly treatment resistant. Studies have indicated that the presence of PDs have a significant impact on the manner in which an individual's ED will shift or change its profile over the course of time (Castellini et al., 2011; Milos, Baur, Muehlebach, & Spindler, 2013; Milos, Spindler, Buddeberg, & Crameri, 2003; Tozzi et al., 2005). This phenomenon, commonly referred to as "diagnostic crossover" or "diagnostic instability", provides further support for the argument discussed earlier (see section 2.2) that EDs be viewed along a continuum or spectrum rather than being categorised as discreet diagnostic entities. Where the study by Milos et al. (2003) found AvPD to be most common amongst individuals with an AN-r profile, they determined that the EDs symptoms served several adaptive functions. First, significant weight loss created the notion that these individuals could "disappear" from their social environment and feel less exposed or vulnerable to criticism or devaluation. Second, the AN-r behaviours served as a substitute for interpersonal relationships, given that such behaviours are predictable, are carried out in private, fill time and provide a sense of comfort. Third, the AN-r behaviour of avoidant individuals was used to create distance between themselves and others, where excessive exercise and/or starvation promoted further self-alienation as well as self-degradation in such individuals. Garner & Garfinkel (1997) noted that for some avoidant individuals, the fantasised expectations of significant weight loss were seen as a renewed hope of greater social connectedness. This is in keeping with the ST perspective, demonstrating how an individual with AvPD will often engage in a combination of coping behaviour that manifests as AN-r in an attempt to manage overwhelming emotion being triggered by EMSs in the Child.

The study by Blinder, Cumella, and Sanathara (2006) that indicates that 97% of female inpatients with an ED diagnosis have at least one additional psychiatric disorder holds little value. Besides essentially confirming that EDs almost never exist in isolation as a psychopathology, like many other studies (Blinder et al., 2006; Hasler, et al., 2005; Kaye, et al., 2004; Milos et al., 2013; Spindler & Milos, 2007; Wildman et al., 2004), this study does not differentiate whether the additional psychiatric disorder pre-existed, developed simultaneously to, or followed the

manifestation of the ED. Valderas, Starfield, Sibbald, Salisbury, and Roland (2009), for instance, state that the presence of other diagnostic entities amongst patients with EDs is less a concern than considering the timeline, sequence of onset and the potential impact of coexisting conditions on the treatment and prognosis of the ED. One study that addresses the sequential development of such conditions indicates that the presence of at least one pre-existent Axis I disorder equates to a sevenfold increased risk of an adolescent female subsequently developing an ED (Patton, Selzer, Coffey, Carlin, & Wolfe, 1999).

Irrespective of the sequential development of conditions, the substantial literature that reflects the notion of extremely high rates of what traditional psychiatric research refers to as "co-morbidity" amongst individuals with EDs, is viewed differently from the ST perspective. Rather than pigeon-holing or classifying psychiatric conditions as distinct diagnostic entities, schema therapists derive more value from observing and investigating these phenomena within a single conceptualisation, each condition being influenced by, and influencing, the other. A ST case conceptualisation thus holds more value in the identification of an individual's specific child and adult modes before outlining the specific coping modes that attempt to resolve the Child's emotional pain. For instance, someone's diagnosis of major depressive disorder might be contextualised within the ST perspective as being blunted by the effects of the DePr coping mode blocking emotion in the VuCh. Similarly, the behaviour of an individual diagnosed with OCD or obsessive compulsive personality disorder (OCPD) might be viewed as the effects of the Obsessive Overcontroller (ObOv), while an individual being diagnosed with BED would likely be viewed as engaging in DeSS coping behaviour in order to dampen the distressing emotion residing within the VuCh. The notion of co-morbidity is tantamount to saying that the vast majority of individuals who engage in food-related coping mode behaviour will also demonstrate at least one additional pre-existing or subsequent problem expressed through the interplay of coping modes, the triggering of one or more EMSs, or the activation of a dysfunctional parent mode (DPM). For instance, Lawson, Waller, & Lockwood (2007) found anxious behaviour to be significantly associated with four EMSs in their sample of 62 patients with EDs, namely mistrust/abuse, defectiveness/shame, dependence/incompetence and subjugation.

The literature on BED provides another example of an ED in which such individuals inevitably struggle with coexisting conditions. While for such individuals there is an absence of weight compensatory behaviours to counter binge-eating, the medical complications associated with being overweight and obesity are important considerations (Kessler et al., 2013; Aloi, et al., 2015). However, such individuals also frequently experience symptoms of depression and anxiety linked to particular concerns about food, body shape and weight (Grilo, White, Gueorguieva, Wilson, & Masheb, 2013). As is often the case with individuals with other EDs, patients with BED often have deficits in emotional identification and regulation (Carano, et al., 2012; Compare, Callus, Grossi, 2012), which accounts for the high propensity for interpersonal problems amongst this patient population (Blomquist, Ansell, White, Masheb, & Grilo, 2012). As with the other EDs, there is a high propensity for PDs

amongst BED patients, while substance abuse is a common problem (Kessler, et al., 2015). So significant are these other disorders amongst patients with BED that Peterson, Miller, Crow, Thuras, and Mitchell (2005) have proposed them as markers of major severity, rather than just associated conditions (Peterson, Miller, Crow, Thuras, & Mitchell, 2005).

It is thus clear that an ED seldom, if ever, exists as an isolated condition, and that the case conceptualisation method in ST is well-suited to address the multitude of problems facing such an individual. As such, this myriad of diagnostic entities might be better viewed through the ST lens as the interplay of a constellation of modes, in which the ED is but one expression of coping mode behaviour. The implications for treatment would thus necessitate the therapist to help bring the Child to a place of safety, who should ultimately be secured by the guardianship of the HeAd.

2.6. Development and Course of Eating Disorders

AN typically starts in the mid-teenage years with the onset of dietary restriction, which then accelerates out of control. In some instances, it is short-lived and may never be treated, or may only require brief intervention. In others, the disorder becomes more deeply entrenched and requires more intensive treatment (Fairburn & Harrison, 2003). In 10 to 20% of individuals, the disorder proves intractable and unremitting (Steinhausen, 2002). Binge-eating frequently occurs in AN patients, with half the cases developing full criteria for BN (Eddy, Keel, & Dorer, 2002). The most prominent of the favourable prognostic factors are an early age of onset and a short duration of illness, while conversely, unfavourable prognostic factors include an extended duration of illness, severe weight loss and the presence of binge-eating and vomiting (Steinhausen, 2002).

BN has a slightly later age of onset than AN and usually starts in much the same way as does AN. In about a quarter of cases, the diagnostic criteria for AN are met for a time (Sullivan, Bulik, Carter, Gendall, & Joyce, 1996). However, once the binge-eating interrupts the dietary restriction, body weight increases to within normal levels. The disorder tends to be self-perpetuating, which accounts for the average length of history at presentation of approximately five years, although 30% to 50% of patients will still have an ED of clinical severity after a decade of suffering, albeit often being atypical in form (Herzog, Dorer, & Keel, 1999). Estimates of remission over time range from 31% to 74% (Ben-Tovim et al., 2001; Grillo et al., 2003; Milos, Spindler, Schnyder, & Fairburn, 2005). No consistent predictors of outcome have been identified, although there is evidence that childhood obesity, low self-esteem, interpersonal difficulties and, as outlined earlier, the increased severity of personality disturbance (see section 2.7.2c) are all associated with a poor prognosis (Fairburn, Norman, Welch, O'Conner, Doll, & Peveler, 1995; Bell, 2002).

Little is known about BED, which was recently coded as an autonomous diagnosis in DSM-5 (APA, 2013). Although it overlaps with BN with the symptom of binge-eating, there is little shared symptomatology with the other EDs.

Recent evidence has emerged that it already occurs in adolescence and childhood, with an average age of onset ranging from late teenage years to early 20s (Kessler, et al., 2013). Individuals affected by BED show significantly lower quality of life and perceived health, and carry higher psychological distress compared with the non-BED population (Amiano, Ottone, Abbate-Daga, & Fassino, 2015). Alio et al. (2015) found that such patients suffer attention deficit and struggle to adapt to changes in a new environment. Similarly to patients with BN, Fairburn, Cooper, and Shafran (2003) have proposed that patients with BED who have a low self-esteem that is body image-related generates anxiety and negative emotions, and that this results in excessive dietary restriction which, in turn, triggers binge-eating.

The manner in which the course of these different ED entities frequently overlap and that the criteria change over time further argues the consideration that EDs be viewed transdiagnostically, rather than being seen as separate, discreet entities.

2.7. Causes of Eating Disorders

There is a plethora of published work that has attempted to specify the exact causes of EDs, and yet establishing causality for specific EDs has proven difficult (Woerwag & Treasure, 2008). However, the consensual approach that integrates the numerous factors that contribute to the development of EDs is conceptually referred to as the "biopsychosocial" model. This method of conceptualisation has the advantage of taking into account the influence of a broad spectrum of factors ranging from the broadly cultural to the familial, social, cognitive, learning and personality factors, in addition to the various biological factors (Leung et al., 1996). While the advantage of this model rests in its inclusiveness, Polivy and Herman (2002) caution to its lack of specificity and the diversity of models that adopt this approach. However, a recent publication by Munro, Randell, and Lawrie (2017) provides rejuvenated interest in an integrative biopsychosocial theory of AN through a synthesis of theoretical ideas from clinical practice and a broad review of theoretical ideas within the ED and wider biopsychosocial literature. Their model attests to the significance of the lack of trust, emotional security and self-acceptance amongst individuals with AN, and the centrality of addressing unmet physical and psychological needs in comprehensively providing a healing pathway for this fragile patient group. As such, it is important to outline the numerous identified aetiological factors along a predisposing, precipitating and perpetuating continuum of factors.

Developed in the 1980s, the integrative conceptualisation of AN as a multi-determined disorder remained the most dominant and widely recognised ED model. In fact, this framework remains relevant today, and the process by which it describes the development and perpetuation of AN is still frequently cited in more recently developed theories (Fairburn & Harrison, 2003; Munro et al., 2016; Treasure, Schimdt, & McDonald, 2009). It holds that a substantial number of individuals have, or are exposed to, a range of individual, familial and socio-cultural predisposing factors identified as potential risk factors to developing AN (Connan, Campbell, Katzman, Lightman, &

Treasure, 2003; Jacobi, Hayward, de Zwaan, Kraemer, & Agras, 2004; Lilenfeld, Wonderlich, Riso, Crosby, & Mitchell, 2006, Stice, 2002). While the presence of predisposing factors increases an individual's susceptibility to distress, the authors explain how stressors such as an interpersonal conflict, bereavement, the onset of puberty, abuse or simply being teased or bullied about weight or shape may precipitate dissatisfaction with body weight and shape, and a subsequent drive for thinness. The vigorous dietary and weight loss behaviour serves as a means of coping with the unmanageable emotion associated with the stressors. Once the ED has manifested, the perpetuating factors, which include the physiological effects of starvation, positive social feedback and the perceived benefits of managing difficult emotion, reinforce the food restriction and any additional possible compensatory behaviour that maintains the AN status (Garner & Garfinkel, 1997). Their model is represented in Figure 4 below.

Figure 4: Anorexia Nervosa as a Multi-determined Disorder (Garner 1993)

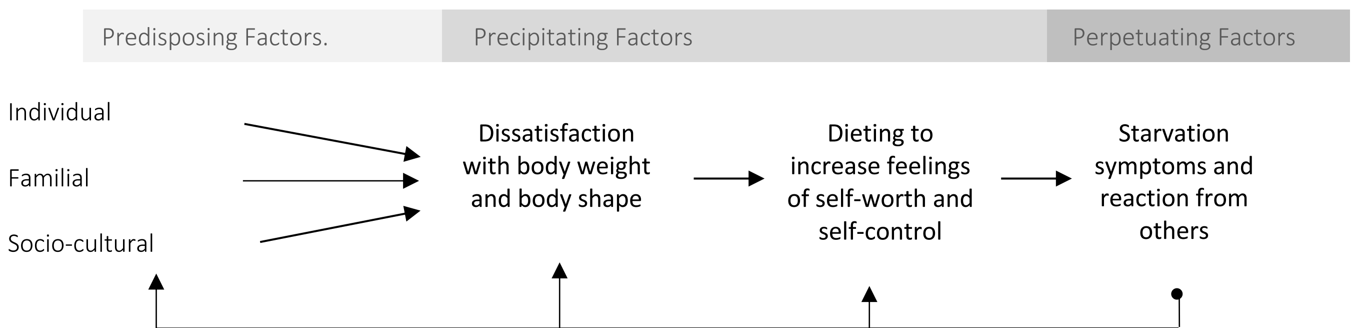
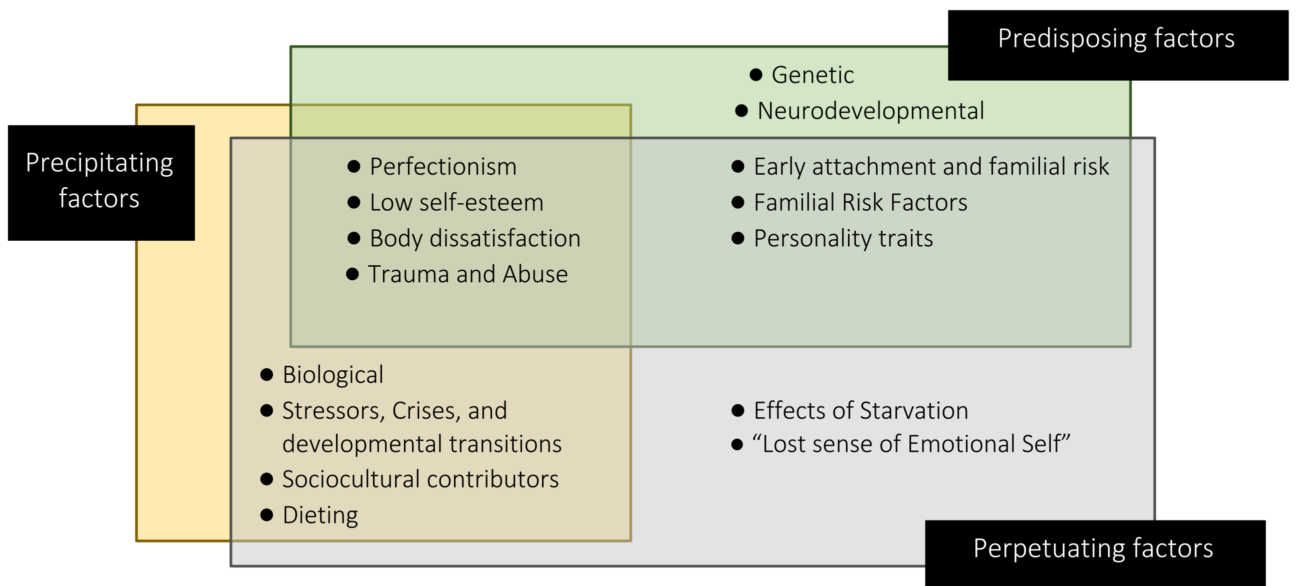


Figure 5: Predisposing, Precipitating, and Perpetuating factors in the development of AN



Elaborating considerably on the Garner and Garfinkel (1980) model, both Jacobi et al. (2004) and Woerwag-Mehta and Treasure (2008) have provided more comprehensive reviews of the longitudinal studies in identifying the biological, psychological and social risk factors involved in the pathogenesis of EDs. Their very comprehensive account of the predisposing, precipitating and perpetuating factors not only contribute to the development of effective treatment strategies to prevent and treat AN, but also in identifying those individuals that are unlikely to respond favourably to treatment or to be treatment resistant. All the specific risk factors from these models are summarised in Figure 5 on the previous page in such a manner that not only distinguishes between the predisposing, precipitating and perpetuating factors, but also specifies by way of a colour-coding system which of these factors belong in two or more of these three temporal categories. The Jacobi et al. (2004) and Woerwag-Mehta and Treasure (2008) models can be found in Tables 9 and 10 respectively of Appendix 9.

2.7.1. Predisposing Factors

(a) Genetic Factors

The past decade has seen both increased impetus and advances in research to better understand the underlying genetic componentry to eating pathology (Trace, Baker, Penas-Lledo, & Bulik, 2013). The familial nature of AN is well-established, where Strober, Freeman, Lambert, Diamond, and Kaye (2000) have determined that first degree relatives of individuals with AN have an eleven-fold greater chance of having lifetime AN than are relatives of unaffected controls. Population-based twin studies also reflect the familiarity of AN, providing further evidence for the operation of genetic factors. Although a comprehensive review of family studies conducted by Spelt and Meyer (1995) provides consistent evidence of EDs aggregating in families, the difficulty in disentangling genetic from environmental transmission partially explains the uncomfortably broad heritability estimates for AN of between 28% to 74%, where the remaining variance is largely attributable to the myriad of environmental factors, whether developmental, psychological or cultural (Bulik, Reba, Siega-Riz, & Reichborn-Kjennerud, 2005; Klump, Miller, Keel, McGue, & Iacono, 2001; Kortegaard, Hoerder, Joergensen, Gillberg, & Kyvik, 2001; Loeb, Le Grange, & Lock, 2005; Mazzeo, Zucker, Gerke, Mitchell, & Bulik, 2005; Neumark-Sztainer, Eisenberg, Fulkerson, Story, & Larson, 2008; Stein et al., 2006; Striegel-Moore & Bulik, 2007). While twin studies consistently suggest that BN is also influenced by genetic factors, similarly to the AN studies, highly variable heritability estimates of between 28% and 83% provide inconclusive evidence in drawing a divide between the genetic and environmental components (Bulik, Sullivan, Wade, & Kendler, 2000).

When considering the heritability of complex traits or phenotypes, of which EDs serve as good examples, it should be noted that they have a polygenetic pattern of inheritance, whereby the combined or additive effect of numerous genes is responsible for the development of such complex traits or phenotypes. This makes the identification of specific genes difficult in light of each gene likely only contributing a small proportion of variance

to the observed trait or phenotype. The significance with which the qualities of perfectionism, the obsessive preoccupation with detail, rigidity and a need for order and control, are not only evident amongst relatives of patients with AN (Anderluh, Tchanturia, & Rabe-Hesketh, 2003; Sutander-Pinnock, Blake, & Carter, 2003) but are also evident in such patients both preceding the development and following the remission of their AN strongly suggests a genetic component has implications for gene-searching efforts (Kaye, Bulik, Thornton, Barbarich, & Masters, 2004). Polivy and Herman (2002) more cautiously acknowledge evidence for the genetic transmission of EDs, noting that numerous researchers have shown commendable reluctance to promote biological correlates of EDs into candidate causes due to the repeated warnings that EDs have the potential to disrupt and influence appetite and broader neuroendocrine systems. One must surmise that biological anomalies may just as likely be effects as they are causes.

While the substantial number of gene studies of AN not only cover serotonergic, dopaminergic and opiodergic genes, but also many others that influence, for example, appetite-regulation, food intake and weight regulation, such studies have, unfortunately, been inconsistent and plagued with numerous methodological problems. (Trace, Baker, Peñas-Lledó, & Bulik, 2013). Even the results of more recent studies that have used genome-wide approaches have, thus far, proven inconclusive. As such, it appears that we are far from being able to make definitive conclusions about which specific genes and to what specific extent genetic factors actually influence the risk for AN. This is reflected in Hewitt's (1997, p.355) statement that "although there is consistent evidence for genetic factors influencing vulnerability to EDs, the details are far from clear". Unfortunately, genetic studies for BN have been inadequate in both scope and methodological design for the purpose of identifying susceptibility loci. This has prompted Trace et al. (2013) to call for genome-wide association studies and for greater methodological rigour where, for instance, patients with BN should be differentiated between those who engage in self-inducing vomiting and those who exercise excessively.

More recently, epigenetic studies are focusing on heritable changes in gene expression not caused by changes in DNA, but by environmental exposure, where the epigenome has the ability to respond to a rapidly changing environment (Petronis, 2010). While the study by Cnattingius, Hultman, Dahl, and Sparen (1999) confirms that pregnancy and perinatal complication are associated with the subsequent development of AN, it is one of very few studies to have been conducted in this arena. There is thus a call for further studies to observe the link between prenatal, perinatal and early development risk factors and the development of EDs (Petronis, 2010). This is of particular interest to schema therapists and attachment theorists, given the capacity for the development of EMSs during the perinatal and even prenatal stages of life.

(b) Neurodevelopment Factors

There is much evidence that crucial periods during foetal development play a key role in the aetiology of neurodevelopmental disorders and many other conditions, including AN. A number of complications throughout pregnancy have been associated with increasing the susceptibility to and reducing the age of onset of AN (Favaro, Tenconi, & Santonastaso, 2006). Others have speculated that the subtle neurocognitive deficits observed amongst patients with AN should not be solely attributed to the neuro-malnutrition associated with the condition, but be related to a number of prenatal, perinatal and postnatal complications (Tchanturia, Campbell, Morris, & Treasure, 2005). Others have supported the notion that inadequate nutrition to the foetus or infant exhorts an influence on the nutritional status and appetite programming throughout an individual's life (Hales & Barker, 2001; Russell, Treasure, & Eisler, 1998). Further evidence is supported by the observation that being born prematurely and of low birth weight is significantly greater amongst patients who have AN compared to normal controls (Sollid, Wisborg, Hjort, & Secher, 2004).

Supporting the notion of a neurodevelopmental component to the aetiology of AN, Connan and colleagues proposed a neurodevelopmental model for AN that is multifactorial in its design. While they acknowledge that the numerous genetic, biological, psychological and socio-cultural factors (each of which is outlined in this chapter) contribute significantly to the susceptibility of AN, they emphasise that none of these factors are singularly either necessary or sufficient to precipitate this disorder. They outline how the interaction of genetic factors and early life experiences create susceptibility to a chronic submissive-type stress response and to hypothalamic-pituitary-adrenal (HPA) axis dysregulation. Where, according to social ranking theory, an individual holds a low prospect of winning conflicts, they resolve such social conflicts by submission or by escape (Gilbert & Allan, 1998), which is conceptualised within the ST framework by the coping mode categories of surrender and avoidance respectively. If escape is not possible, that individual becomes trapped in a submissive stance. Theory holds that it is this perception of involuntary submission to dominant others that lends to depression in humans (Gilbert, 1992). While traumas, severe stressors, low self-esteem, lack of mastery and helplessness may all be conducive to low social ranking, submissive behaviour may be further exacerbated by the characteristic placation and perfectionism of AN and the sociocultural prescriptions for powerlessness of women (Katzman & Lee, 1997). Troop, Allan, Treasure, and Katzman (2003) have confirmed that women with AN rate themselves unfavourably socially in comparison with others, and report high levels of submissive behaviour, even after recovery. It has thus been hypothesised that stressful encounters in the context of an impaired or dysfunctional coping response will be perceived as overwhelming, uncontrollable and inescapable; inevitably entrapping such individuals in an ego-dystonic submissive response, resulting in chronic stress (Connan et al., 2003). While the psychosocial and biological changes associated with puberty create vulnerability and inevitable stress, the coping response is maladaptive, and an atypical HPA axis response is elicited. Where this HPA axis fails to adapt to the chronicity of

stressor(s), there is an elevation in corticotrophin releasing hormone (CRH) activity, which leads to a persistent loss of nutritional homeostasis, thus creating a biological contributor to the development of this multifactorial illness (Connan, et al., 2003).

2.7.2. Predisposing and Perpetuating Factors

As can be seen in Figure 5, these factors can be viewed as both predisposing and perpetuating.

(a) Early Attachment

While acknowledging the numerous risk factors associated with AN, O'Shaughnessy and Dallos (2004) argue that attachment theory offers a single, comprehensive framework for understanding the vulnerability to AN and provides illumination for how the numerous risk factors contribute to the development of this complex and often fatal condition. While the focus of attachment theory is on parental response to danger, distress and discomfort, food and hunger are both the earliest sources of anxiety and stress, and a source of pleasure for the infant child (Farber, 2008). It is thus helpful to explore the contribution of the attachment theory framework and see how early responses set in motion specific patterns of eating (O'Shaughnessy & Dallos, 2009). Bowlby (1980) postulated that infants are biologically predisposed through an evolutionary-based instinct to form attachment relationships for the purpose of ensuring their protection, safety and comfort. In response to a threat, the infant develops a repertoire of behaviours (e.g., crying, clinging) to restore safety and closeness to the caregiver, usually the mother. The nature of the attachment is determined by the interaction between the infant and the caregiver, where the latter's sensitivity and responsiveness shape the infant's ability to regulate emotional responses. Responsive caregiving, for instance, will best ensure that the infant regulates distress with strategies to seek comfort and support, which, in turn, facilitates the development of secure attachment. Should distress cues be met with inconsistency, insensitivity or unresponsiveness, the infant will then associate such distress with aversive consequences and will cultivate strategies leading to an insecure attachment pattern (Ainsworth, Blehar, Waters, & Wall, 2014).

Ainsworth and colleagues were the first to develop an attachment classification system based on the infant's response to a structured separation procedure called the "Strange Situation". Infants with a secure attachment are seen to be harmonious and co-operative in their interactions with their caregivers, where such infants are quickly soothed by their caregiver's gentle and sensitive response. By contrast, infants with an insecure-avoidant attachment show typically little response to separation and conspicuously avoid proximal seeking or interaction with their attachment figures. Mothers typically responded in a rejecting way to their infants. Infants with an insecure-resistant/ambivalent attachment respond to separation with instant and intense distress, and are less quickly soothed by their mothers. These mothers are seen to be more intrusive and inconsistent in their responses to the infant's communication (Ainsworth et al., 2014). A further category of

disorganised/disorientated attachment was later added to the classification system for infants who were originally seen as unclassifiable. These infants behave in a contradictory and incoherent manner when their mothers are present and appear to lack an organised strategy for dealing with the stress of separation. The mothers' frightened and/or frightening behaviour leaves the infant confused, frightened and incapable of relieving their distress (Main & Solomon, 1990). Bowlby maintained that the early experiences of attachment relationships lead to the development of a cognitive model (internal working model) of relationships, which influences and is influenced by subsequent relationships throughout an individual's life (O'Shaughnessy& Dallos, 2009).

While almost four decades ago Bruch advocated the role of attachment and early social experiences in the development of AN (Treasure & Cardi, 2017), a review of studies by O'Kearney (1995) confirmed subsequent and significant evidence for the connection between disrupted attachment and the development of EDs. Subsequent research has confirmed this, with insecure attachment being common in this group (Benedettini, & Treasure, 2000; Daniel, Poulsen, & Lunn, 2016; Tasca & Balfour, 2014; Tasca et al., 2006; Ward, Ramsay, & Treasure, 2000; Ward, Ramsay, Turnbull, Benedettini, & Treasure, 2000; Ward, Ramsay, Turnbull, Steele, Steele, & Treasure, 2001), where prevalence rates range between 70% (Ramacciotti et al., 2001) and 100% (Ringer & Crittenden, 2007; Zachrisson & Kulbotten, 2006). Ringer and Crittenden (2007), who have conducted the most thorough and complex study of attachment style amongst woman with EDs, suggest that individuals with AN-r are more associated with the insecure-avoidant attachment style. Others have said that the severity of the ED is more relevant than the specific ED diagnosis subgroup in the specificity of the disrupted attachment style (Troisi, Di Lorenzo, Alcini, Nanni, Pasquale, & Siracusano, 2006; Zachrisson & Kulbotten, 2006). Earlier studies from the 1970s already reported oversensitivity to early separation in individuals with EDs (Sours, 1974) and difficulties with the separation-individuation process, which is supported in Bruch's (1978) early theory of EDs, which will be outlined later. Here, Armstrong and Roth (1989) found a significant 96% of their sample of individuals with EDs having an ambivalent attachment. Troisi, Massaroni, & Massimo (2005) also detected high levels of separation anxiety within their sample of patients with EDs. On the Attachment Style Questionnaire (ASQ; Feeney, Noller, & Hanrahan, 1994), they found that the most statistically significant effects were on the 'Need for Approval Scale', thus suggesting that identity is organised around a strong need for approval from significant others, while simultaneously avoiding rejection. This echoes the 'push-pull' relationship style described by Ward et al. (2000) and by Ringer and Crittenden (2007); an interpersonal style often observed in individuals with EDs, where they oscillate between the urgent need to be looked after and the apparent contradictory need to avoid intimacy.

The period of infancy is defined by significant plasticity in which the intricate interplay of psychosocial, biological, genetic and environmental factors is pertinent in the development of an individual. The plethora of research that has explored the influence of attachment styles in the susceptibility to developing EDs has provided overwhelming evidence of insecure attachment amongst ED sufferers. Anxious, insecure attachment is a consistent finding in the

EDs literature (Ward, Ramsay, & Treasure, 2000), and a plausible consequence of an environment filled with anxiety and unresolved loss. So, too, is the dismissive-avoidant attachment style over-represented amongst those with AN and also their parents (Ward, Ramsay, Turnbull, Steele, Steele, & Treasure, 2001). This is associated with deficits in emotional expression and processing, and sets the child on a developmental trajectory in which emotional regulation, and the means of resolving trauma and loss, are impaired (Soufre, 1997).

The substantial literature that consistently demonstrates a powerful association between insecure early attachment and the subsequent development of EDs provides sound evidence that these complex psychiatric conditions are not an exclusive reflection of emotional distress experienced during adolescence or early adulthood when they typically manifest, but are shaped by the accumulation of unresolved early emotional distress that form belief systems that are defined in ST by EMSs. While attachment theory is significantly reflected in the ST design, the development of the schema mode model provides an intricate means of differentiating the intrapersonal components whereby the child modes, in the absence of sufficient HeAd, are injured by the DPMs and thus steered towards various coping modes that define the various faces of EDs. It is this sophisticated interplay of modes that provides not only a rich and comprehensive understanding of the role and meaning being communicated by the EDs, but the insight to the source of anguish, pain and abuse that necessitated the Child to turn to the EDs as a means of coping.

(b) Familial Risk Factors

For an infant growing into a child, the family serves as the nucleus of the infant's life and plays a fundamental role in shaping his or her behaviours, attitudes and values. Here, numerous clinicians have theorised about the role of family dynamics in the development of EDs (Baker, Whisman, & Brownell, 2000; Benowitz-Fredericks, Garcia, Massey, Vasagar, & Borzekowski, 2012; Francis, & Birch, 2005; Minuchin, Rosman, & Baker, 1978; Shoebridge & Gowers, 2000; Thelen, Lawrence, & Powell, 2013; Wertheim, Martin, Prior, Sanson, & Smart, 2002). In the late 1970s, Minuchin et al. (1978) described the 'anorexic family' as having a characteristic style of interaction that was rigid, enmeshed, intrusive, hostile, over-protective, poor in conflict resolution and negating of the patient's emotional needs. This view maintained unchallenged traction over the next two decades, with numerous researchers still maintaining that the risk for developing EDs is greater in adolescents who experience family life in which there is poor interpersonal communication, high levels of conflict, criticism, high expectations, over-involvement, under-involvement, low affection and/or a discouragement of autonomy (Graber, Brooks-Gunn, Paikoff, & Warren, 1994; Welch, Doll, & Fairburn, 1997). Similarly, Haworth-Hoeppner (2000) outlined how patients with EDs mostly described a critical family environment that features coercive parental control. The same can be said for a home environment in which there is abuse, whether emotional, physical or sexual (Neumark-Sztainer, 2000; Strong & Huon, 1998). Patients with EDs, especially those with BN, also report greater levels of

parental intrusiveness, especially maternal invasion of privacy, jealousy and competition (Rorty, Yager, Rossotto, & Buckwalter, 2000).

Much has been documented, more specifically, on the impact of parents' negative family food-related experiences in the development of EDs (Kluck, 2008, 2010). For instance, the mothers of patients with EDs have been found to be more dissatisfied with the general functioning of their family system and are, themselves, more eating disordered than are the mothers of girls with no eating pathology (Hill & Franklin, 1998; Hirsch, 1994; Humphrey & Stern, 1988; Likierman, 1997; Loth, Neumark-Sztainer, & Croll, 2009; Marsden, 1997; Ogden & Steward, 2000; Rorty et al., 2000; Strober & Humphrey, 1987). While Ogden and Steward (2000) found that direct maternal comments about weight and shape appear to be more influential than simple modelling of the same concerns, others have noted that modelling alone still influences elementary school learners' weight and shape-related attitudes and behaviour (Francis, & Birch, 2005; Kluck, 2008; Smolak, Levine, & Schermer, 1999). Others, however, found that modelling did not lend to increased body dissatisfaction or dieting, but that it did correlate positively with binge-eating (Byely, Archibald, Graber, & Brooks-Gunn, 2000; Stice, Presnell, & Spangler, 2002) and other bulimic symptoms (Stice, 1998). Furthermore, mothers who have an ED themselves tend to have a deleterious influence on their children's attitudes and behaviours towards eating, weight and shape. This creates a significantly greater risk for the development of EDs (Agras, Hammer, & McNicholas, 1999). Whelan and Cooper (2000) went even further, demonstrating that mothers who suffer from EDs actually produce childhood feeding problems in their offspring, half of whom will develop psychiatric disorders (Hodes, Timimi, & Robinson, 1997). While the majority of the studies on this topic have focused on the influence of mothers, Johnson, Cohen, Kasen, and Brook (2002) found that the maladaptive behaviour of fathers plays a greater role than that of mothers in the development of EDs in their offspring. They found that low paternal affection, care and empathy, unfriendliness, overprotectiveness, high paternal control, and seductiveness are all associated with the development of EDs in their children.

Despite numerous researchers having provided fairly consistent accounts of the family dynamics in which individuals who actively suffer an ED are raised, others have argued that there is relatively little objective evidence for such characteristic styles in these specific families (le Grange, Lock, Loeb, & Nicholls, 2010; Strober & Peris, 2011). Klump, Bulik, Kaye, Treasure, and Tyson (2009), for instance, have shown such characteristics are not specific to families in which an individual suffers an ED, but to families within which an individual has a diagnosis across a much broader spectrum of psychopathology. Many researchers have further cautioned that many of these supposedly predisposing dysfunctional family characteristics might, in fact, be a consequence of a family member having developed an ED, rather than it being causative (le Grange et al., 2010; Polivy & Herman, 2002; Ward, et al., 2000b). While the position of the Academy for Eating Disorders is that family factors can play a role in both the genesis and perpetuation of EDs, they strongly refute any aetiological model of EDs in which family

influences are seen as the primary cause of EDs, and condemn the notion of families being blamed for the presence of an ED in the family (le Grange et al, 2010). As much as it is agreed that therapists should never blame or shame family for the cause and/or maintenance of an ED, it is equally imperative that therapists engage family members in the treatment, especially of younger sufferers, for the purpose of compassionately assisting and helping to create a safe pathway in the recovery process. As such, what contribution the family plays in the maintenance of the ED needs to be directly addressed in the treatment.

(c) Personality Traits

Research into the link between personality pathology and EDs has gained significant momentum since the millennium, where "Personality Disorders and Eating Disorders – Exploring the Frontier", edited by Sansone and Levitt (2006), has become the definitive text. A PD is defined in the DSM-5 (2013, p.645) as "an enduring pattern of inner experience and behaviour that deviates markedly from the expectations of the individual's culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment". Every experienced clinician in the field of EDs will have encountered numerous multi-symptomatic and challenging patients who manifest longstanding personality pathology. In an epidemiological review of numerous studies spanning three decades, Sansone et al. (2006) were able to illustrate that PDs and EDs seem to exhibit recurrent patterns of association. To a lesser or greater extent there is evidence of each of the PDs amongst each of the recognised EDs diagnoses, with the exception that no patient with AN-r has ever been diagnosed with AsPD.

It has been established that the most frequent PD among patients with AN-r is OCPD, where almost a quarter of sufferers meet the full criteria (Sansone et al., 2006, Sansone, Levitt, & Sansone, 2004). This is a PD that is associated with emotional abuse in childhood and where such children were required to attain high standards of achievement and burdened with undue responsibilities (Arntz, 2010; Lobbestael, Arntz, & Bernstein, 2010). A retrospective study conducted by Anderluh et al. (2003) found that obsessive-compulsive traits, including checking, washing and doubting, were more prevalent in girls who subsequently developed an ED during adolescence. It was further found that individuals with EDs who reported perfectionism and rigidity in childhood also reported significantly higher OCPD traits as adults, leading the authors to conclude that such traits in childhood are risk factors for the later development of AN-r. Individuals with AN-r are also particularly susceptible to AvPD (19%), while 11% of this subgroup meets the diagnostic criteria for BPD or dependent PD (DPD). Only 5% evidence Cluster A PDs (paranoid PD, schizoid PD, & schizotypal PD). Overall, Cluster C PDs (AvPD, DPD, & OCPD) appear predominant among these individuals. This fits the clinical picture in which consistently high levels of restraint and self-monitoring are required in maintaining this type of eating pathology. An obsessive drive appears necessary in order for such individuals to sustain the psychological stamina required to gradually and consistently starve themselves (Sansone et al., 2006). The figures are quite different for AN-b/p, where as many as one in four

patients meet the criteria for BPD (Sansone et al., 2006; Sansone et al., 2004). The prevalence of both AvPD and DPD in this subgroup is roughly 15%, while 10% have a HiPD. Both Cluster B (AsPD, BPD, histrionic PD and NPD) and Cluster C PDs are predominant within this subgroup of patients.

The majority of studies in the area of PDs and EDs have been undertaken in those with BN (Sansone et al., 2006). Here, BPD is the most frequent Axis II condition, with a prevalence rate of almost 30% (Sansone et al., 2006; Sansone et al., 2004). This is followed by DPD, HiPD and AvPD, each with prevalence rates of approximately 20%. Similar to the profile for AN-b/p, patients with BN suffer predominantly Cluster B and, to a lesser degree, Cluster C PDs. For these EDs there are obviously higher levels of impulsivity, as exemplified in the binge-eating and purging behaviours. Sansone et al. (2006) caution clinicians that such impulsive eating pathology alone is not indicative of BPD pathology, for which there are typically a host of adjunctive self-regulatory difficulties (e.g., substance abuse, promiscuity, erratic spending) in addition to longstanding self-harm behaviours (e.g., cutting, burning, suicide attempts, abusive relationships and other high-risk behaviours).

Amongst patients suffering from BED, obsessive-compulsive PD is most common, closely followed by Cluster A PDs, with the prevalence rate for both groupings being approximately 15%. Approximately 12% of patients with BED fulfil the criteria for avoidant PD and borderline PD. The data reflect a broad array of Cluster A, Cluster B and Cluster C PDs being encountered in patients with BED, illustrating the heterogeneity in Axis II pathology among this EDs subgroup. Of these four ED diagnoses, patients with BED have the least Axis II pathology, suggesting that the use of pathological counter-regulatory behaviours in AN and BN is associated with a heightened likelihood of additional Axis II psychopathology (Sansone, et al., 2006).

While the significant association between EDs and PD pathology is indisputable, and while it is largely agreed that PD traits precede are either intensified or disguised by the EDs pathology and are often evident once the ED pathology has remitted, the actual prevalence rates of PDs amongst EDs sufferers remain a source of debate. Sansone et al. (2006) attribute this mostly to methodological problems, whether small sample sizes in empirical studies, the manner in which EDs and other Axis I pathology either exacerbates or dampens PD symptoms, the difficulties inherent in PD diagnoses or the effects of biased sampling, where there is an increased propensity of PDs amongst sufferers admitted to inpatient facilities where participants are most commonly recruited for studies. The strong association between these two ambits of psychopathology, however, makes the application of ST for the treatment of EDs particularly pertinent, especially where the foundation of its design was to specifically address individuals with severe personality pathology and whose psychopathological profiles were particularly ego-syntonic in nature.

2.7.3. Predisposing, Precipitating and Perpetuating factors

As can be seen in Figure 5, these particular factors can predispose, precipitate and/or perpetuate AN.

Perfectionism, low self-esteem and body dissatisfaction are three factors that deserve special mention, where research has indicated that these phenomena can play a key role in the predisposition, precipitation and perpetuation of AN.

(a) Perfectionism

Perfectionism, which is analogous to obsessive-compulsive traits, appears to play a vital role in the aetiology, maintenance and course of various psychopathologies, and has been identified as a specific risk factor in the development of AN (Bulik, Tozzi, Anderson, Mazzeo, Aggen, & Sullivan, 2003; Fairburn, 2008; Fairburn, Cooper, Doll, & Welch, 1999; Keel & Forney, 2013; Machado, Gonçalves, Martins, Hoek, & Machado, 2014) and BN (Fairburn, Doll, Welch, Hay, Davies, & O'Conner, 1998). While numerous attempts have been made to define "perfectionism", or what Horney (1950) referred to as "the tyranny of the shoulds", the construct proposed by Shafran et al. (2002) appears to capture the core characteristics. "Clinical perfectionism", that describes the extreme end of the trait, is defined as "the overdependence of self-evaluation on the determined pursuit of personally demanding, self-imposed standards in at least one highly salient domain, despite adverse consequences" (Shafran et al., 2002, p.778). Such adverse consequences may be emotional (e.g., depression), social (e.g., social isolation), physical (e.g., insomnia), cognitive (e.g., impaired concentration) or behavioural (e.g., task repetition) (Rhéaume et al., 2000). These are not viewed as aversive but tolerated because the individual's self-evaluation is contingent to the pursuit and attainment of their goals. Underlying this ego-syntonic pursuit, the individual holds the belief that perfection actually exists and should be exhaustively pursued, irrespective of the consequences (Halmi et al., 2000). This inevitably leads to self-criticism and negative self-evaluation.

Individuals who are perfectionistic have a dysfunctional scheme for self-evaluation. They are overly reliant on striving for and achieving personally demanding standards in which the self-evaluation is extremely susceptible to the failure to meet such standards. Early ST theory conceptualised this quality as the manifest efforts of the Unrelenting Standards EMS, a secondary schema that evolves in an effort to offset and dampen the impact of primary EMSs like Defectiveness/Shame or Failure. With the advent of the schema mode model reflecting specific states, the drive for perfection would typically be reflected in the PeOv, an overcompensatory coping mode that may be trying to counter the threats being imposed on the VuCh by the demanding parent (DePa) or PuPa modes. As such, the schema mode model provides a sequence of modes that has its source in Defectiveness/Shame or Failure EMSs.

Various authors have described how the omnipotent "anorexic identity" provides sufferers with a sense of empowerment and "perfection" with regards to their eating behaviour and physical appearance, and that this serves as a distraction from an existing underlying sense of despair, emptiness and self-loathing (Bruch, 1978; Cruzat-Mandich, Dias-Castrillón, Escobar-Koch, & Simpson, 2015; Levenkron, 1983). As an extended and "specialised" form of perfectionistic expression, the anorexic's overcompensatory behaviour is defined by an

unrelenting pursuit for control over eating, weight and shape (Shafran, et al., 2002). They will exhaustively evaluate their progress towards their chosen goal weight by ritualistically checking or measuring their body weight and/or size (Shafran, et al., 2002). They will also typically focus on one or two areas of their body for which they feel absolute distain, and not deviate from the distorted perception of this body part (Garfinkel & Garner, 1982). This perfectionism is often motivated by a fear of failure which, for an individual with AN, often manifests as a fear of weight gain or un-sustained weight loss. The self-critical component often manifests as a perception that their efforts to lose weight are never quite good enough. Even if patients with AN do achieve their predetermined goal weight, they will often re-appraise it by rationalising that it must have been insufficiently demanding and that they should renew their efforts to restrict their intake, engage in compensatory behaviour and pursue an even lower goal weight (Shafran, et al., 2002). The thinking of such individuals is inflexible, absolute and dichotomous, whereby the world is perceived in black and white, and stringent self-imposed rules are either simply met or not met. There is a blind spot to moderation so that one is either eating or not eating, exercising or not exercising, and anything less than perfect equates to absolute failure (Garfinkel & Garner, 1982; Shafran et al., 2002).

Whereas perfectionism is a typical characteristic of individuals with AN, research has noted its significantly higher prevalence in females with AN compared to those with BN (Bulik, et al., 2003) and normal controls (Halmi, et al., 2000). Halmi and colleagues have also noted a positive correlation between the severity levels of the ED symptomatology (e.g., body dissatisfaction) and perfectionism (Halmi, et al., 2000). There is also substantial evidence that it may be a pre-existing risk factor in the development of AN (Anderluh, Tchanturia, Rabe-Hesketh, & Treasure, 2003; Bulik, et al., 2003; Fairburn, 2008; Shafran et al., 2002). For instance, Anderluh et al. (2003) found that two-thirds of their sample of young adult females with AN reported perfectionism and rigidity in their childhood preceding the onset of their AN diagnosis. This finding suggests perfectionism to be a premorbid trait that places an individual at risk to developing AN. While Fairburn (2008) has explained the psychopathology of clinical perfectionism to be similar in form to that of an eating disorder, Shafran and her colleagues have even gone so far as to suggest that AN could be considered an expression of perfectionism (Shafran et al., 2002). As a personality characteristic, it will manifest in an individual’s behaviour via strict and inflexible rules, but when it finds expression within the ambit of food, weight or shape, such perfectionism will become a maladaptive preoccupation (Lilenfeld et al., 2006). For instance, very weight-conscious individuals might set themselves an upper weight range limit beyond which they may not exceed, despite this upper limit being an unrealistically low weight. Even the slightest surpassing of this limit will be experienced as a catastrophic loss of control and a failure (Garfinkel & Garner, 1982).

(b) Low Self-Esteem

Low self-esteem refers to an individual’s global negative view of their self-identity and their self-worth (Fairburn et al., 2003), and is conducive to a variety of psychiatric conditions, including EDs (Fairburn, 2008; Fairburn, Welch,

Doll, Davies, & O'Connor, 1997; Leary, Schreindorfer, & Haupt, 1995). Dieting, which is very prone to disruptions that result in overeating, can often prompt a downward spiralling of self-esteem that contributes more specifically to EDs, rather than, for example, depression (Heatherton & Polivy, 1992; Klaczynski, Goold, & Mudry, 2004). While it has been well established that weight and shape-based self-esteem is reduced in individuals with EDs (Geller, Johnston, Madsen, Goldner, Remick, & Birmingham, 1998), various studies have also confirmed that girls with an existing low self-esteem are more susceptible to develop EDs (Button, Sonuga-Barke, Davies, & Thompson, 1996, Serpell, Treasure, Teasdale, & Sullivan, 1999, Weaver, Wuest, & Ciliska, 2005). Women who score high on perfectionism and who consider themselves overweight are more prone to exhibit bulimic symptoms if they have low self-esteem. In addressing this, a programme conducted by O'Dea and Abraham (2000) that aimed at improving self-esteem in a group of 11- to 14-year-olds considered at risk for developing EDs significantly lowered the incidence of weight loss and ED symptomatology on follow-up a year later.

While lower self-esteem in individuals with EDs is associated with a poor response to treatment, Fairburn (2008) claims that in most instances it does not need to be directly addressed in treatment, as it seldom obstructs change. Furthermore, he claims that it commonly improves with the resolution of an ED, even if it has not been explicitly targeted during treatment. However, there is a subgroup of patients who possess extreme or, what Fairburn (2008) calls, "core low self-esteem" that hinders change in the ED as a result of two main processes. First, the intensity of these individuals' low self-esteem leads them to more vigilantly strive to control their eating, weight and shape in the pursuit of some sense of self-worth. Having difficulty moderating their dieting and compensatory behaviours, they have an additional mechanism driving their ED. Second, the unconditional and pervasive nature of these patients' derogatory view of themselves results in a very pessimistic prospect of recovery and a sense of resignation from the outset of treatment. In this specific subgroup of patients, the treatment is unlikely to succeed unless the core low self-esteem is also addressed. These patients have little, if any, value of themselves as individuals and often describe themselves using such terms as "worthless", "useless", "stupid", "unlovable" and "failure". Their persistent and profoundly negative view of the self is largely independent of current circumstances and performance. Viewing this from a ST perspective would typically see the Defectiveness/Shame, Social Isolation/Alienation or Failure EMSs being activated in the defective or inferior VuCh as a result of triggering elicited from a DPM. Fairburn (2008) has identified six cognitive processes associated with individuals with core low self-esteem that lends to the negative bias about themselves and the world. First, they overlook their positive qualities by only noticing and recalling their perceived negative qualities. Second, they have selective attention to information that is consistent with their derogatory view of themselves. Third, they carry double standards by which they reserve one set of harsh standards for judging themselves and another more lenient set for everyone else. Fourth, they engage in over-generalisation by tending to view any instance of not succeeding as a failure, which is then generalised to being utterly "a failure". Fifth, they maintain a dichotomous or black-and-white appraisal of self-worth. A typical example would be the deduction that "if I am not strong, I

must be weak" or "if I am not thin, I must be fat." Lastly, dysfunctional beliefs are almost ubiquitous amongst patients with core low self-esteem and Fairburn (2008) recommends the use of standard CBT procedures to help patients dismantle such beliefs and form a more balanced self-view.

(c) Body Dissatisfaction

For individuals with EDs, body dissatisfaction manifests where self-worth is equated to unattainable external standards of physical appearance (Garfinkel & Garner, 1982). Body dissatisfaction is defined by an individual's negative evaluation of the shape and/or size of their body or parts of their body. It is here that individuals with EDs typically channel their generally negative affect and negative feelings about themselves (Presnell, Bearman, & Stice, 2004). It should be noted that the broader construct of "negative body image" comprises both body dissatisfaction and a body misperception/distortion, which typically involves an overestimation of the actual body size. This kind of distortion is not always present in individuals with EDs and has received less research emphasis in recent years. Body dissatisfaction, however, plays a prominent causal role in the driving force behind weight loss amongst patients with EDs. It is also strongly associated with, and often precipitates dieting behaviour, which is why AN and BN are often referred to as the "dieting disorders" (Polivy & Herman, 2002; Stice, Ng, & Shaw, 2010).

The negative impact of media and various interpersonal stressors that all converge in leaving especially females very dissatisfied with their body image have already been highlighted (Paxton, Schutz, Wertheim, & Muir, 1999). Although Polivy and Herman (2002) view body dissatisfaction as a necessary phenomenon in the emergence of EDs, it is certainly not singularly sufficient, because many individuals who are dissatisfied with their body do nothing or little about it. Those that go the EDs route seize upon weight and shape as resolution to their identity and control problems, some of whom become invested in achieving a "perfect" body as a means of giving their otherwise empty lives a sense of meaning, coherence and emotional fulfilment. Some aspire to achieving absolute control over their eating, weight and shape, believing that control along these domains is possible even though such control is lacking elsewhere in their lives. For many patients with EDs, these two goals coincide. While the narrow ambitions of such patients with an ED focus exclusively on weight and the pursuit of a "perfect body", they simultaneously pursue a life that seems simpler, more certain and more effective (Polivy & Herman, 2002). As Vitousek and Hollon (1990, p.197) describe it "She finds a maladaptive solution to her suffering, confusion, and sense of inadequacy by identifying herself with her weight.". What seems quite contradictory is that although most individuals with AN are oblivious to their physically wasted state, they still experience tremendous pride in their progressively skeletal-like and emaciated appearance; their means of self-identity, as well as a display of their self-discipline and superior sense of control (Bruch, 1978).

It is well documented that young females, in particular, are prone to developing significant body dissatisfaction. In a study on secondary school female learners conducted by Paxton et al. (1991), nearly 44% regarded themselves as overweight, when the actual figure, according to BMI norms, was 12%. Seven of the 18 girls who were

underweight believed their weight to fall within the normal range. Almost three quarters of the sample of 341 learners wanted to be thinner than their current figure, while 80% of the sample held the belief that being thinner would be advantageous to their well-being, success, health, popularity, attractiveness, intelligence and even the ease with which their needs would be met. The study by Dohnt and Tiggemann (2006) revealed body dissatisfaction to be the conscious preoccupation of prepubescent girls, where they found that almost half of their sample of girls aged five to eight years desired a thinner body. This demonstrates the impact of media exposure and the effects of peer influence in the early school years, and reveals that body dissatisfaction is not purely associated with the onset of puberty, although it is likely exacerbated by pubertal changes (Birbeck & Drummond, 2009).

(d) Trauma and Abuse

The Substance Abuse and Mental Health Services Administration (SAMHSA; 2014, p.445) recently published a working definition of individual trauma as "resulting from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being". This definition has the advantage of including not only traumas of commission, which include a variety of adverse events or acts done to or against people, but also traumas of omission, which includes emotional and physical neglect, or acts not done for individuals. Although the majority of studies have explored the impact of overt trauma imposed on patients with EDs, the above definition embraces more subtle forms of abuse, like an invalidating childhood environment which, in impacting on attachment style, can subsequently foster devastating negative core beliefs and an impact on stress tolerance that contributes to the development of EDs (Ford, Waller, & Mountford, 2011; Mountford, Corstorphine, Tomlinson, & Waller, 2007).

There is an abundance of studies that has documented the trauma history of patients with EDs (Dalle Grave, Rigamonti, Todisco, & Oliosi, 1996; Reyes-Rodriguez et al., 2011) with prevalence rates ranging from 37% to 100% (Dalle Grave, Rigamonti, Todisco, & Oliosi, 1996; Mitchell, Mazzeo, Schlesinger, Brewerton, & Smith, 2012). The study by Schmidt, Tiller, Blanchard, Andrews, and Treasure (1997), for example, identified that 67% of their clinical sample of patients with AN experienced at least one severe interpersonal trauma or difficulty prior to the onset of their illness. Childhood sexual abuse is the most well-documented trauma amongst such patients (De Groot & Rodin, 1999; Wonderlich et al., 2001), where Brewerton (2007) concluded it to be a significant, although non-specific, risk factor for EDs. However, a review of the literature by Connors and Morse (1993) exploring the association between sexual abuse and EDs concluded that the approximately 30% of EDs patients with a prior childhood history of such abuse was relatively comparable to rates within the normal population, while others have pointed to the fact that the rate of sexual abuse is equally evident amongst patients with depression, anxiety disorders and other psychological disturbances (Chen et al., 2010; Polivy & Herman, 2002). Other forms of trauma

reported amongst patients with EDs include physical and emotional abuse (Kent, Waller, & Dagnan, 1999; Rorty, Yager, & Rossotto, 1994), teasing and bullying (Mazzeo & Espelage, 2002), as well as parental break-up and loss of a family member (Dalle Grave et al., 1996; Mahon, Bradley, Harvey, Winston, & Paler, 2001). Kent, Waller, and Dagnan's (1999) study on a large non-clinical sample determined that emotional abuse was a more powerful predictor of ED pathology than physical and sexual abuse, yet a subsequent study by Johnson et al. (2002) found physical and sexual abuse to be the most prevalent form of abuse amongst the disordered eating subgroups that engaged in restrictive eating and who experienced recurrent weight fluctuation. Yet the study by Hartt and Waller (2002) found no dimensional relationship between any form of abuse (emotional abuse, neglect, physical abuse and sexual abuse) in a sample suffering specifically bulimic pathology. Given that these studies were not consistent in their sample profile, it is plausible that different ED subgroups vary in their susceptibility to different types of abuse.

In a study of adolescents with AN who had experienced emotional, physical and/or sexual abuse, the results of self-report inventories indicated higher rates of abuse among patients with AN-b/p compared with patients with AN-r and healthy controls (Jaite, Schneider, Hilbert, Pfeiffer, Lehmkuhl, & Salbach-Andrae, 2012). This propensity for higher prevalence rate of childhood emotional abuse among the group of ED patients with bulimic symptoms compared to the non-bulimic group is consistent with many existing studies (Fisher, Stojek, & Hartzell, 2010; Groleau et al., 2011; Kennedy, Ip, Samra, & Gorzalka, 2007; Messman-Moore & Garrigus, 2007; Mitchell et al., 2012; Rorty, Yager, & Rossotto, 1994; Smolak & Murnen, 2002; Steiger & Zanko, 1990; Striegel-Moore, Dohm, Pike, Wilfley, & Fairburn, 2002; Waller & Hartt 2002; Waller, Halek, & Crisp, 1993; van Gerko, Hughes, Hamill, & Waller, 2005; Waller, Meyer, Ohanian, Elliott, Dickson, & Sellings, 2001; Wonderlich et al., 2007). However, one has to consider possible methodological errors in these studies, where patients with AN-r more readily under-reported their abuse experiences. Jaite et al. (2012) suggested that where abuse influences an individual's self-esteem, level of inadequacy and the capacity for affect regulation, such abuse may increase the level of instability of ED symptomatology, which is highest amongst patients with bulimic features.

The results of the substantial quantity of research exploring the relationship between different forms of abuse and the development of EDs seem inconclusive, given the very diverse and even contradictory findings. However, researchers appear to unanimously agree that there are two pathways by which abuse exacerbates the risk of developing AN, especially during the adolescent years during which such individuals face significant transformation. First, as a means of coping with the abuse and gaining control of their lives, such individuals resort to vigilantly controlling their eating and weight. Second, abused individuals appear to develop a self-loathing, shame or disgust that is directed at the body in a striving to become emaciated. For victims of sexual abuse, this seems to serve the purpose of not only making their bodies less appealing and desirable to their abusers, but to

also dissociate from their own physical/sexual identity (Byram, Wagner, & Waller, 1995; Halse, Honey, & Boughtwood, 2008; Waller, Hamilton, Rose, Sumra, & Baldwin, 1993).

Schema therapists need to be vigilantly aware of the manner in which abuse will inevitably lead to the development of any number of the eighteen EMSs. Ongoing abuse and/or the lack of acknowledgement and, hence, resolution of such abuse circumstances will likely lend to such EMSs becoming even more entrenched, exacerbating the impact of the VuCh and AnCh modes. Limited reparenting is the process by which much of the abuse and trauma can be resolved in therapy, where repeat use of techniques like chair work and imagery rescripting are valuable in providing the necessary corrective experience for the wounded Child. And while the therapist models the empathy and compassion of the HeAd, the goal of treatment is to help patients cultivate a secure and solid HeAd/HaCh dyad. Without such reparation, it is extremely unlikely that a patient is going to be able to relinquish their constellation of coping modes, of which EDs may be represented as one or more components of such coping.

2.7.4. Precipitating and Perpetuating Factors

As indicated in Figure 5 (see section 2.7.) there are four factors that serve as precipitating and/or perpetuating factors, namely biological factors, stressors and crises (that includes development transition difficulties), sociocultural factors and dieting.

(a) Biological Factors

Although the details are beyond the scope of this study and a genetic component should not be excluded, it should be noted that there are both acute immediate and chronic neurochemical consequences associated with severe weight loss due to starvation. While increased serotonin production lends to reduced anxiety and an increased sense of well-being and euphoria (Kaye, Gendall, & Strober, 2001), it also appears that a broader scope of neurotransmitter depletion and the endocrine adjustments associated with significant weight loss reinforce and exacerbate AN symptoms relating to decreased appetite, obsessional and rigid thinking, body image distortion, cognitive fall-off, and the urgency to increase physical activity (Holtkamp et al., 2003; Kaye, Frank, Bailer, & Henry, 2005; Licinio, Wong, & Gold, 1996; Monteleone, Tortorella, Martiadis, Serritella, Fuschino, & Maj, 2004; Nakazato, Hashimoto, Yoshimura, Hashimoto, Shimizu, & Iyo, 2006; Tagami, Satoh, Usui, Yamada, Shimatsu, & Kuzuya, 2004).

While this and a broader range of biological factors and mechanisms are involved in the pathological processes that precipitate and perpetuate AN, it is important to note that these factors contribute to the biopsychosocial aetiology and maintenance of these complex conditions. The implications for treatment are that it is important for both clinicians and patients to appreciate that much of the behaviour associated with EDs has a neurobiological basis, and that weight restoration and the re-establishment of normal eating habits are a vital component of

recovery, and that normalised neurobiological activity may assist in the broader challenge of convincing such patients to surrender their deeply-entrenched ED behaviour and beliefs.

(b) Stressors, Crises, and Developmental Transitions

Lazarus and Folkman (1984) define stress as an individual's response to an environment that is experienced as strenuous or exceeds the individual's personal resources and is threatening to his or her well-being. It is widely acknowledged that adolescence is an extremely challenging life phase where the many stressors often lead to serious disorders such as substance abuse, mood disorders, violence and, amongst many other psychiatric conditions, EDs (Harvey & Spigner, 1995; Hoffman, Cerbone, & Syu, 2000). Despite abrupt and severe trauma (see section 2.7.3d), the most frequent and most prominent stressors associated with the adolescent developmental period are what Compas, Orosan, and Grant (1993) describe as "generic stressors". Such stressors result from everyday interactions, and typically include peer and family conflict, academic challenges, school transition, the challenging dynamics of friendships, self-image and puberty concerns, as well as financial and work-related issues (Bagley & Mallick, 1997; Grour, Thomas, & Shoffner, 1992; Hartos & Power, 1997). According to Jorgensen and Dusek (1990), individuals will either respond to such challenges in ways that are constructive and appropriate (positive coping) or in ways that are maladaptive (negative coping). Examples of the former include healthy communication and the sourcing of support from others, optimal relaxation and exercise, problem solving and sustained emotional regulation (Ayers, Sandler, West, & Roosa, 1996; Fanshawe & Burnett, 1991). Negative coping is typified by dysfunctional expressions of anger, the blaming of others and avoidance mechanisms, all of which schema therapists will designate to various dysfunctional Child mode behaviours and/or the broad domain of surrender, avoidance or overcompensatory coping modes. The various behaviours displayed by patients with EDs belong within this broad ambit of coping modes. Of course, an individual's response to stressors and crises is associated with the quality of early attachment, a section that was outlined earlier (see section 2.7.2a), where Howard and Medway's (2004) quantitative study of adolescents confirmed that a more secure attachment style was associated with positive coping, while insecure attachment was reflected in negative coping behaviour, of which EDs behaviour is a good example and the focus of this thesis.

A number of studies conducted on non-clinical samples confirm both a positive relationship between EDs behaviour and the broader spectrum of negative coping or coping mode behaviour (Mayhew & Edelmann, 1989; Shatford & Evans, 1986; Janzen, Kelly, & Saklofske, 1992), and a negative relationship between bulimic symptoms and task-oriented coping (Janzen et al., 1992). Other studies have shown similar results for females diagnosed with an active ED (Berge, Loth, Hanson, Croll-Lampert, & Neumark-Sztainer, 2012; Loth et al., 2009; Schmidt, Tiller, Andrews, Blanchard, & Treasure, 1997; Soukup et al., 1990; Swarr & Richards, 1996; Yager, Rorty, & Rossotto, 1995). The retrospective qualitative study conducted by Berge et al. (2012), for instance, identified various themes of family life cycle transitional events that preceded the onset of EDs, especially where there was

insufficient support for the ED sufferer. These themes, of which all but the last are echoed in Compas et al.'s (1993) generic stressors, include school transitions, loss or death of a family member, interpersonal conflict and changes (especially parental conflict), home and job transitions, illness or hospitalisation, and various forms of abuse. While it has been established that patients with EDs also experience greater stress during the course of their illness (Soukup, Beiler, & Terrell, 1990), it is clear that stressors and crises play a significant role in both the precipitation and perpetuation of EDs. Studies have suggested that patients within the broad spectrum of EDs struggle significantly more than controls with social adjustment and are more reluctant to receive support from other individuals (Morris, Bramham, Smith, & Tchanturia, 2014; Striegel-Moore, Silberstein, & Rodin, 1993; Tiller, Sloane, Schmidt, Troop, Power, & Treasure, 1997). In addition to struggling more with interpersonal relationships, such patients also perceive relationship difficulties as more threatening, and engage in more escape-avoidance behaviours than do controls (Troop, Holbrey, & Treasure, 1998). It has thus been recommended that patients with EDs develop the appropriate skills to address the various stressors that trigger or perpetuate EDs. With respect to prevention, a number of researchers have emphasised the importance of parents not only supporting and protecting their children during such periods of transition, but also fostering self-nurturance and confidence in the child's pathway towards autonomy (Berge, Loth, Hanson, Croll-Lampert, & Neumark-Sztainer, 2012; Loth et al., 2009; Swarr & Richards, 1996).

Although it has been established that vulnerability to stress and crises (including developmental transitions) has much variability with respect to age (McCrae & Costa, 2003), it is well-established that EDs most commonly develop in the years following puberty. This is due to this complex developmental transition that sees many physical and psychosocial challenges converge in the young female adolescent's rapidly changing social arena (APA, 2013; Bakalar, Shank, Vannucci, Radin, & Tanofsky-Kraff, 2015; Bruch, 1978; Bulik, 2002; Fairburn & Harrison, 2003; Fornari & Dancyger, 2003; Gower & Shore, 2001; Klump, 2013). Many such adolescents view their hormonally driven physical transformation during puberty with a particularly critical eye, agonising as their bodies steer away from the societal body ideal of slimness (Bruch, 1978; Klump, 2013). For instance, the mean proportion of body fat in girls rises from 8% in pre-pubertal children to 22% following puberty, while body weight rises by approximately 40% from age 11 to 13 years, the period of maximum growth (Tanner, 1989). There is also a link between childhood obesity and early menarche, which is a recognised risk factor for the development of BN (Fairburn et al, 1997). Whilst it has already been mentioned that weight and shape concerns can be found in children as young as 5 or 6 years (Davison, Markey, & Birch, 2000), these concerns increase with age and peak in the post-pubertal years for girls (Cooper & Goodyer, 1997; de Castro & Goldstein, 1995). Cooper and Goodyer's (1997) study that measured the prevalence of strictly defined eating and weight concerns between different cohorts in a female community sample, for instance, increased from 14.5% in 11- to 12-year-olds to 18.9% in the 15- to 16-year-old cohort. Studies have confirmed that, for many girls, primary menarche provokes an increasing drive for thinness and greater body dissatisfaction, thus increasing the risk for the development of an ED (Klump,

2013; Wertheim, 2002). However, the challenges of puberty go far beyond the psychosocial challenges where more recent research is exploring the effects of oestrogen in a genetic explanation for the frequent onset of EDs during puberty (Klump, 2013).

Treatment from a ST perspective requires a diligent observation of the EMSs triggered in the Child following stressors, crises and the difficult adjustments associated with puberty and adolescence. As such, it is important for clinicians to guide patients towards more HeAd means of negotiating such challenges instead of reflexively turning to coping mode responses. While many patients with AN insulate themselves with various avoidant and overcompensatory coping mode behaviours in an attempt to be more self-determined, it is valuable for them to realise that an important aspect of the HeAd involves the need to draw on the support of others and be more dependable in their relationships with others. Especially for patients with AN-r, who are very prone to resorting to obsessive and rigid overcompensatory behaviour when feeling "out of control" during times of change, it is valuable to assist them to be more flexible and adapt to changing circumstances, rather than resisting change.

(c) Sociocultural Contributors

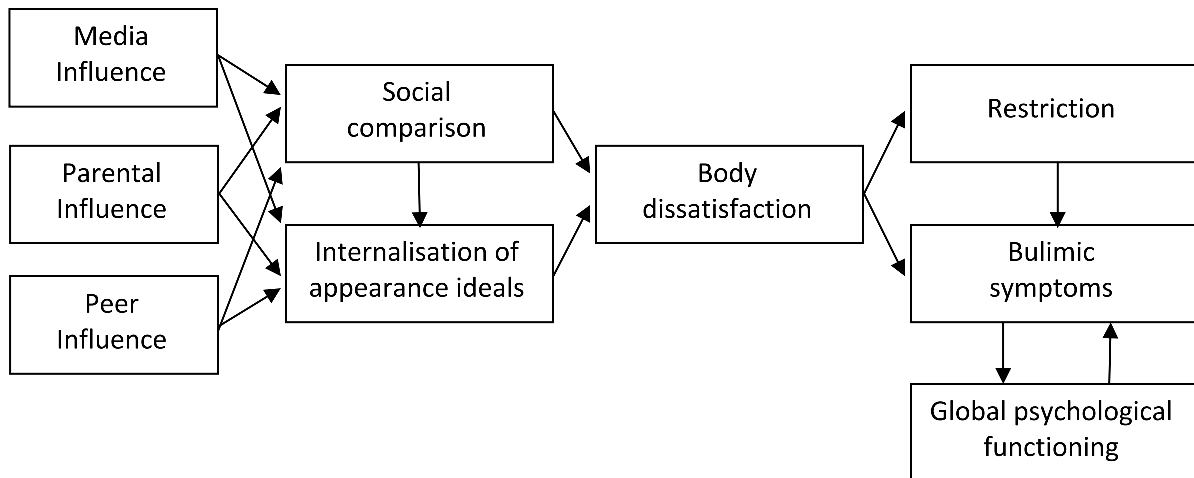
The most widely tested and well-validated sociocultural model of EDs is the Tripartite Influence Model (TIM) of body-image and eating disturbance (Keery, van den Berg, & Thompson, 2004; Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999). This model of body-image and eating disturbance proposes that the three primary sources of influences of peers, parents and media exert their effect on both body-image and ED problems through two mediational mechanisms, namely, appearance comparison and the thin body ideal. Another aspect of the model involves the proposed directional link from the dietary restrictive aspect of ED disturbance to bulimic symptoms via the influence of psychological phenomena like self-esteem and depression (Keery, van den Berg, & Thompson, 2004).

Figure 6 on the next page outlines all the hypothesised interplay of variables predicted by this model, as originally outlined by Thompson et al. (1999). Their work, and the work of other investigators supports the role of specific peer, parental and media factors as a predictor of body image and eating problems using path models and prospective studies (Field, Camargo, Taylor, Berkey, & Colditz, 1999; Field, Camargo, Taylor, Berkey, Roberts, & Colditz, 2001; McKnight Investigators, 2003; Thompson & Stice, 2001). Stice (2001) notes strength in this model in its ability to integrate the broader sociocultural factors and individual difference factors.

All sociocultural models of EDs emphasise the notion of the Western cultural female body ideal of slimness and thinness, and the objectification of the female body as specific risk factors for the development of EDs (Rohde, Stice, & Marti, 2015; Stice, Marti, & Durant, 2011; Striegel-Moore & Bulik, 2007; Treasure, Schmidt, & Furth, 2005). This culture promotes the concept of self-worth, power, happiness, success, health and positive

relationships as the rewards for achieving the body ideal, and that self-improvement is reliant on physical appearance (Levitt, 2003; Thomas, Weber, & Brown, 2002).

Figure 6: Tripartite Influence Model of body image and eating disturbance (adapted from Thompson, Heinberg, Altabe, & Tantleff-Dunn, 1999)



Societal perception also holds that thin females are more independent, harder working and have more self-control; while overweight females are perceived as lazy, self-indulgent and lacking in self-control (Hesse-Biber, Leavy, Quinn, & Zoino, 2006). It has also been demonstrated in a sample of females aged between 14 and 59 years that a greater internalisation of societal standards of attractiveness is associated with an increased drive for thinness, body dissatisfaction, dietary restraint and a diminished self-esteem (Vartanian, 2009). Although the literature has mostly emphasised the societal pressure to be thin as an exclusively Western cultural phenomenon, the globalization of cultural norms and global economic development that has resulted in an increase in EDs and obesity in Asia suggests that no culture is immune to such dangers (Pike & Dunne, 2015; Pike, Dunne, & Grant, 2015). The studies in South Africa cited earlier (see section 2.3.) (le Grange et al., 1998; Szabo & Hollands, 1997; Wassenaar, le Grange, Winship, & Lachenicht, 2000) echo this.

The cultural models describe a sequence which is initiated by the exposure to and internalisation of the thin ideal. This exposes a perceived discrepancy between self and ideal, which manifests in body dissatisfaction and subsequent dietary restraint or restriction. In some instances, the insufficient nutrition provokes subsequent overeating which, in turn, amplifies body image concerns and further attempts to restrain or restrict intake (Elran-Barak, 2015). Objectification of the female body also serves as a risk by teaching females that they are valued primarily for their appearance, which reinforces the need to pursue physical attractiveness (Moradi, Dirks, & Matteson, 2005). To explain why only certain females develop EDs in this cultural climate, one has to consider

individual exposure to additional variables that either amplify or alleviate the risk arising from the thin beauty ideal (Striegel-Moore, Silberstein, & Rodin, 1986). These include further social pressures to be thin (e.g., exposure to media images, exposure to social media, or peer teasing) and a combination of the various individual psychological and biological variables discussed earlier (Furguson, Munoz, Garza, & Galindo, 2014; Hilbert et al., 2014; Mabe, Forney, & Keel, 2014; Machado, Goncalves, Martins, Hoek, & Machado, 2014). By integrating objectification theory with an understanding of embodied cognition and social neuroscience, Riva (2014) has proposed that individuals who develop EDs may be unable to alter the misleading way in which their body is experienced. This has prompted the call for further integration of socio-cultural theories relating to eating and body dissatisfaction with psychosocial and neuro-biological models (Munro, et al., 2016).

There are three lines of evidence in support of the cultural models. The first is the preponderance of female cases of AN and BN, for which the female to male ration is 8:1 (Steinhausen & Jensen, 2015). Worldwide, females with AN and BN outnumber males by a significant margin in every study (Hoek, 2006; Wittchen & Jacobi, 2005). However, gender differences are far less pronounced in BED (Hudson, Hiripi, Pope, & Kessler, 2007), with recurrent binge-eating being shown to be similar in both sexes (Reagan & Hersch, 2005). Hence, the EDs for which weight concerns are the defining feature are substantially more common among females than among males (Streigel-Moore & Bulik, 2007). Second, the rising incidence of AN and BN in females coincides with the decreasing body-size ideal for women. The third line of evidence points to the cross-cultural differences in both the incidence and prevalence of EDs, with higher incidence-prevalence in cultures that favour extreme female thinness (Striegel-Moore & Bulik, 2007). Chaplin (2015) argues for the gender differences in emotional expression, which arise through a combination of biological determinants, socialisation, social context and cultural expectations. Oldershaw, Startup and Lavender (2019) argue that gender socialisation and the social construction of emotional expectations from as early as infancy play a role in women being vulnerable to the development of EDs. Zeman, Cassano and Adrian (2013), for instance, point to how, from a young age, parents socialise emotional expression based on gender stereotypes and expectations; encouraging internalising emotions such as fear, sadness, shame and guilt, while discouraging angry expression in girls, and encouraging it in boys. This is particularly the case for shame (Oldershaw, Lavender & Schmidt, 2015). Girls are even expected to display a broader array of emotions than boys, especially positive emotions (Brody & Hall, 2009). There are other factors that point to a sociocultural influence in the development of EDs. The literature shows remarkable consistency in demonstrating that EDs typically manifest during adolescence. Much research has highlighted the influence of peers during these years as a significant risk factor in the development of EDs (Dohnt & Tiggemann, 2006a; Ogle & Damhorst, 2000). Paxton and colleagues also revealed that adolescent females that regard their friends as an important source of influence had friends that valued the thinness ideal and dieted, experienced peer teasing, and compared their own bodies with that of their peers. This was significantly associated with their body image concerns, dietary restraint, extreme weight loss behaviours and binge-eating (Field et al., 2008; Paxton et al., 1999). The influence of peers

has been noted in girls as young as six to eight years (Dohnt & Tiggemann, 2006b). While the onset of AN and BN is far less common in adulthood (Striegel-Moore et al., 2005), the onset of BED often occurs in the early-20s (Kessler, et al., 2013).

Viewing this model through the ST perspective demonstrates the extent to which the negative body image influences imparted by parents and authorities, peers and those reflecting societal norms through media explain the source of primary EMSs such as Defectiveness/Shame and Failure, and the subsequent development of secondary EMSs such as Approval-seeking/Recognition-seeking and Unrelenting Standards. When these blatant and sometimes subtly critical or demanding messages are absorbed to become introjects of DPMs, they have the capacity to perpetuate the wounding initially imposed on the Child by societal forces. Although such wounding can translate directly into body-related attitudes and perceptions that urge the Child to find temporary solace in coping mode behaviour that primarily serves to vigilantly manipulate body shape and size, such injurious commentary can also provoke coping behaviour to dampen a broader sense of defectiveness, inadequacy and isolation.

Fairburn (2008) has identified a subgroup of patients with EDs in which the over-evaluation of control of their eating supersedes their desire to control their intake for the purpose of manipulating their weight and body shape. These patients demonstrate an especially high level of dietary restraint and conform to a high number of food rules. They are particular vigilant in observing the details in their eating behaviour as a means of assessing their degree of control over eating. They tend to count calories, weigh their food and keep meticulous records of their energy intake/output ratio. Fairburn (2008) advises therapists to address this subgroup of patients by identifying the over-evaluation and its consequences before enhancing the importance of other domains for self-evaluation. Such patients should then be encouraged to suspend their obsessive eating and food-related behaviours, after which the therapist should explore the origins of the over-evaluation, which likely extend beyond the ambit of food and weight.

This subgroup is very closely aligned to the concept of "orthorexia", a term first coined by Bratman in 1997 to describe a psychological condition epitomised by an extreme obsession with highly limiting food philosophies that see "healthy" foods as a solution to most, if not all, diseases. What starts out as a quest for a "healthy diet" develops into an obsession to achieve a "perfect diet" predicated on the exclusion of major food groups and types deemed toxic or dangerous. The limiting quality of such diets inevitably jeopardises physical health and lends to malnutrition as well as social and emotional retardation as such individuals are forced into increasing social isolation. Although it is a term mostly seen in the popular press and is not specified in the DSM-5 (APA, 2013), it has, nevertheless, still attracted academic interest from a medical perspective (Bosi, Ḉamur, & Güler, 2007; Donini,

Marsili, Graziani, Imbriale, & Cannella, 2004; Donini, Marsili, Graziani, Imbriale, & Cannella, 2005; Eriksson, Baigi, Marklund, & Lindgren, 2008).

(d) Dieting

The literature is consistent with the finding that individuals diet prior to developing EDs, and that it is a key precipitant that works in conjunction with a range of other precipitating and predisposing factors (Bruch, 1978; Fairburn, 2008; Fairburn & Harrison, 2003; Favaro, Ferrara, & Santonastaso, 2003; Patton et al., 1999; Polivy & Herman, 2002; Stice et al., 2010; Walsh, 2013). While some equate the commencement of severe dieting to be a prodromal phase of EDs (Patton et al., 1999; Stice et al., 2010), others have observed a positive correlation between the number of dieting regimens completed by young adult women and the risk of developing an ED (Favaro et al., 2003). Various studies have determined that between 28% and 67% of normal weight adolescent girls are on a weight loss diet at any given time (Fairburn & Harrison, 2003; Huon & Brown, 1986; Hsu, 1996; Jacobi et al., 2004; Kelly & Patten, 1985; McCreary & Sasse, 2002; Rosen & Gross, 1987). The contrast of these findings might be explained by the diversity in sample groups chosen, or the variable means by which "dieting" is defined. Where a significant proportion of girls overestimate their shape and size, they constitute an important high-risk group for the development of EDs (Fairburn, Cooper, Doll, & Davies, 2014). A study conducted by Fairburn et al. (2014) using certain items from the Eating Disorders Examination Questionnaire (EDEQ; Fairburn & Beglin, 1994) identified particular eating habits and attitudes of dieters that would place them at greater risk to developing an ED. Although only 3.5% of their cohort of almost 3000 participants developed an ED, their findings justified the recommendation that individuals embarking on a weight loss diet be provided with a simple questionnaire that would flag those that were at greater risk of developing an ED. Some of the key elements of the EDEQ that were incorporated in the high-risk questionnaire included frequency of binge-eating, eating in secrecy, low BMI, preoccupation with food and eating, desire for stomach emptiness, the fear of losing control over eating, and the preoccupation with weight and shape. Correlational studies have demonstrated that dieting for weight loss is significantly associated with depression (McCreary & Sasse, 2002), substance abuse disorders, and a general pattern of negative psychosocial and health-related variables (French, Story, Downes, Resnick, & Blum, 1995).

2.7.5. Perpetuating Factors

As dietary restrictive behaviour becomes progressively rigid and entrenched, the myriad of biological, psychological and social factors already outlined above impact on the sufferer in maintaining their disordered eating patterns. However, most of the risk factors outlined earlier in the chapter continue to play a role in the maintenance of AN. These include gender, biological factors, birth trauma, temperament and personality, insecure attachment, a family history of an ED or addiction, early food conflict, low interoceptive awareness, abuse and neglect, adolescence, social culture, psychiatric co-morbidities and negative affect, body image concerns, low self-esteem and ineffectiveness, low frustration tolerance and avoidant coping, and low social support; all of which

play a role in maintaining or perpetuating the anorexic state. Similarly, so do the many maintenance factors that were outlined earlier in the chapter also contribute to the maintenance of the anorexic state. These include pro-anorexic beliefs, information processing styles like perfectionism, socio-emotional difficulties like emotional avoidance, mood intolerance, interpersonal difficulties and conflicts, poor self-esteem, low interoception and high expressed emotion within the family.

Bruch (1978) described how sustained dietary restraint amongst individuals with AN not only leads to an obsessive preoccupation with food, but an eventual sense of euphoria as a result of being hungry, particularly once the biophysical effects of hunger impact on bodily sensations (Polivy & Herman, 2002). The effects of starvation, hence, deserve special attention as a maintaining factor in AN. Many of the symptoms initially thought to be the primary features of AN are actually symptoms of starvation and weight loss (Garner & Garfinkel, 1997). This was powerfully illustrated in the "starvation study" conducted by Keys and colleagues in 1950 on 36 healthy and well-adjusted Minnesota volunteers who were restricted to half portions for six months before being gradually re-nourished. To varying levels, the men experienced dramatic physical, psychological and social changes during the restrictive and rehabilitation phases (Keys, Brozek, Henschell, Mickelsen, & Taylor, 1950). One of the most striking changes that occurred was the dramatic increase in food preoccupation. This phenomenon is shared by individuals with AN as their ED state progresses, thus providing a physiological explanation for the behaviour such patients display (Bruch, 1978; Garfinkel & Garner, 1982). Individuals with AN regularly report intrusive thoughts about food and food-related activities. This includes cooking for others; being preoccupied with food-related material in books, magazines, on television or the internet; constantly talking about food; and being totally preoccupied with food in daily conversation (Bruch, 1978, Fairburn & Harrison, 2003, Garfinkel & Garner, 1982). The preoccupation with food tends to exacerbate dietary behaviour as individuals with AN become increasingly fearful of not being able to control their appetite (Garfinkel & Garner, 1982). This often lends to bizarre eating behaviour like eating extremely slowly, eating in isolation, combining foods with unusual ingredients in order to make food less tempting and palatable, and developing bizarre rituals around their eating. For such individuals, the social isolation that comes with eating in private contributes to their feelings of loneliness and social inadequacy. As food becomes an increasing preoccupation, interest in all other activities, including sexual intimacy, diminishes (Fairburn & Harrison, 2003). Similar observations were made among volunteers on the Keys study, indicative of the significant physiological basis for this behaviour (Keys et al., 1950).

Not only do individuals with AN and BN experience distorted perceptions of weight, shape and size, but their perception of satiety is also distorted. While many individuals with EDs consider it necessary to lose weight due to the overestimation of their weight and body size as "fat" (Kaye, Fudge, & Paulus, 2009), some are merely dissatisfied with particular body parts, most notable the stomach, buttocks and thighs (Garfinkel & Garner, 1982). As AN progresses, many individuals experience a "blind spot" to their progressively shrinking body, despite

numerous concerns being voiced by family and friends to their wasting body (Bruch, 1978). The unrelenting pursuit for thinness is driven by this distortion, together with a denial of symptoms by most sufferers. This distorted perception of satiety or limited interoceptive awareness results in such patients feeling physically full and severely bloated after the consumption of even a small quantity of food. Yet some sufferers are thrilled to feel hungry as this contributes to them "feeling" thinner and believing that they are more in control by successfully exercising a defiance of normal bodily sensation. Bruch (1978) held the view that individuals with AN do not lose their appetite, but rather convince themselves that they are not hungry so as to avoid the temptation of eating, and that this leads to their altered perceptions and feelings.

Psychotherapeutic models for AN need to be perceptive to the myriad of predisposing, precipitating and maintaining factors, all of which have been outlined above. The architects of such treatment designs need to appreciate the devastating psychological and medical impact of the starvation state; interrupting its escalating course to guide steady weight restoration. However, this is but one priority. Sternheim et al. (2012) point to how ED-related themes only account for one percent of the key difficulties underlying EDs. Instead, it is the issues of interpersonal difficulties that are far more significant, where rejection and abandonment account for 42 percent of key issues underlying an ED. Similarly, so did they find that negative self-perception account for 22 percent, while emotional experience accounts for a further 20 percent of key issues underlying the ED. While the starvation state that intensifies these underlying issues justifies the focus on weight restoration efforts, it is these underlying and complex emotional forces that need to be brought into focus to not only break the entrenched nature of AN, but offer hope for the healing and well-being of the individual behind the illness. The next chapter thus reviews the existing models of ED treatment.

CHAPTER THREE: TREATING EATING DISORDERS

3.1. Introduction

Despite the most effective current interventions still failing to help a significant portion of patients across the EDs diagnostic spectrum, it is acknowledged that significant progress has been made over the past few decades in the development of evidence-based psychological treatments for EDs (Wilson, Grilo, & Vitousek, 2007). While numerous models from significantly contrasting frameworks have been developed, there has become an increasing appreciation amongst clinicians and researchers that the complexity of EDs, with its multifactorial aetiology and biopsychosocial nature, requires a treatment that is integrated, especially with respect to balancing an attention to the medical risks, the maintaining factors, and an exploration, confrontation and resolution of the complex psychological factors that lie at the epicentre of such conditions. What follows is not an exhaustive review of the specific treatments developed for EDs, but the most historically significant, relevant and efficacious treatments developed to date. While the majority of the treatment models outlined below have been designed for one specific ED diagnostic entity (AN, BN or BED), these entities will not be discussed under separate headings due to the stance being adopted of viewing EDs from a transdiagnostic perspective.

3.2. Psychotherapeutic Treatments for Eating Disorders

3.2.1. Psychodynamic Therapy

Beyond the fundamentals of psychodynamic theory developed by Sigmund Freud in the late 19th century, numerous clinicians and researchers throughout the next century and into the new millennium have developed a diversity of models, some of which have been closely evaluated for the treatment of EDs. Due to psychodynamic therapies differing widely in objectives and techniques, one useful means of both tracking the development of and distinguishing the different models of "psychodynamic psychotherapy" (PDT) is to identify how they operate along an interpretive-supportive continuum (Gunderson & Gabbard, 1999; Wallerstein, 1989). Interpretive interventions, reflected in classical psychoanalysis, heighten the patient's awareness to the repetitive conflicts and traumas underlying a patient's problems (Gabbard, 2010; Luborsky, 1984). Supportive interventions, by contrast, emphasise improving the patient's immediate adaptation to their environment, and are characterised by the therapist praising their patient, guiding them through structured problem-solving and goal-setting, and being self-disclosing as one means of fostering a strong therapeutic alliance (Crits-Christoph & Gibbons, 2003; Luborsky, 1984). Although both forms can be effective, deciding where to stance the intervention along the interpretive-supportive continuum should be individualised to the patient's needs. However, it is generally agreed that the more disturbed the patient or the more acute their problems are, the more supportive and the less interpretive the interventions should be (Luborsky, 1984; Wallerstein, 1989). Given the gravity and breadth of risks that most

patients with EDs face, especially those with longstanding and treatment-resistant conditions, it is clear that the more supportive PDT models of treatment are indicated.

Each patient has a unique personal history, and behind every symptom of disordered eating there exists a tragically painful story that needs to be shared. This is reiterated by Zerbe (2015, p.266), where she says that EDs are "the quintessential psychosomatic disorder that pits mind against body". These are complex conditions with a multifactorial aetiology (as outlined earlier in section 2.7.) inevitably associated with adjunct injuries relating to early attachment problems, unresolved trauma and abuse, the deprivation of needs, unresolved loss, dysfunctional interpersonal dynamics, problems with affect modulation, demanding cultural and societal expectations, and, finally, a myriad of other obstacles that obstruct normal and healthy development (Zerbe, 2001, 2015). It is only through directly addressing these deeply entrenched conflicts that the cycle of repeated injury can be dismantled and replaced by a firm foundation upon which the individual can live a fully functional life. It is here that ST echoed its roots in psychodynamic theory, holding central the collaborative journey required to bring the necessary emotional healing to a wounded Child. Charlotte Prozan (1992, p.334) illustrates this core feature of both PDT and ST when she says "You cannot have change without struggle, and you can't plant seeds without turning the earth". Only by extracting and healing the deeply entrenched pain residing in the Child can the once necessary and well-established mechanisms of defence or coping be made redundant in order for the Child to be free to flourish. As is the task of schema therapists to reflect and to help their patient establish a prominent HeAd, so do psychodynamic therapists guide and assist patients to set firm boundaries and readily tolerate, with minimal emotional dysregulation, a journey of healing from the dark and sometimes torturous arenas of sadness, fear, resignation, loneliness and anger.

Zerbe (2020) holds central to the principles and methods employed in PDT the unique energy and precarious nature of the therapeutic relationship. Where existing repetitive patterns of behaviour are enacted in the therapeutic relationship by both the patient and the therapist; what psychodynamic theory calls transference-countertransference paradigms; this focal therapeutic dyad serves as a powerful arena within which to explore the patient's self-representations, deficits in early attachment, their family narrative, established character traits, abuse, a broader psychiatric profile, body image, and the individual metaphors surrounding food and eating (Zerbe, 2001, 2008, 2010, 2015). While the ST model has not adopted the terms "transference" and "countertransference" into its language, schema therapists are trained to be attuned to the manner in which both their patients' and their own EMSs and schema modes are activated in sessions in providing vital clues to the relational processes being addressed in treatment. This is a reminder of the centrality of the therapeutic alliance in ST, even though it is an important feature in almost all modalities of therapy, including CT and CBT (Waddington, 2002).

Contemporary psychodynamic therapists working with patients with EDs have the opportunity to draw on an ever-expanding theoretical repertoire and research base; borrowing and blending their technical interventions from a myriad of "schools" that have both challenged and shaped the psychodynamic discipline for over a century. Despite their many differences, classical and contemporary Freudian viewpoints, ego psychology, object relations, self-psychology and attachment theories still all share an exploration of feelings, perceptions, memories, fantasies and wishes, conflicts and defences, as well as the individuals' relationships with others and with themselves. All these common features assist patients with EDs to confront their pathological relationship to food, to their bodies, and in the relationship with themselves. Even the central thrust of early psychoanalysis of "making the unconscious conscious" remains relevant in helping patients transform into language the affect that was previously submerged and thoroughly distorted by the ED (Zerbe, 2015).

The importance of disturbances related to the quantity of food intake, the role that eating patterns play in early development, as well as the psychological meaning of eating, food and body-image disturbances were already referenced in some of Freud's early case studies (Gardiner, Freud, Brunswick, 1971; Mahony, 1986). To place into historic context, the broad array of difficulties - including AN, binge-eating, addictions and mood disturbances – were, until the middle of the 20th century, explained to problems in negotiating the oral phase of psychosexual development, which can also be explained as disturbances in drive discharge; the biological and psychological processes by which an individual achieves homeostasis by dampening their innate impulses of libido and aggression (Zerbe, 2010). Primary defences like denial, repression, reaction formation and the over- or under-control of impulses were observed in patients with AN or compulsive over-eating, with the former condition being described as a "monosymptomatic hypochondriacal delusion" that results from the denial accompanying the extreme control of normal oral impulses and an excessively harsh superego (Zenbe, 2010, p.341). The case conceptualisations by early psychoanalyst thus viewed all EDs, whether AN or other hysterical features like psychogenic vomiting, as distortions in the oral developmental phase and unresolved sexual conflicts (Bruch, 1973; Wilson, Hogan & Mintz, 1985). While the psychoanalyst serves as a "blank screen", the healing process exclusively involves the therapist's interpretation of the patient's repressed conflicts, thus providing the patient with the insight to bring about change.

A shift towards the middle of the 20th century saw the classical psychoanalytic concepts and purely interpretive models of EDs treatment becoming archaic and making way for more supportive interventions, strongly influenced by attachment theory and an emphasis on internal object relations and the development of a sense of self. Interruptions to the separation-individuation process created by inadequate primary caretaking explain intra-psychic injuries to the child that result in impaired object constancy, intense anxiety and urgent efforts to cling to the primary object, dysfunctional control behaviour, or to find other means of self-soothing (Mahler, Pine, & Bergman, 1975). As such, EDs became conceptualised as the unconscious efforts engaged in by individuals in order

to try and negotiate the pathway towards healthy independence, autonomy and age-appropriate dependence on others.

The seminal work of Bruch (1973, 1974, 1985) addressed the tension between separation and individuation in patients with AN. Her conceptualisation of AN emphasises the distortion of body image, an impaired self-perception, a deep sense of inadequacy, and impaired autonomy as significant disturbances in normal development. Her theory holds that during adolescence, an early dependency on the mother obstructs the pubescent girl from identifying her inner needs and making her own appropriate decisions. Females with AN thus experience the dramatic physical and emotional changes that accompany adolescence as threatening; a phase associated with the demanding expectation to become separate and self-sufficient as adult women. By maintaining a pre-pubescent body, the patient attempts to interrupt the separation process, with their ED serving as a form of compensatory identity of the self. This marked obstruction in her development of autonomy is what Arthur Crisp described as a "flight from growth" (Crisp, 1997). Bruch's (1988) treatment approach served as one of the earliest in demonstrating the important shift away from the interpretative to the supportive therapeutic stances, where the therapist supports the patient in negotiating the separation-individuation process and cultivating a healthy sense of self.

Psychodynamic therapists influenced by the work of Klein, Fairbairn and Winnicott conceptualised patients' internal worlds as failed attachments to, and struggles to extricate themselves from, "bad" internal objects (Greenberg & Mitchell, 1983; Hughes, 1990), or what schema therapists would conceptualise as the self-condemnation or self-disgust experienced by the VuCh in the wake of criticism imposed by a PuPa. Winnicott's (1965) numerous observations of mother-child interaction that resulted in his conceptualisation of the "True Self" and "False Self" were significant. He maintained that a parenting environment experienced by a child as "good enough" will be conducive to the development of a "True Self", where the child will feel recognised and validated, is capable of being both creative and imaginative, and feels alive. This is synonymous with the ST model's notion of the HaCh mode described earlier (see section 1.5.). Deprived of such psychological nourishment, the child will develop a "False Self" which, besides overshadowing the "True Self", will adopt the precarious caretaker role (the parentified child) in an environment that has dismally failed them (Bornstein, 2013; Phillips, 1988; Winnicott, 1965). For instance, the physical symptoms of severe restriction, purging, excessive exercising and the preoccupation with physical perfection can, in many cases, be conceptualised as "False Self" phenomena. As such, EDs symptoms are conceptualised as providing a self-protective function for many patients, where the "False Self" provides an inflexible source of illusory "comfort and solace" in diluting emotional hardship (Zerbe, 2015), despite its glaringly obvious dangers. Of course, this conceptualisation of the ED is synonymous with the role of coping behaviour in ST.

Palazzoli (1974) provided another view in explaining the precipitation of AN in girls during puberty. Her object-relations stance holds that the AN sufferer, who has a particularly symbiotic or enmeshed relationship with an over-controlling mother experiences her sexually developing body as "the maternal object, from which the ego wishes to separate itself at all costs" (Palazzoli, 1974, p.90). She thus experiences her body as a threat and a partially "bad" aspect of her mother. As such, self-imposed starvation thus serves as an interruption of her sexually developing body; an unconscious mechanism by which she attempts to still negotiate a separation and individuation from the threatening maternal figure (Palazzoli, 1974). Like Bruch, Palazzoli is essentially conceptualising AN as an avoidant means of coping with a challenging and difficult phase of transition.

The basic assumptions of the two major theoretical fields of attachment theory (Bowlby, 1973, 1980, 1982, 1988) and interpersonal theory (Kiesler, 1982a, 1996, Sullivan, 1953a, 1953b) converge to suggest that the interpersonal orientation of both the patient and the therapist is the key to understanding their match or therapeutic compatibility. While there is value in the therapist and their patient sharing similarities along certain domains, these theories also emphasise how contrasting interpersonal orientations of the therapist and patient are conducive to a favourable outcome of the treatment relationship and a positive therapeutic process. By virtue of the corrective emotional experience, (Alexander, 1950; Alexander and French, 1946), the therapist is able to provide an experiential re-learning by which the patient can safely alter their rigid relational patterns through being exposed to new interpersonal experiences in the therapeutic setting. The patient is thus provided with the opportunity to gradually develop a more flexible and diverse repertoire of interpersonal behaviours (Teyber, 2000) towards personal growth.

As a psychoanalyst and researcher, the invaluable contribution that John Bowlby made to attachment theory from the 1970s has been applied to numerous conditions, including EDs. According to Bowlby, and those who have elaborated on his work (Bowlby, 2005; Fonagy, Gerely, Jurist, & Target, 2002; Goldberg, Muir, & Kerr, 1995; Stein, Fonagy, Ferguson, & Wisman, 2000), individuals are born with an innate biological need to make safe and close bonds with others. As such, children construct "internal working models" or internal representations of themselves and others that provide the foundation for subsequent personality organisation and the capacity to develop reliable and secure attachments with which they will later safely negotiate the world around them. Insecure attachment, as has already been discussed (see section 2.7.2a), will interrupt the necessary "feedback loop" that Bowlby (1988) said was essential in the processing of feelings like anger, rage and abandonment. This inability to reflect on feelings and be conscious of them due to a lack of a secure base is what restricts emotional growth and development (Holmes, 1993). Such individuals will inevitably experience any number of psychopathological problems, including hypervigilance, angry threats, compulsive behaviour (Armstrong & Roth, 1989) and other self-regulatory problems, all of which are displayed amongst individuals who suffer from an ED (Zerbe, 2010). While separation anxiety is an expected and normal experience for anyone, the substantial

impairments and disruptions with the relied-upon caretakers is what results in anxious, ambivalent and dysregulated attachment styles that evoke feelings of abandonment and a lack of creative curiosity, and which consequently manifest in psychopathology, including EDs (Armstrong & Roth, 1989). Here, psychodynamic therapists have the opportunity to draw on attachment theory to build case conceptualisations that appreciate the failed attempts that patients with EDs make to mute the painful experiences of separation and be inevitably drawn into self-blame, anger and an agonizing emptiness. This lack of responsiveness and "containing envelope" (Winter, 2002, p.36) explains the enormous difficulty that many patients with EDs have in forming or sustaining a close working alliance in therapy. While restrictive dieting, paradoxically, provides a perceived "blanket of security" in negating the need for interpersonal intimacy, binge-eating may provide a sense of nurturance or self-soothing as a substitute for trusted and intimate relationships (Armstrong & Roth, 1989). Again, this strongly resonates with the ST conceptualisation of EDs operating as an overcompensatory or avoidant means of coping in order to evade or dampen overwhelming emotion pain.

A recent and promising area of research lies in "mentalisation-based therapy" (MBT) for EDs, drawing on the already established findings that insecure attachment (Ramsay, et al., 2000), especially the dismissive attachment styles (Ramsay et al., 2001) (see section 2.7.2a), are conducive to the development of EDs. They defined mentalisation as the process by which individuals implicitly and explicitly interpret the actions of themselves and others as meaningful on the basis of intentional mental states. This conscious realisation of feeling, which is essentially a metacognitive move, is similar to Bowlby's (1988) concept of feedback loop to process feelings in a conscious way. Developed and manualised by Fonagy and Bateman (Bateman & Fonagy, 2004), MBT is an integrative therapeutic model that was initially designed for the treatment of BPD; drawing on PDT and CBT, as well as systemic and ecological approaches, for the treatment of BPD. The rationale for MBT is to increase the mentalisation capacity for the purpose of reducing impulsive self-destructive behaviours and improving affect regulation and the quality of interpersonal relationships. Whereby some primary caretakers transmit faulty attachment patterns to their children that result in their inability to emotionally process feelings, especially loss, manuals are being developed to assist individuals with EDs to rehabilitate the mentalisation function. Data is forthcoming (Skårderud, 2007[a]), but the initial results appear promising in the RCT (Robinson, et al., 2014) that is investigating, concretely, the experiences with body and food, and connecting them with emotional, cognitive and relational experiences.

Advances in self psychological perspectives towards addressing specific diagnoses have been made since the initial work of Kohut in the 1970s. In normal development, the needs of the infant are transformed through the parents' nurturance to ensure that the child has the capacity to regulate the self. Recent infant research has demonstrated how both verbal and non-verbal communication occurs mutually between the infant and their primary caretaker in guiding affect regulation and influencing their relationship over time (Beebe & Lachman, 2013). Feeding is

undoubtedly a primary experience that spontaneously lends itself to the development of self-regulatory capacities that can perilously fail if the primary caretaker struggles to recognise, respond empathically to, and meet the infant's needs. The self psychological approach to the treatment of EDs views AN and BN as specific cases of pathology of the self. Hence, patients with these disorders cannot rely on others to fulfil their selfobject needs; failing to trust that they will relinquish, even temporarily, their own interests and stance for the sake of fulfilling the patient's self-needs, such as regulation of self-esteem, calming, soothing and vitalizing. Instead, such patients turn to mind-altering substance, or the restriction or over-consumption of food, to fulfil these needs. Therapy assists the patient to relinquish the pathological preference for food as a selfobject and begin to rely on others as selfobjects, starting with the therapist. According to Kohut (1977, 1984), the self psychologically informed therapist should prioritise listening empathically and mirroring over interpretation. The therapist should listen with special attentiveness to the patient's vulnerabilities so as to not replicate traumatisation within the therapeutic relationship. The therapist should not actively soothe or comfort the patient, but, instead, empathise with his or her need to merge with a strong selfobject. The self psychologist attends to their patient, focusing strongly on how their patient experiences the therapist's impact on their sense of self (Bacher, Latzer, Kreitler, & Berry, 1999; de Groot & Rodin, 1998). In so doing, it is hoped that this means of providing the corrective emotional experience will help transform the patient's capacity to self-regulate and honour their need to be mirrored, attend to their nutritional needs, and feel safe being emotionally nourished by others (Zerbe, 2010). This significant shift in PDT away from the interpretive towards the more supportive end of the continuum provides a clue to the source influence of the therapeutic relationship in ST, where the concepts of limited reparenting and empathic confrontation echo, respectively, those of the corrective emotional experience and appropriately timed challenges in PDT. Given the strong theoretical grounding of ST, it is clear that this framework offers strength at both the interpretive and supportive levels.

Interpersonal psychotherapy (IPT) is another evidence-based and time-limited therapy that most notably focuses on improving the patient's interpersonal functioning by relating psychiatric symptoms to problematic areas within interpersonal relationships (Freeman & Gil, 2004; Klerman, Weissman, Rounsaville, & Chevron, 1984). Emanating from the psychodynamic discipline, it is grounded in the theoretical frameworks developed by Adolf Meyer, Harry Stack Sullivan, and John Bowlby, each of which recognises the quality of interpersonal functioning as a crucial component of psychological adjustment and overall well-being (Kass, Patmore, & Wilfley, 2015). The basic principle of this approach is that the development, maintenance, response to treatment and prognosis of many psychiatric conditions exist in a social and interpersonal context influenced by the patient's significant interpersonal relationships. Strategies are developed to improve interpersonal functioning within four social domains, namely: grief, role transitions, interpersonal role disputes and interpersonal deficits. The primary goal of IPT is to identify and change the dysfunctional interpersonal context in which the psychiatric condition developed

and was maintained, and to resolve such symptoms through improving the quality of the patient's current interpersonal relationships and social functioning (Kass, et al., 2015).

While initially developed as a short-term and structured psychotherapy for depression (Weissman & Markowitz, 1994), IPT was adapted by Fairburn (Fairburn, Jones, Peveler, Hope, & O'Connor, 1993) for the treatment of BN. The primarily goal lies in identifying and modifying interpersonal problems that are hypothesised to develop and/or maintain the ED. It directly addresses these social deficits by assisting patients in identifying patterns of binge-eating and purging as a coping strategy, a concept shared by ST, in order to deal with interpersonal stressors and negative affect, and to ultimately improve interpersonal skills in a way that promotes self-esteem and resolves negative affect (Kass, et al., 2015). Without focusing directly on the ED symptoms, the treatment is both non-directive and non-interpretive (Wilson et al., 2007).

IPT is delivered in three phases, typically comprising once weekly sessions over four to five months. As is the case with ST, the initial phase involves a comprehensive assessment, with a full history of relevant life events and a list of ED symptoms being prioritised. Thereafter, the therapist provides a rationale for the therapeutic framework and explains how addressing interpersonal problems will help to alleviate ED behaviours. The therapist conducts an "interpersonal inventory" by assessing the patient's current relationships, interpersonal functioning, as well as their relationship expectations and patterns. This is used to develop an interpersonal conceptualisation from which problem areas are identified, and the focus of treatment determined. The 10 to 12 sessions of the intermediate or "work phase" involves a weekly collaborative review of problematic interpersonal situations that arose in the preceding week, which is then linked to active disordered eating behaviour. Once interpersonal problems that trigger ED symptoms are identified, strategies are devised to alter the interpersonal context to effectively interrupt EDs behaviour. This is not dissimilar to the method behind schema therapists identifying the source of triggering in the Child and, where relevant, intercepting an interpersonal sequencing or cycle of modes that perpetually culminates in dysfunctional coping behaviour. The goal would thus be to strengthen the patient's ability to engage in HeAd responses that protect and nurture the Child, rather than the destructive cycle being perpetuated. IPT recognises the importance of therapists affirming their patients for successfully suspending EDs behaviour. Emphasis is placed during this phase of treatment to help patients more effectively identify and express their emotions, which is conducive to improvements in their interpersonal relationships (Wilfley, MacKenzie, Welch, Ayres, & Weissman, 2000).

Since it is well established that negative affect is a common antecedent to binge-eating (Wolfe et al., 2009), it is important that the therapist assist the patient to acknowledge and express painful emotions that would likely be suppressed in order to foster healthy interpersonal change (Wilfley et al., 2000). The therapists may employ communication analysis to help the patient improve their communication skills. After a patient has described a recent interaction with a significant person, the therapist then uses this detailed analysis to identify the patient's

ineffective communication patterns and work with the patient in improving his or her communication strategies. During this phase it is vital that the therapist remains attuned to helping the patient make links between his or her interpersonal problems and ED symptoms. Even if the patient is tempted to focus on the ED symptoms, the therapist should reinforce the treatment goals and, in a gentle manner, firmly reposition the focus on the interpersonal context in which the ED symptoms occurred. The final phase of treatment involves the explicit discussion of plans towards the termination of treatment. A collaborative effort is made in evaluating and consolidating the gains made during treatment and the planning of post-treatment goals, typically identifying high risk situations and early warning signs for lapses (e.g., binge-eating, dietary restriction), and discussing strategies for effective coping (Kass, et al., 2015).

The important consideration that IPT brings to the treatment of EDs is the significant role interpersonal relationships play in their aetiology and maintenance (Thompson-Brenner, 2016). While the importance of attachment theory has already been outlined, it is vitally important that the painful emotion associated with early schema injury that finds expression in later interpersonal relationships is acknowledged and addressed through the corrective relational experience. While the therapeutic relationship serves as an ideal arena within which to initiate this corrective process, IPT provides a context in which the dynamics of important interpersonal relationship challenges can be addressed in order to curb the propensity for ED behaviour.

Streeck's (2006) development of "psychoanalytic-interactional psychotherapy" (PIP) provides a specific method for treating severely disturbed patients with conditions like BPD, addictions and EDs. It emphasises interpersonal processes and the subjective experiences of the here-and-now with the therapist. Once the therapist has verbalised the affect and experiences they observe in his or her patient, the patient is encouraged to share his or her own reflections and feelings about the perceptions made, thus enhancing the experience of interpersonal boundaries and subjectivity. Furthermore, the therapist is required to directly address dysfunctional behaviour patterns with the goal of fostering differentiation of self from other (Zerbe, 2010). Several small studies (Roth & Fonagy, 2005; Shadish, Matt, Navarro, & Phillips, 2000; Streeck, 2006) evaluating the effectiveness of PIP have demonstrated its ability to reduce interpersonal problems as well as EDs features and many of the self-destructive traits associated with BPD. This has prompted PIP researchers to not only call for follow-up studies to test the stability of treatment effects for ED symptoms, but also for a combination of naturalistic studies and RCT to comprehensively evaluate quality and nature of this modality of treatment.

The centrality of the therapeutic alliance, reduction of internal criticism, a positive development of the core self, and the scrutiny of dysfunctional interpersonal relationships consistently emerged as important features of PDT towards reducing ED symptoms and improving quality of life. The relevance of insecure attachment (Tasca, Ritchie, & Balfour, 2011; Treasure, Corfield, & Cardi, 2012) and an unremittingly punitive superego (Bers, Blatt, & Dolinski, 2004; Teusch, 2012) are two further core issues addressed in a psychodynamic approach. All the aforementioned

features central to psychodynamic therapy have left an indelible mark in the design of ST, especially where the prominent focus on addressing and resolving interpersonal and intrapersonal conflict is effectively addressed via the various techniques that highlight the multiplicity of modes representing parts of the self. Whether Winnicott's conceptualisation of the "False Self", or Bruch and Palazzoli's understanding of the role AN plays in easing the tensions associated with sexual maturation and the individuation process, these conceptualisations all point to an adaptive role that AN serves as a protective device in suspending the emotional challenges associated with a child's transition into young adulthood. So, too, does the ST mode model reflect the stance where, not just for AN, but for the broad spectrum of EDs, such pathological food-related phenomena serve as devices by which the vulnerable, angry or impulsive Child copes with the emotional distress associated with perceived interpersonal and intrapersonal challenges, including the unpredictability of change. It should not be forgotten that many psychodynamic therapists will still integrate elements of other treatment modalities (motivational interviewing, CBT, psychopharmacology) to enhance their treatment design (Tobin, Banker, Weisberg, & Bowers, 2007); another element that it reflects in the innately integrative quality and design of ST that insures that there are a vast array of tools to individualise treatment to the patient's particular needs. Finally, a necessary aspect of ST is echoed in Zerbe's (2015) caution that psychodynamic therapy for the EDs requires much patience and endurance in order for the sufferer to process loss and negotiate a new pathway towards personal transformation. A gentle embrace of guardianship is required to fuel the capacity for the sufferer to feel joy and happiness, to experience their therapist as both witnessing and holding their inevitable life challenges, and to encourage and affirm the tentative steps towards recovery amidst the inevitable lapses along the pathway to personal liberation.

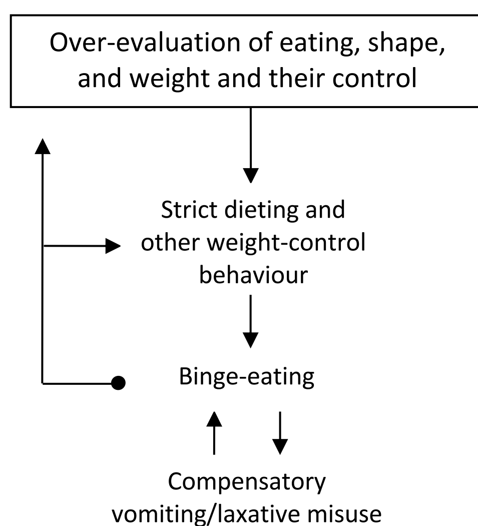
3.2.2. Cognitive Behavioural Therapies

While the first models of ED treatment emerged from the psychodynamic schools, it is those developed within the CBT framework that are readily used by clinicians, and deemed the most efficacious within the research arena, especially for the treatment of BN. Theory-driven, manualised CBT is based on a cognitive model that addresses the primary mechanisms that maintain ED symptomatic behaviour (Fairburn, 1981; Fairburn, 1985; Fairburn, Marcus, & Wilson, 1993). This model holds that a dysfunctional system of evaluating self-worth lies as a foundation in the maintenance of EDs. While most individuals evaluate their self-worth on performance along a variety of domains (e.g., the quality of their work, studies, relationships, parenting skills, sporting ability, etc.), what appears common amongst individuals with EDs is their capacity to evaluate themselves, even exclusively, on their eating habits, weight and shape, and their ability to "control" these domains. As such, their lives are obsessively focused on eating, weight and shape with dietary control and weight loss, while thinness remains an active preoccupation. Likewise, overeating, weight gain and being overweight are persistently avoided. This over-evaluation and control over eating, weight and shape is viewed as the focal point in maintaining the disorders, while most of the other clinical features are viewed as stemming directly from this "core psychopathology". This includes the extreme

weight control behaviours (dietary restriction, purging, laxative/diuretic abuse and excessive exercise), the various rituals of body checking and means of avoidance, and the rumination about eating, weight and shape. Binge-eating, which is not seen as a direct expression of the core psychopathology, is understood to be a combination of the inevitable physiological consequence of the inability to sustain weight loss efforts and the emotional triggering brought about by acute and adverse changes in mood. The emotionally numbing effect of such binge-eating, together with the renewed efforts towards weight loss and the unrelenting self-imposed standards that lend to enormously negative self-evaluation perpetuates the cycle that typifies these disorders (Fairburn et al., 2003). Figure 7 below provides a schematic representation of the primary processes involved in the first model developed for BN.

For the purpose of addressing the negative concerns about weight and shape that leads to dysfunctional dieting and other pathological weight-controlling behaviours, the treatment comprises cognitive and behavioural procedures that are designed to enhance motivation for change, to replace dysfunctional dieting with a flexible and moderate pattern of eating, to reduce the preoccupation with weight and body shape, and prevent relapse. While individual therapy typically consists of once weekly individual sessions over four to five months, the same treatment has been effectively conducted in a group therapy context (Chen et al., 2003; Nevonen & Broberg, 2006). It is this model of treatment that the British National Institute for Health and Care Excellence (NICE; 2004) has recommended as a first choice of treatment for BN. While it has been demonstrated to be more efficacious than antidepressant medication in curbing binge-eating and purging (Wilson & Shafran, 2005), it has also demonstrated superiority when compared with other psychological treatment for adults (Wilson & Fairburn, 2002, cited in Wilson et al., 2007). While also reducing the rate of adjunct psychiatric symptoms and improving self-esteem and social functioning, this treatment model still only appears to help 30% to 50% of sufferers achieve and sustain full remission (Agras et al., 2000; Poulsen, Lunn, Daniel, Folke, Mathiesen, & Katznelson, 2014; Wilson, Fairburn, Agras, Walsh, & Kraemer, 2000).

Figure 7: A schematic representation of the cognitive behavioural theory of the maintenance of BN
(modified from Fairburn, Marcus, & Wilson, 1993)



Controlled studies using a manualised CBT treatment for BED (Fairburn et al., 1993) adapted from the version used to treat (CBT-BN) has been shown to substantially reduce binge-eating and many of the associated problems, the benefits of which were retained at 12-month follow-up. It should be noted, however, that the treatment did not result in weight loss where this was indicated (Grilo & Masheb, 2005; Grilo, Masheb, Wilson, Gueorguieva, & White, 2011; Hilbert, Hildebrandt, Agras, Wilfrey, & Wilson, 2015; Wilfrey et al., 1993; Wilfrey et al., 2002). Wilson and colleagues have thus encouraged the development of treatment models to address the specific symptoms of BED rather than the reliance on a modification of existing models for similar disorders (Wilson et al., 2007). While it appears that manualised CBT in conjunction with both weight loss medication (Grilo, Masheb, & Salant, 2005) and cardiovascular exercise (Cook et al., 2015; Pendleton, Goodrick, Poston, Reeves, & Foreyt, 2002) has facilitated weight loss for obese patients with BED, no other treatment models have yet shown much promise (Wilson et al., 2007).

The first CBT model to specifically address AN was developed by Garner and Vitousek[3] (Garner & Bemis, 1982; Garner, Bemis, & Pike, 1997) and overlaps considerably with Fairburn's (1981; 1985) analysis of BN, thus supporting the view that these conditions have core features in common. While both models share many strategies, there are some key differences in emphasis for the AN model. While priority is made to attend to the problems associated with semi-starvation and the need for weight restoration (Garner et al., 1997), much attention is also assigned to enhancing motivation for change and the building of a collaborative therapeutic relationship (Garner et al., 1997; Vitousek, Watson, & Wilson, 1998). Patients who begin treatment at a low weight typically require two years of individual therapy, with normal weight typically being restored half-way through the treatment (Wilson et al., 2007).

Recognised as the most comprehensive and empirically validated affect regulation treatment (Linehan et al., 2006; Safer, Telch, & Agras, 2001a), dialectical behaviour therapy (DBT) was developed by Marsha Linehan (1993) specifically for females diagnosed with BPD. Such individuals are particularly prone to para-suicidal and other self-harming behaviour in the face of chronic emotional dysregulation (Cronwell, Beauchaine, & Linehan, 2009). The standard DBT treatment package comprises four modules of psycho-education skills training groups held over approximately six months, including: core mindfulness, emotional regulation, distress tolerance and interpersonal effectiveness. Weekly individual therapy sessions aim to further promote the management of emotions and the surrendering of ineffective behaviour. As is the case in ST, homework and self-monitoring tools provide the opportunity to further reinforce and refine skills beyond the therapy room. While patients also attend weekly professional multidisciplinary team meetings, telephone consultations with the designated primary therapist serve to support the patient in a crisis situation, where the emphasis lies in postponing the impulses to self-harm. Linehan (1993) introduced the concept of "dialectics" to the behavioural treatment model, where dialectic

[3] Kelly M. Vitousek's former name is Kelly M. Bemis

resolution involves systematically comparing opposites or apparent contradictions, and finding a moderate path. The primary dialectic or tension addressed in DBT is "acceptance versus change."

In addressing EDs, Wisniewski and Kelly (2003) have suggested that this primary dialectic would translate into achieving a dialectical synthesis of rigidly over-controlled eating versus mindless eating. It is thus not difficult to conceptualise the EDs behaviour of this extremely harm-avoidant and emotionally vulnerable patient population (Fassino, Amianto, Gramaglia, Facchini, & Daga, 2004) as mood-dependent. This heightened sensitivity to harm-avoidance lends such patients to be inclined to largely control and avoid negative affect by using disordered eating behaviours to facilitate experiential avoidance. Again, this largely echoes the ST conceptualisation of viewing EDs as coping behaviour in order to arrest negative and unmanageable affect. With this conceptualisation, Bishop (2015) proposed the application of DBT for all patients with EDs who have not responded favourably to the existing evidence-based treatment models, and not only those with an adjunct BPD diagnosis. In fact, research on the application of DBT to the treatment of EDs dates back to the mid-1990s. Bishop's (2013) survey of over fifty EDs treatment facilities in the United States revealed that almost three quarters employed DBT as at least one of their treatment modalities in their programme. Zimmerman & Mattia (1999) have postulated that this might be due to EDs behaviour being viewed as self-harming behaviour, and that such eating pathology is often merely one of a number of coexisting self-injurious behaviours seen amongst patients with BPD.

This shift towards DBT and other contemporary therapies appears to reflect the change in treatment emphasis from the more cognitive therapies towards affect-regulation models (Bankoff, Karpel, Forbes, & Pantalone, 2012; Chen & Safer, 2010). An adapted version of DBT for the treatment of EDs holds that one or more of the four modes of treatment can be excluded or modified, although it has been recommended that skills in mindfulness, emotional regulation and distress tolerance always be included. Mindfulness skills are taught to interrupt the tendency to use binge-eating to avoid emotional awareness and, instead, invite consciousness to the emotions in a non-judgmental manner. The mindfulness skills also serve as a valuable foundation for the emotion regulation and distress tolerance modules, as they enable patients to both recognise and acknowledge their emotional states instead of engaging reflexively in impulsive behaviour. Once in a state of mindful awareness, the patient is better equipped to make adaptive choices about emotion regulation and have the distress tolerance skills to dissuade binge-eating (Kristeller, Baer, & Quillian-Wolever, 2006). Additional skills that focus on eating behaviour, such as mindful eating, urge-surfing, behavioural chain analysis and incorporating eating behaviour into the diary card have all proven useful (Chen & Safer, 2010; Wisniewski & Kelly, 2003).

While not demonstrating the same remission rates as CBT and IPT, DBT has also shown itself to be a promising treatment model for BED, especially where its emphasis on strategic training towards greater awareness and emotional regulation helps to address the chaotic eating patterns associated with this disorder (Grilo et al., 2001; Telch et al., 2001). While the cognitive tools appear useful in addressing the level of motivation for change and the

value of developing moderate behaviour, the emphasis on affect-regulation reiterates the need for a therapy that addresses intolerable mood states and the urgency that patients have in finding a means of avoiding such overwhelming emotion.

As discussed earlier, (see section 2.2.), for some time numerous experts have proposed that EDs should all be merged into a single diagnostic category, arguing that the instability of subtype diagnoses, the evidence of cross-transmission of familial risks, the similarity of symptomatology and distribution patterns, and the high percentage of non-specified cases (OSFED) all affirm to the operation of common mechanisms (Beumont, Garner, & Touyz, 1994; Holmgren, Humble, Norring, & Roos, 1983). This has been echoed by the CBT theorists (Fairburn & Garner, 1988), albeit cautioning that some important specifics to the treatment approach will vary with respects to the patient's current weight status and level of motivation for change (Garner, Vitousek, & Pike, 1997). In one of the most cited papers in the psychiatric literature, Fairburn, Cooper and Shafran (2003) address the persistent nature of EDs and argue that there is no valid reason to differentiate the various EDs diagnostic entities as outlined in the DSM-5 (APA, 2013) and its preceding editions. They argue that although each condition has some distinct features, the clinical features are maintained by similar psychopathological processes. They also argue that CBT for bulimia, the leading evidence-based theory of the maintenance of EDs, be extended in its focus to address four additional maintaining mechanisms, any combination of which interact with the core ED maintaining mechanisms that obstruct change in many patients. Somewhat reflective of the focal points of DBT, these four mechanisms involve the influence of clinical perfectionism, core low self-esteem, mood intolerance and interpersonal difficulties. They thus suggest that common mechanisms are involved in the persistent nature of each of the recognised diagnostic entities, and propose a transdiagnostic theory of the maintenance of the full spectrum of EDs and a theory that encompasses a broader range of maintaining mechanisms than did the existing theory concerning BN (Fairburn et al., 2003).

While perfectionism and poor self-esteem have already been discussed (See 2.7.3a and 2.7.3b respectively), many patients with EDs also struggle with mood intolerance or mood dysregulation. While such intolerance usually involves adverse mood states like anger, anxiety or depression, it can include all intense mood states, including positive ones (e.g., excitement). Instead of responding appropriately to different mood states, these individuals engage in dysfunctional mood modulatory behaviour to reduce or neutralise their awareness of the triggered mood state and its associated cognition. Again, this echoes the ST conceptualisation of EDs as selective coping modes. Besides binge-eating, purging and excessive exercise serving as a means of self-soothing, self-stimulating or overcompensation amongst patients with EDs, other behaviours like self-injury (e.g., cutting, punching, or burning themselves) or psychoactive substance abuse (e.g., alcohol, narcotics, or tranquilizers) are well-documented behaviours amongst patients with EDs as a means of dampening emotion via self-soothing or over-stimulating coping behaviour (Anestis et al., 2012; Claes, Soenens, Vansteenkiste, & Vandereycken, 2012; Paul,

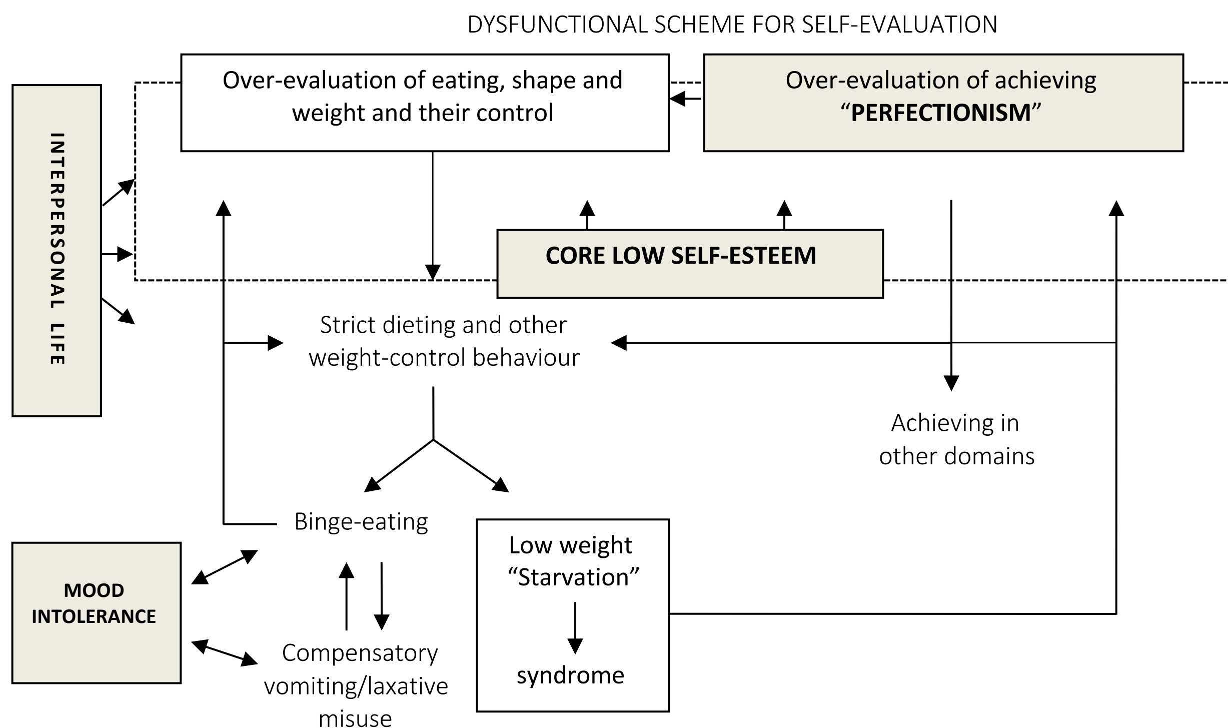
Schroeter, Dahme, & Nutzinger, 2014). The impact of interpersonal relationships on ED behaviour is evident in the research using IPT and PIP. Interpersonal conflict may be within the family context or within intimate relationships that influences self-esteem levels and reinforces the preoccupation with control around eating, weight and shape. Although it is not known exactly how IPT achieves its beneficial influence on patients with EDs, it is certain that interpersonal difficulties exacerbate ED behaviour, while there is also evidence that the resolution of such relational difficulties does facilitate healthy change. It is likely that the corrective emotional experience provided by the therapist is a key element that facilitates change.

From a transdiagnostic perspective, it is evident that AN, BN, BED and atypical EDs have much in common and share the same core psychopathological behaviour and attitudes regarding an over-evaluation of eating, weight and shape, and the control thereof. The major distinction between these diagnostic entities lies in the volume and manner in which food is consumed and its effect on body weight and shape, as well as the variable emphasis of the clinical features maintaining the distinct EDs. Here, perfectionism and core low self-esteem are more prominent in patients with AN than those with BN, while mood intolerance is more prominent in patients who binge-eat and purge (Fairburn et al., 2003). Interpersonal difficulties also appear to be more frequent among patients with AN, which explains the widespread use of family therapy (Eisler, 2005; Le Grange et al., 2009) and the recent interest in IPT and PIP for such patients (McIntosh, Bulik, McKenzie, Luty, & Jordan, 2000). While Fairburn et al. (2003) argue that variable levels of perfectionism, core low self-esteem, mood intolerance and interpersonal difficulties feature in the conceptualisation of all EDs, there is also much evidence of the commonality between the different ED entities by the frequency with which cross-over occurs between them. For instance, as many as a quarter of patients initially diagnosed with AN are subsequently diagnosed with BN (Agras et al., 2000; Sullivan, Bulik, Fear, & Pickering, 1998). Figure 8 on the next page illustrates in schematic form the transdiagnostic theory of the maintenance of EDs. Fairburn and colleagues have cautioned that unless these four maintaining clinical features are resolved for individuals suffering from any ED, a stance shared by schema therapists, treatment is unlikely to secure a full and consistent remission. On the basis of this cognitive behavioural theory, transdiagnostic treatment is suitable for all forms of clinical EDs, with the specific ED diagnosis being irrelevant in the treatment.

The content of the treatment is more dictated by the specific psychopathological features present and the processes that maintain them. The 20-session treatment, which has a longer version for patients that need to restore weight, moves through four stages. The first stage is an intensive one that involves engaging with the patient, providing psychoeducation, creating a personalized conceptualisation and obtaining optimal behavioural change. The second stage includes a detailed review of progress and the identification of resistance to change, which is mostly done by assessing each of the four clinical features that maintain the ED. Through this, the conceptualisation is revised and extended in a collaborative manner. The content of the third and most lengthy stage of treatment is dictated by the revised conceptualisation, where treatment modules for each of the four

clinical features that maintain the ED, where indicated, are addressed. In the final stage of treatment, during which sessions are held fortnightly, the focus is on ensuring continued progress after the treatment has been terminated (Fairburn et al., 2003). What this and the ST model share in common is the strong emphasis on the development and continual updating of a working conceptualisation to ensure that a deepening understanding of the causative factors is made, and that the treatment goals remain in focus.

Figure 8: A Schematic Representation of the Transdiagnostic Theory of the Maintenance of Eating Disorders (Fairburn et al., 2003)



3.2.3. Family Therapy

One of the major paradigms for family therapy is Minuchin's conceptualisation of the "psychosomatic family" (Minuchin, Rosman, Baker, & Minuchin, 2009). Not only has it had a major impact on the treatment of AN, but it has also significantly influenced the development of family therapy, particularly structural family therapy (Eisler, 2005). Despite Bruch's (1973, 2001) conceptualisation that the anorexic's struggle for separation/individuation was a significant contribution to the psychodynamic theory of EDs, her notion that the "anorexigenic mother" (Bruch, 1973) transfers the detrimental attitudes and beliefs that result in her offspring becoming anorexic has been challenged as an unfortunate over-generalisation (Ciao, Anderson, & Le Grange, 2015). In fact, studies have confirmed that there is no consistent pattern of family structure or family functioning in families where someone suffers from AN. Hence, relinquishing the search for the "anorexigenic family" (Eisler, 2005, p.113) and accepting that EDs develop in a variety of family contexts, the question turns to the apparent similarity of experiences that families describe having when a member of the family is suffering with AN. Maudsley-based clinician-researcher,

Ivan Eisler (2005), speaks of the remarkable consistency with which families not only become organised around the ED, but also feel utterly controlled by the situation, while demonstrating how the centrality of the ED amplifies certain aspects of the family's dynamics and narrows the range of their adaptive behaviours. The way families respond to this crisis will vary depending on the nature of the family organisation, the family style of each individual family and the particular life-cycle stage they are at when the illness occurs. In fact, observing how families reorganise themselves around the problem is far more relevant from a treatment perspective than knowing how the problem developed, partly because the way the family is currently functioning may have become part of what maintains the problem and partly because it may be limiting the family's ability to use its adaptive mechanisms to help overcome the problem (Eisler, 2005). So, while the vast majority of treatment models prior to the 1980s excluded parents ("parentectomy") and family members in the treatment of adolescents with AN, Eisler (2005) notes how the more recent research strongly advocates the systemic inclusion of family as an essential component in the treatment of this younger age group. Although it is essential that family members not be blamed for the sufferer's condition, their inclusion in the treatment design can often demonstrate EDs to be closely associated with a complex interplay of dysfunctional interpersonal dynamics, even at a broader societal level through all stages of life leading into early adulthood.

The acceleration of research since the 1990s into the more contemporary family therapy models for the treatment of adolescent AN have shown encouraging results, especially on follow-up. The most studied approach is a specific model known interchangeably as the "Maudsley method" or "family-based treatment" (FBT; Couturier, Kimber, & Szatmari, 2013; Ellison et al., 2012; Hildebrandt, Bacow, Markella, & Loeb, 2012; le Grange et al., 2012; Smith & Cook-Cottone, 2011). Designed for adolescents, this manualised treatment involved 10 to 20 family sessions held typically over six to twelve months. The conjoint format recommends that all family members be seen together. The first phase of treatment guides parents to effectively assume absolute control over their anorexic child's eating habits and weight restoration. The therapist works with the family as an expert consultant, assuming a non-authoritarian stance in order to encourage and empower parents to assume the lead in whatever ways are most conducive to helping their child resolve their ED (Ciao et al., 2015). When the first phase of treatment is successfully negotiated, the subsequent two phases ensure a gentle transition from that of parental authority to an age-appropriate autonomy for the patient, which is explicitly linked to the resolution of her ED. The focus of the third and final phase lies in assisting the patient to deal with the typical challenges that are faced during the transition phase from adolescence to adulthood.

While there is very little resemblance between ST and the initial phase of FBT treatment which, for the sufferer, is essentially prescriptive and non-collaborative, the latter phases of FBT treatment, in which remission has already been secured, more collaboratively assists the recovering adolescent to maintain healthy eating habits, develop their autonomy and skilfully negotiate a safer pathway towards early adulthood. While there might be some merit

in parents maintaining an authoritative role for the adolescent who is extremely treatment-resistant, ST minimises the risk of the likely interpersonal conflict that will ensue in FBT, and addresses the conflict at an intrapersonal level from the outset through the guidance of a trusting and collaborative therapeutic relationship.

3.2.4. Experiential Therapies

Emotion is central to human functioning, dysfunction and change. It is thus an essential basis for practice, requiring an appreciation for its forms, structure and a variety of emotion processes (Elliott & Greenberg, 2007). Experiential therapy "involve treatment techniques, based on psychological principles, that are developed and used with the specific intention of increasing patients' present awareness of feelings, perceptions, cognitions, and sensations; that is, their in-the-moment experience" (Hornyak and Baker, 1989, p.3). More than three decades ago, "Experiential therapies for eating disorders" was published. Edited by Hornyak and Baker (1989), it had already become evident how ED patients adopt physical and often complex metaphors as an expression of their inner emotional turmoil. While AN has a physical and somatic component with its concomitant body image disturbances, Wooley and Kearney-Cooke (1986) remind us of how expressive therapies that involve guided imagery, dance and movement, art and music, psychodrama, as well as poetry and written narrative are capable of accessing emotion and memories that reside deeply within the body. Dolhanty and Greenberg (2007, 2009) point to a number of features that make EFT a compelling treatment for EDs. Simpson (2020) reminds us how "experiential techniques 'fire-up' the cognitive work, transcending intellectual change and penetrating EMSs that are held deep embodies level" (p.82). It is only through such shifts at a deeply held EMS level that real behavioural change can be established to bring about sustained recovery from an ED. Where individuals with AN have difficulty regulating affect - whether over-regulating or under-regulating - this treatment holds affect as a central determinant of human functioning; a positive force and a source of wisdom and rich information. The overriding goal of this approach is to get behind secondary emotions such as despair and hopelessness that obscure or protect the primary emotions, thus gaining access to the core maladaptive emotions such as loneliness, fear of rejection and criticism/shame. With the supportive guidance of the therapist, EFT promotes an acceptance of experienced emotion; a capacity to capably regulate emotion and a transformation of destructive or maladaptive emotions for more healthy and functional alternatives. This process lends to the dismantling of dysfunctional behaviour patterns, thus rendering the ED obsolete as a means of coping. The presenting maladaptive emotions, such as shame, rage, self-loathing or hopeless despair need to be processed; emotions that are painful and seemingly intractable feelings that dilute the self. Such "processing", or what Elliott and Greenberg (2007) term "process guiding", involves attending to the emotions, inviting them in, expressing them, symbolising them through meaning-making, evaluating their trustiness to guide action and transforming them when appropriate. Processing thus involves a heightened awareness of healthy innate emotions and transforming maladaptive emotions. Greenberg, Rice and Elliot (1993) point to importance of such emotion being an in vivo experience in sessions,

which is what renders it amenable to transformation. This is what makes the process-experiential nature of EFT so particularly suited to the ED population. Such emotional connection is often gained through a bodily-felt sensation. Greenberg et al. (1993), like others, caution how talking about emotion has the dead-end effect of maintaining distance from the very feelings that the sufferer so desperately seeks to avoid.

EFT provides an "emotion-friendly" approach whereby emotion is viewed as innately adaptive and a source of vital information and wisdom about the self in the world. It draws attention to important cues, provides basic interpretations and guides action (Dolhanty & Greenberg, 2007). EFT works directly with the ED sufferer's fear of emotion and, by its very structure, challenges fundamentally his or her inclination to steer away from such emotion and see it as inherently bad. By venturing closer to this secondary or maladaptive emotion, the primary emotion can be exposed, tolerated, processed and, through corrective experiences, viewed as a pathway to authentic healing. The role of the therapist is to be an "emotion coach", guiding or closely following the patient forward in the present emotional experience, while also maintaining them within a zone of what Siegel (2020) calls a "window of tolerance"; a level within which the patient can work in an optimal manner without becoming emotionally overwhelmed and, hence, disengage. As such, the emotion can be tolerated, explored and reflected upon in a creative way to determine its adaptive or maladaptive nature. This approach allows therapists to avoid the "tautological trap" (Vitousek, Watson & Wilson, 1998) of becoming stalemated by the patient's lack of readiness to change. By working within the window of tolerance, EFT allows the therapist to honour the patient's stage of readiness to change, while still providing a means of moving forward that is tolerable and enhances the capacity for change. Elliott and Greenberg (2007) describe the dialectic of the process-experiential emotion-focused therapist integrating, leading and following at the same time; a creative tension being held between two vitally important aspects of therapy that is analogous to a dance in which each partner responds to the other by alternately leading and following. In this collaborative process, it is the therapist's task to constantly monitor the state of the therapeutic alliance and the current therapeutic tasks in order to judge the best balance of active stimulation with responsive attunement.

Empathy is an essential ingredient of EFT, and a precondition for therapeutic change. Where the therapist raises awareness of emotion, attends to it, and fosters an attitude allowing and encouraging its moment-by-moment expression, it is the therapist's empathic attunement to the reflection of such experiences that fosters enhanced awareness and acceptance. This is particularly relevant to patients with AN who typically feel empty and are mostly devoid of emotion. EFT therapists also talk of empathic conjecture which involves leading the patient within their window of tolerance while the therapist draws on their own felt sense of the moment. The therapist's empathy aims to gain an "imaginary entry into the experience of the other" to conjecture as to where to lead the current processing (Dolhanty & Greenberg, 2007, p.103). EFT also holds the view of a multiplicity of parts that form the self, working with splits where parts are either cut-off or in conflict with each other. They speak of three

main types of "splits", the first involving working with an internal "critic" or critical voice. This is particularly pertinent with patients with ED where, seldom, is there not a vicious cycle of body disparagement from an "anorexic voice" that sets rules, demands compliance or berates the self for breach of said rules. Validating this voice is seen as an essential process. The second involves working with self-interruptive processes where emotion is shut down or blocked. This is where a patient will reflect feeling nothing or a numbness. It is this nothingness or numbness that needs to be brought to life and validated as "something". The third involved working on "unfinished business" with a significant who has been introjected to become an inner voice of his or her own. They recommend chair work for bringing alive the inner dialogues. This work addresses the developmental issues relating to the ED and helps to unearth primary core emotions such as a fear of abandonment that is hidden behind secondary emotions such as self-loathing or self-contempt. It is easy to see the influence that EFT has had in the development of ST and the role that emotion focused techniques play in its design.

A recent paper by Oldershaw, Startup and Lavender (2019) argues how AN can be explained as arising from a "lost sense of emotional self", and how experiential techniques employed by EFT and ST can be employed to achieve the emergence of, and an integration of, an "emotional self". Oldershaw and her colleagues remind us of how emotions act as a super-ordinate system; as though the conductor of an orchestra comprising cognitive, behavioural, physiological and social functions (Oldershaw, Lavender, Sallis, Stahl & Schmidt, 2015). Dysfunctional emotional processing and regulation underpin many psychiatric conditions (Schäfer, Naumann, Holmes, Tuschen-Caffier & Samson, 2017), including EDs (Lavender et al., 2015; Oldershaw et al., 2015; Mallorqui-Bague et al., 2018), and play a significant role in both the development and maintenance of AN (Treasure & Schmidt, 2013; Wildes, Marcus, Cheng, McCabe & Gaskill, 2014). Once starved, the suppressed physiological state numbs emotion and its values. The emaciated state enables the maladaptive expression of distress and pain (Serpell, Teasdale, Troop & Treasure, 2004), while the ever-narrowing interpersonal life engenders a greater reliance on AN (Schmidt & Treasure, 2006). Here lies the vicious cycle of AN. Where our identity is rooted in emotion, emerges in relationships and develops as a dynamic self-organising system (Bosma & Kunnen, 2001), AN serves to dismantle this system, thus deeming the sense of self "lost". AN becomes a blind search for identity where an unstable and fragile "true self" (Williams, King & Fox, 2016) is replaced by what Bruch (1988) described as a "False Self". The paradox lies in AN being a search for a congruent self, yet only removing the sufferer further from an authentic sense of self. Through emotion-focused interventions, the model proposed by Oldershaw et al. (2019) sees the cultivation of a core emotional sense of self as the primary goal of therapy; an identity that can be both flexible and adaptive in meeting the individual's personal needs and relationships.

3.3. The Motivation to Change

Given the strong ego-syntonic nature of EDs, persuading a sufferer to relinquish the eating pathology that serves the adaptive role of evading or dampening negative emotion is necessary towards establishing an authentic and

collaborative recovery path. Although not stand-alone treatment modalities, the transtheoretical stages of change model (TSCM; Prochaska & DiClemente, 1884; Prochaska, DiClemente, & Norcross, 1992) and motivational interviewing (MI; Miller & Rollnick, 2013) are two well-established tools that measure a patient's willingness to change and, subsequently, persuade them to engage in a genuine and personally-invested recovery.

3.3.1. The Transtheoretical Stages of Change Model

Developed in the early 1980s, the TSCM (Prochaska & DiClemente, 1982; Prochaska, DiClemente, & Norcross, 1992) has enjoyed immense popularity as a means of understanding and promoting behaviour change amongst addicts (Wilson & Schlam, 2004). According to this model, a patient reflects a readiness for changes by passing through a defined sequence of qualitatively distinct stages. Where the "pre-contemplation" stage reflects a patient's absolute refusal to change his or her health-threatened behaviour, the patient is encouraged to step back and take a more global perspective on his or her life values and beliefs. In the "contemplation" stage there is recognition of the problem, albeit with ambivalence. The therapist should, thus, increase any dissonance between the patient's current circumstances and future dreams. When the patient clearly recognises the contradiction in their actions and commits to changing, the "preparation" stage requires an introspection and reaffirmation of the needs and wishes to change behaviour. The "action" stage reflects the patient's committed effort towards change. The therapist assists the patient through the implementation of the standard behaviour change principles like setting goals, designing behavioural experiments, planning their implementation, and both predicting and preventing obstacles that might derail the process (Treasure, 2010).

The different stages of readiness to change are hypothesised to predict a number of factors, including the willingness to participate in treatment, the risk of drop-out, treatment effectiveness and the long-term maintenance of recovery (Prochaska, Redding, and & Evers, 2002). A key assumption of the model is that interventions need to be matched to the individual patient's specific stage of change to be effective. Prochaska et al. (2002) claim that provided therapists are highly attuned to the patients' current stage, such stage-matched treatment should be more effective than traditional action-oriented psychological treatments that navigate patients towards recovery. The model also describes a number of cognitive and experiential processes that guide patients through the early stages of change (e.g., consciousness raising, self-re-evaluation), while behavioural processes (e.g., stimulus control, contingency management) are used more frequently in the latter stages of the model. Prochaska et al. (2002, p.63) describe these processes to be "like individual variables that people need to apply" in order to progress through the various stages of change. The model also incorporates the constructs of self-efficacy and the perceived costs and benefits of change (Wilson & Schlam, 2004).

The model has, however, been the subject of a number of conceptual and empirical critiques (Drieschner, Lammers, & van der Staak, 2004; Littell & Girvin, 2002), whether the variable way in which the various stages have been defined, the lack of discrete boundaries between the different stages or the lack of a necessarily sequential

transition across different stages (Sutton, 2001; Weinstein, Rothman, & Sutton, 1998). Even the ten processes of change that supposedly facilitate stage progression have been criticised as an eclectic multi-theoretical mix with contradictory prescriptions (Bandura, 1997), with Davidson (1992, p.414) describing the model as "atheoretical". Some critics claim that it does not reliably predict outcome (Blanchard, Morgenstern, Morgan, Labouvie, & Bux, 2003; Carlson, Taenzer, Koopmans, & Casebeer, 2003). Most of the research using the TSCM has centred on smoking cessation and alcohol as single behaviours. While it is worth considering that a stages of change model might be applicable to the treatment of EDs, Wilson and Schlam (2004) point to the concern that the treatment of such conditions requires changing multiple behaviours, which further complicates the assessment of stages of change.

3.3.2. Motivational Interviewing

Miller and Rollnick (2013, p. 29) have defined motivational interviewing (MI) as "a collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion." Although it can be used in the form of motivational enhancement therapy (MET), it is a style that can be effectively implemented in conjunction with numerous therapeutic frameworks. Where most patients with EDs, especially AN, are marked by high ego-syntonicity, low confidence about change and emotional difficulties, the MI style has been soundly woven into an FBT model of treatment adapted for adults with AN (MANTRA; Schmidt et al., 2013; Wade, Treasure, & Schmidt, 2011). For outpatient treatment of adolescents with AN, a study has demonstrated the efficacy of training family members and carers in the use of MI skills while participating in the treatment process (MacDonald et al., 2014). Elsewhere, research evidence has demonstrated both the efficacy and effectiveness of MI in the very brief treatment of a variety of health-related problems (Arkowitz, Westra, Miller, & Rollnick, 2008), including substance abuse (Ball et al., 2007, Carroll et al., 2006) and other measures of behaviour change, including weight loss, cigarette smoking, HIV positive risk and hypertension (Burke, Arkowitz, & Menchola, 2003; Dunn, Deroo, & Rivara, 2001; Lundahl, Kunz, Brownell, Tollefson, & Burke, 2010; Rubak, Sandbæk, Lauritzen, & Christensen, 2005).

There are four key interrelated elements to the foundation of MI. The first is "partnership", which reflects the active collaborative nature of communication between experts. "Acceptance" of what the patient brings to sessions is the second element, which includes acknowledging the patient's full worth and autonomy, demonstrating empathy, and affirming his or her strengths and progress. "Compassion" is the third element and refers to an active promotion of the patient's welfare and prioritisation of his or her needs. The fourth element, "evocation," emphasises focusing on and developing what is already present in the patient, rather than focusing on installing what is missing. These four elements are, in fact, central in describing the nature of the therapeutic relationship in ST. While the collaborative element in MI is central in describing the therapy relationship in ST, the

notion of a non-judgmental acknowledgement of the patient's current state is also a vital consideration towards securing a strong therapeutic alliance.

According to Miller & Rollnick (2009), MI is only useful for patients who have not yet reached the preparation level of readiness for change. For complex problems such as EDs where there are various levels of symptoms, the therapist is advised to diligently switch between MI and more action-oriented and evidence-based approaches (Macdonald & Treasure, 2015). A core feature of AN is that the patient is blinded from recognising their problem and often feels coerced into treatment. Where MI posits that even good-intentioned confrontation lends to increased resistance, a patient with AN will likely retreat into intensified EDs behaviour and social isolation when challenged by family and professionals. A recent study demonstrated MI to be helpful in reducing anxiety levels and increasing calorie consumption for patients with AN during supervised meals in both family-assisted outpatient and nursing-assisted inpatient settings (Cardi, Krug, Perpiñá, Mataix-Cols, Roncero, & Treasure, 2012; Cardi, Lounes, Kan, & Treasure, 2013). This style of communication explicitly provides a framework to work with patients who have EDs, rather than against them (Price-Evans & Treasure, 2011; Treasure & Schmidt, 2010). MI may also be an effective style for curbing maladaptive interpersonal responses to the pathology within a family of someone who has an ED or to use within the therapeutic relationship. It can thus serve as an excellent adjunct to IPT.

While two recent literature reviews have provided evidence that the use of MI may increase "readiness to change" amongst patients with EDs (Dray & Wade, 2012; MacDonald, Hibbs, Cornfield, & Treasure 2012), the results of studies utilising the TSCM, most notably a RCT conducted by Treasure, Katzman, Schmidt, Troop, Todd, and de Silva (1999) using MET for patients with BN, was less substantial. However, DiLillo, Siegfried, and West (2003) have advocated adding MI to existing ED models for two reasons. First, MI addresses ambivalence in the way that many ED behavioural treatments allegedly don't, and second, they recognise the flexibility with which MI can be individualised to meet patients' goals more effectively than do many of them, especially manualised, behavioural programmes.

3.4. Evaluation of Eating Disorders Treatment Models

As new and increasingly diverse EDs treatment models are developed, so researchers, clinicians, patients, health agencies and even medical insurance companies demand that efficacy studies be performed before endorsing their wide scale application. It is later argued that systematic case studies provide an invaluable means of gaining a microcosmic view of the sometimes very subtle therapeutic processes at work in particular models of treatment (see section 5.4.). However, it is the quantitative studies in which data is generally expressed by means of descriptive or inferential statistical analysis that are demanded by these various interest groups to instil the confidence that a particular treatment model is reliable, valid and efficacious. In this respect, the RCT is still widely

regarded as the gold standard. What follows is not an exhaustive review, but a summary of many of the significant quantitative studies that have been conducted within the frameworks outlined earlier.

3.4.1. Psychodynamic Therapy Studies

The literature pertaining to the application of the broad ambit of psychodynamic theory to the treatment of EDs is limited, but growing (Bachar, Latzer, Kreitler, & Berry, 1999; Dare, 1997; Dare, Eisler, Russell, Treasure, & Dodge, 2001; Thompson-Brenner, Weingeroff, & Westen, 2010; Tobin, Banker, Weisberg, & Bowers, 2007). While too few patients maintain a lasting benefit from short-term, symptom relief treatments, it has to be considered that the majority of patients with EDs might require a long-term therapy in order to willingly relinquish the secondary benefits of symptoms and then find a personal identity outside of the one partially or entirely defined by the ED. Psychodynamic treatments make interpersonal relationships the major theme. They are less directive than CBT treatments and prioritise the amplification of emotion in sourcing the root of the ED. In fact, intensive PDT has already demonstrated itself to be more cost effective than many short-term manualised therapies when such therapies, whether for the treatment of depression, anxiety disorders, PDs and substance abuse disorders, have repeatedly proven ineffective and requiring regularly and expensive repeats (Berghout, Zevalkink, Katzko, & de Jong, 2012; Dancyger, Krakower, & Fornari, 2013; Lazar, 2010). Despite this, there remains a paucity of controlled trials of the psychodynamic treatment of EDs, which amounts to five for AN (Bachar et al., 1999; Dare et al., 2001; Cowers, Norton, Halek, & Crisp, 1994; Treasure, Todd, Brolly, Tiller, Nehmed, & Denman, 1995; Zipfel et al., 2013), three for BN (Bachar et al, 1999; Fairburn, Kirk, O'Connor, Cooper, 1986; Garner, Rockert, Davis, Garner, Olmsted, & Eagle,1993) and one for BED (Tasca et al., 2006).

The study by Cowers et al. (1994) included 40 patients diagnosed with AN. While half the patients were assigned to the control group that only received a one-off assessment, the remaining twenty patients received 12 individual therapy sessions over a ten-month period that included cognitive and behavioural elements, as well as an emphasis on psychodynamic issues and attention to the transference/counter-transference relationship. Due to time constraints, the 60 to 90-minute sessions were somewhat focused and directed in a style of a range of short-term dynamic therapies (Koss & Butcher, 1986). Nutritional counselling was also provided as well as conjoint family consultations, where applicable. Results at one and two years' follow-up demonstrated that the individuals receiving psychotherapy were significantly improved in comparison with the control group on outcome measures pertaining to weight increase, and those for psychological, sexual and socioeconomic adjustment (Cowers et al., 1994).

The RCT conducted by Dare et al. (2001) assigned 84 adults with AN to one of four outpatient treatments. The first of these was standardised focal psychoanalytic psychotherapy (FPT), derived from the focused and time-limited psychoanalytic therapy of Malan (1976). It is non-directive, gives no advice regarding eating behaviour and symptom management, and primarily addresses the conscious and unconscious meanings of the ED in relation to

their history and family experiences and its effect of the ED symptoms on relationships, including the transference relationship. The cognitive-analytic therapy (CAT) combined elements of cognitive therapy and brief, focused PDT (Ryle, Poyton, & Brockman, 1990; Treasure, Todd, Brolly, Tiller, Nehmed, & Denman, 1995). The patients were helped to construct a formal, mapped-out structure of the intrapersonal location of the AN and place it within the context of their current and past relationships. Very similar to ST, the conceptualisation of the ED is displayed in diagrammatic form and systematically modified over the course of treatment to illustrate the multi-faceted nature of the patient's personality. Even the therapeutic relationship is mapped into the CAT diagram for exploration. The family therapy took the form of FBT, but modified for the treatment of adults. The primary focus involved eliminating the AN from its destructively controlling role in determining the relationships between the sufferer and their fellow family members. The education-based "routine" treatment involved the provision of specific information about the nature and consequences of AN, the prescription of a more regular, moderate and sustainable diet, and medical monitoring. Results at one year reflected modest symptomatic improvement in the whole group of patients, with patients in the FPT and family therapy cohorts demonstrating significantly superior than the control treatment, while CAT[4] showed some benefit.

A recent multicentre RCT conducted by Zipfel et al. (2013) aimed to assess the efficacy and safety of two manualised outpatient treatments for AN - focal psychodynamic psychotherapy (M-FPT) and CBT-E - versus optimised treatment as usual (TAU). Recruited from ten university hospitals in Germany, 242 participants were randomly allocated to one of the three treatments for ten months of therapy. The M-FPT treatment manual is divided into three treatment phases. While the first phase focuses primarily on the therapeutic alliance, pro-anorectic behaviour, ego-syntonic beliefs and self-esteem, the second phase primarily focuses on relevant interpersonal relationships and their association with the EDs behaviour. The final phase addresses the termination of therapy and the transfer of newly learned skills into everyday life. At the end of treatment, all three treatment groups experienced comparative BMI increases, which was the primary outcome measure. While the CBT-E treatment group experienced the fastest rate of weight gain and resolution of EDs psychopathology, the M-FPT treatment group experienced greater weight restoration at 12-month follow-up and demonstrated significantly greater recovery rates than optimal TAU. While, like other single-centre studies (Fairburn, Cooper, Doll, O'Connor, Palmer, & Dalle Grave, 2013; McIntosh et al., 2005; Touyz, le Grange, & Lacey, 2013), this study failed to confirm any one treatment to be superior, the M-FPT treatment group required significantly fewer inpatient admissions than the other two treatments, suggesting PDT as a very viable specifically-tailored outpatient treatment for AN.

The small RCT for patients with AN and BN conducted by Bachar et al. (1999) compared self psychological treatment (SPT), as outlined by Kohut (1977), to cognitive-orientation treatment (COT), with nutritional counselling (C/NC) serving as a control. The SPT approach to the treatment of EDs views AN and BN as specific cases of

[4] Patients assigned to the CAT cohort only received 7 months of treatment, compared to 12 months for the other three cohorts.

pathology. While the SPT adopted in this study has already been outlined earlier (see section 3.2.1.), COT differs somewhat from traditional CBT and is based on the work of Kreitler and Kreitler (2013). Their theory generated a systematic procedure for exploring the meaning of a particular behaviour. For predicting over-eating, for instance, this approach refers to generic themes such as rejection or avoidance of overt expressions of hostility, given that these have been empirically found to govern over-eating behaviour (Kreitler & Chemerinski, 1988). The questionnaire items refer to beliefs related to these generic themes rather than directly to the eating behaviour. The procedure for modifying the behaviour thus focuses on systematically changing the beliefs related to the themes (such as aggression and avoidance) rather than the beliefs referring directly to the eating behaviour. Contrary to the traditional cognitive approach, and more in keeping with the approach in ST, the therapist does not automatically dissuade the patient from seeing their beliefs as incorrect or maladaptive, but helps them to acquire contrary beliefs that are conducive to recovering from the ED. Results of this study demonstrated that SPT achieved significant improvements for patients with BN and AN on measures that included clinical symptoms, attitudes to food and weight, and self-structure. Patients receiving COT showed some, but non-significant improvement, while no changes were detected for those receiving C/NC.

In an earlier RCT conducted by Garner et al. (1993), fifty patients diagnosed with BN underwent eighteen sessions of either supportive-expressive therapy (SET) or CBT. The SET used the treatment manual developed by Luborsky (1984), supplemented by other psychodynamic writings on EDs. The style of the treatment was non-directive, with an emphasis on listening to the patient in order to help identify problems to address. The therapists were instructed to avoid giving advice, but rather facilitated the patients' personal responsibility for change. Adapted to EDs, the SET approach strongly echoed that of ST with the premise that ED symptoms serve a functional role by disguising underlying interpersonal problems. Results of the study demonstrated SET and CBT to be equally efficacious in reducing BN symptoms and psychosocial disturbances (Garner et al., 1993).

The first RCT within the EDs arena was conducted by Fairburn et al. (1986). It compared CBT with a treatment modelled on Rosen's (1979) structured brief psychotherapy that drew on the work of Bruch (1973) and Stunkard (1980) in conceptualising BN symptoms as a maladaptive resolve for underlying difficulties. The two treatments proved equally efficacious in the primary measures of BN symptomatology. A follow-up of this study conducted a decade later demonstrated that both treatments retained their efficacy (Fairburn, Norman, Welsh, O'Connor, Doll, & Peveler, 1995). The only RCT to have been conducted for BED demonstrated 16 sessions of group psychodynamic interpersonal therapy or group CBT to be equally efficacious in reducing binge-eating, both upon completion of treatment as well as on follow-up.

While some studies have demonstrated IPT to be less effective than manualised CBT in achieving full remission of BN at the termination of treatment, two studies have demonstrated them to be equally effective on follow-up at both one and six years (Agras, Walsh, Fairburn, Wilson, & Kraemer, 2000; Fairburn et al., 1993). This suggests that

the application of interpersonal communication skills developed during treatment might be retained or even improve post-treatment. IPT for BN has since been modified for application in clinical practice (Arcelus et al., 2009), and subsequently condensed into a brief ten-session format due to the demand for time-limited therapies (Arcelus, Whight, Brewin, & McGrain, 2012). Results of pilot studies suggest these treatment adaptations may be feasible and warrant further investigation. Studies have also identified IPT to be as equally effective as CBT in the treatment of BED (Tanofsy-Kraff, Shomaker, Young, & Wilfley, 2016; Wilfrey et al., 1993; Wilfrey et al., 2002).

3.4.2. Cognitive Behavioural Therapy Studies

Various studies that have compared CBT with alternative models of therapy have yet to demonstrate one modality of individual therapy to be conclusively superior. While CBT is the most frequently evaluated individual treatment for AN, results should be read with caution due to the concern that the majority of the RCTs have methodological problems, including design inconsistencies and short treatment duration (Ball & Mitchell, 2004; Carter et al., 2011; Channon, de Silva, Hemsley, & Perkins, 1989; Fairburn, 2005; Wilson et al., 2007; McIntosh et al., 2005). Nevertheless, the contribution of CBT to the treatment of EDs has still been considerable. The behavioural component that prioritises the interruption of ED behaviour and the re-establishment of physical stability is an important component; not only towards restoring medical stability, but for the effects the reversal of the starvation state has on improving mental and cognitive functioning. However, CBT models are most associated with the manner by which distorted cognitions are identified and challenged. Such distortions are mostly the product of early emotional injury and the deprivation of needs, resulting in the formation of negative core beliefs and EMSs. Such models make use of numerous tools in order to challenge and disassemble these adverse belief systems and replace them with a functionality to afford a healthy, authentic and contented way of existence. It is this theoretical system that ST has as a significant component in its model design.

As promising as CBT-E appears, even here the research outcomes have not been particularly promising. Although 56.1% of treatment completers in the CBT-E study conducted by Byrne, Fursland, Allen, and Watson (2011) reported a reduction in EDs symptoms, attrition rates of approximately 50%, and an absence of long-term follow-up, leaves one needing to interpret results with caution. Furthermore, while the hypothesised interactions between components of the CBT-E model have not been adequately supported by research (Byrne & McLean, 2002; Lampard et al., 2013), some additional treatment modules, like clinical perfectionism and mood intolerance, do not appear to produce significant change in respective areas of pathology (Byrne et al., 2011). More recently, however, Fairburn et al. (2012) have provided evidence for the effectiveness of enhanced CBT for patients with severe AN (BMI≤17.5), in which emphasis has been placed on addressing the clinical features that maintain the ED. For almost two-thirds of their adult sample that completed the 40-session treatment trial, weight restoration was significant, and there was a marked reduction in AN symptoms. Furthermore, on 60-week follow-up there was minimal attrition of progress and little need for additional treatment. Very similar results were found in an

identical study design using an adolescent cohort (Dalle Grave, Calugi, Doll, & Fairburn, 2013). While current CBT is necessary, it does not appear sufficiently effective for all patients with EDs, prompting the need for elaboration and ongoing research as a priority.

Through a combination of uncontrolled studies, case studies and RCSs, DBT has been demonstrated as a successful treatment for BN and BED, especially for individuals also diagnosed with BPD, where negative emotion complicates the ED condition (Bankoff, Karpel, Forbes, & Pantalone, 2012; Gatward, McGrain, Palmer, & Birchall, 2000; Linehan & Chen, 2005; Marcus, McCabe, & Levine, 1999; Safer, Telch, & Chen, 2009; Safer, et al., 2001a; Safer, Telch, & Agras, 2001[b] ; Wilson, 2004). Unfortunately, few of the nine DBT studies assessed the remission rate of EDs, while the measure of abstinence of binge-eating and purging behaviour has an uncomfortably broad range of between 29% to 89% (Safer, et al., 2001a; Safer et al., 2001b; Telch, Agras, & Linehan, 2000; Telch, Agras, & Linehan, 2001). Yet studies appear to show a consistently low treatment drop-out rate (Safer et al, 2001a), suggesting that DBT be further investigated as a potentially worthwhile cognitive treatment for all EDs.

The RCT conducted by Schmidt et al. (2012) compared the efficacy and acceptability of a novel cognitive therapy for adult AN (Maudsley Model of Anorexia Nervosa Treatment for Adults, MANTRA) to a specialist supportive clinical management (SSCM) design that served as a control. Conducted over six months, the treatment involved once weekly sessions for the first 20 weeks, after which they were tapered. The latter has been specifically designed as a control treatment and aimed to mimic outpatient treatment that would typically be provided to patients with AN in usual clinical practice (McIntosh et al., 2005). It combines features of clinical management that includes psychoeducation, medical monitoring and nutritional guidance (Fawcett, Epstein, Fiester, Elkin, & Autry, 1987) in addition to supportive therapy that emphasised the fostering of a therapeutic alliance through praise, reassurance and advice (Douglas, 2008). The MANTRA model proposes that AN typically arises in people with anxious/obsessive traits, and is maintained by four broad factors, namely a cognitive rigidity, impairment in the socio-emotional domain, beliefs regarding the utility of AN in their lives (Serpell et al., 1999) and the influence of parents or partners that contribute to the condition through high expressed emotion or enabling behaviours (Sepulveda, Kyriacou, & Treasure, 2009). The model utilises a patient workbook, is collaborative, and draws on the style of MI (Miller & Rollnick, 2012) and the principles of behaviour change outlined by NICE (2007). The treatment moves through phases, starting with an aim to create dissonance by evaluating the significance of risks with the patient's "valued" function of the illness. Similar to ST, a collaborative case conceptualisation is constructed, from which a diagram (similar to the ST mode map) is presented to the patient in order to clarify treatment goals. The working for change phase draws on modules to address the socio-emotional impairments (most notably avoidance) and rigid thinking style. There is a module to assist in the developing of an identity beyond AN for chronic sufferers before addressing termination and relapse-prevention. While patients in both treatment groups improved significantly with respect to ED and other outcomes (depression and anxiety), there were no differences between

groups. However, it was the MANTRA patients that were more likely to require additional inpatient and day-patient treatment than those receiving SSCM (Schmidt et al., 2012), which was an unexpected finding of the study and a challenge to the efficacy of cognitive treatment.

3.4.3. Family Therapy Studies

For the FBT studies conducted on younger patients with a more recent ED onset, an impressive remission rate of 90% was sustained at 5-year follow-up, which was far more effective compared with individual dynamically-orientated treatment (Eisler et al., 1997; Lock, Agras, Bryson, & Kraemer, 2005; Le Grange, Binford, & Loeb, 2005). Not only have controlled studies demonstrated FBT to be the most efficacious treatment to date for adolescents with AN (Ciao et al., 2015), but it has even demonstrated effective when delivered to children as young as age 9 (Lock, le Grange, Forsberg, & Hewell, 2006); even in durations as short as ten sessions (Lock, Agras, Bryson, & Kraemer, 2005; Lock, Couturier, & Agras, 2006). Although research on family therapy for BN is in its infancy, results from two RCTs for BN have demonstrated the value of family involvement in the interruption of disordered eating behaviours and the reduction of bulimic symptoms through an adaption of the FBT model for AN (le Grange et al., 2007; Schmidt et al., 2007). However, Fairburn (2005) has cautioned optimism in response to the existing FBT research findings. He cites consistently small sample sizes as a design weakness of these studies, but more importantly, argues that the high remission rate for adolescents receiving FBT is most likely attributable to the typically short duration (usually less than a year) and early onset of the ED for this age group. As such, it is argued that it is less likely that such sufferers would have deeply entrenched and, hence, less retractable negative core beliefs maintaining the ED. Fairburn's (2005) caution is supported by the results of a study conducted by Wade, Treasure, and Schmidt (2011) in which the same FBT treatment model was adapted for adults with AN, showing an unimpressive remission rate of only 30%. Strictly speaking, however, this modified FBT is not a family therapy, but does include conjoint sessions with family and/or partners where applicable. Nevertheless, NICE (2004), who conducted the most comprehensive and rigorous evaluation of available treatments for EDs, concluded that a family intervention that directly addresses the ED should be used in the treatment of adolescents. A study has demonstrated the "separated" version of this treatment, in which the adolescent with AN and her parents attend separate sessions, to be more effective than the conjoint format of treatment, especially for families rated high in the expression of negative emotion (Eisler et al., 2000). It would thus make sense that a thorough assessment of the family functioning would best determine the format to be adopted.

3.5. Summary on the Treatment of Eating Disorders

Significant progress has been made over the past few decades in the psychological treatment of EDs. Although I have reviewed some discretely identifiable theoretical frameworks above, it should be noted that there is considerable overlap between them, given the manner in which "new" models of therapy reflect an integration and

organic extension of existing knowledge. These developments reflect a quest for models of treatment that comprehensively incorporate the necessary and relevant elements to help patients not only relinquish their symptomatic behaviour, but to identify, confront and resolve a constellation of painful underlying issues that are both causal and maintaining of the ED, denying the individual a meaningful and contented life. It is likely that the consistently favourable response that patients have had to the studies evaluating the efficacy of PDT is due to the emphasis placed on addressing emotional painful issues and resolving interpersonal problems.

While psychodynamic therapy acknowledges the role that the unconscious plays in perpetuating emotional trauma through self-defeating patterns of behaviour, it also holds vital the corrective experience that the therapeutic relationship provides in healing a myriad of deeply entrenched early injury. Psychodynamic therapy also acknowledges the multiplicity of forces that contribute to the eating pathology, some of them subtle and beyond conscious awareness. This framework also views the symptomatic behaviour of EDs as a symbolic expression of the emotional pain that is experienced as too threatening to endure. In contrast to the extended therapeutic process of psychodynamic therapy, CBT introduced the concept of brief, manualised treatment strategies that directly target the primary mechanisms that maintain EDs. While they do acknowledge a dysfunctional system of evaluating self-worth lying at the centre of an ED, CBT still prioritises the dissolution of active eating pathology, which is also conceptualised as serving an adaptive role to avoid or dampen overwhelming emotional distress. Cognitive and behavioural procedures serve to challenge the legitimacy of ED behaviour and instil an authentic motive to adopt healthier, more flexible, and a moderated means of self-care. While the CBT model for treating AN pays special attention to the motivation for change, similar to psychodynamic models, it also holds central the establishment of a strong, collaborative therapeutic relationship. A recent study examining the naturalistic data of experienced psychodynamic and CBT-oriented therapists treating EDs demonstrates that they inevitably draw on a combination of techniques for these patients. While psychodynamic techniques are favoured when addressing PD difficulties that reflect emotional dysregulation and impulsivity problems, CBT techniques are most effectively drawn upon by most therapists in order to nullify ED symptoms (Colli, Gentile, Tanzilli, Speranza, & Lingiardi, 2016). The case study published by Richards, Shingleton, Goldman, Siegel, & Thompson-Brenner (2016) that integrates these two frameworks - “Integrative Dynamic Therapy” for BN – reflects a growing trend of research that acknowledges the value of applying an integrative approach to treatment. Not only does le Grange (2016) remind us that the extremely variable nature of EDs between individuals necessitate the individualisation of treatment but reminds us of the synergistic value of integrating select frameworks and techniques to optimise treatment.

While FBT justifies the prescriptive stance assumed by parents and family members in the initial phase of treatment due to the adolescent sufferer’s resistance or inability to initiate his or her own weight restoration process, the subsequent phases of treatment do address the challenges of assisting the index patient to develop autonomy and safely negotiate the transition from adolescence into adulthood. Although the first phase of FBT

treatment debunks some of the generalisations that were developed within the psychodynamic discipline to exclude family (especially the parents) from treatment, the latter two phases of treatment do reflect Bruch's (1973) thesis that AN serves to evade the difficulties associated with the development of autonomy and the transitional phase from adolescence into womanhood. Couple-based interventions in the treatment of adult AN, like the model developed by Bulik and colleagues, "Uniting Couples (in the treatment of) Anorexia Nervosa" (UCAN; Bulik, Baucom, Kirby, & Pisetsky, 2010; Kirby, Fischer, Raney, Baucom, & Bulic, 2016), also recognises the importance of involving partners and addressing relational issues in treatment. Emanating from the psychodynamic discipline and largely influenced by attachment theory, IPT is a conceptualisation-driven model that for some time has echoed the centrality of the impact of influential interpersonal relationships in the development and maintenance of EDs. In fact, there is a strong resurgence of research in the relationship-focused therapies, given the significant influence that the interpersonal and attachment domains play in the causality and maintenance of EDs. Such studies are demonstrating such therapies to be comparatively as effective and efficacious as the more currently recognised evidence-based models of treatment (Tasca, 2016).

What DBT brings to EDs treatment is the emphasis on managing chronic emotional dysregulation and the importance of finding a moderate path in all key areas of life. It draws on a number of cognitive strategies and mindfulness to challenge the adaptive role that eating pathology plays in dampening emotional distress. DBT is an example of the emphasis shift in EDs treatment away from the purely cognitive therapies towards the more affect-regulation models, thus acknowledging the true source of EDs pathology lying at a deeply rooted level of emotional wounding that, most often, occurred many years prior to the manifestation of the disordered eating. The TSCM, while not a stand-alone therapeutic model, draws on a number of cognitive and experiential processes to guide patients through the stages of change towards a self-determined recovery path. MI, while significantly utilised into the FBT model modified to treat adults with AN, strongly emphasises the notion of partnership, acceptance and compassion, and an insurance that the patient is treated from their current stance rather than imposing expectations for where they need to change. MI is particularly useful in the treatment of EDs, given the particularly ego-syntonic and ambivalent nature of this population. The CBT-E transdiagnostic model for the maintenance of EDs developed by Fairburn et al. (2003) has provided a significant advance in comprehensively treating individuals with all EDs by attending to the urgency for symptomatic relief, but importantly attending to significant deficits at an intrapersonal and interpersonal level. Comparable with a ST approach, this model also views pathological eating behaviour as a strategy to dampen or avoid emotional distress, the priority for a collaborative therapeutic relationship, the provision of psychoeducation, and the creation and revision of a personalised conceptualisation.

In order to fully appreciate the nature of EDs, we need to recognise the diverse nature of these challenging conditions, and the numerous adaptive roles that the various symptoms fulfil as a protection device. The integrative nature of ST appears well suited to the treatment of EDs, where the multiplicity of modes in the mode

model assists in the conceptualisation of a complex of problems defined within a single conceptualisation. Particularly useful in the design of this model is the recognition of the role of coping modes as longstanding survival strategies. Despite them providing some temporary relief and an evasion of distress, they still, nevertheless, deprive the patient from realising their core emotional needs. Although the insight gained from the earlier psychodynamic models and the cognitive techniques of the more recent short-term treatments all hold value, an intellectual understanding or a simple extinguishing of symptomatology does not lend to lasting change for many patients. It is for this reason that the emotion-focused aspect that is central to ST might fulfil a vital role in transcending intellectual change and penetrating the EMSs held at a deeply embodied level. Not only might the ST model be very conducive to reducing the high levels of shame experienced by many patients with EDs, but it may also help cultivate a self-compassion through a very sophisticated understanding of the complex causal and maintaining factors in EDs behaviour. As such, only by identifying the patient's most prominent modes and mode sequences is there a significant prospect of a shift in deeply held dysfunctional beliefs, and the establishment of a securely bound HeAd/Child dyad. The next chapter explores the interface of ST and EDs, highlighting some of the recent research and clinical work that explores the prospect of the ST mode model serving as an effective and efficacious treatment for this difficult-to-treat patient population.

CHAPTER FOUR: SCHEMA THERAPY FOR EATING DISORDERS

4.1. Negative Core Beliefs and Early Maladaptive Schemas in Eating Disorders

Numerous studies have confirmed that patients across the diagnostic domain of EDs have elevated negative core beliefs and EMSs when compared with dieters and normal controls (Cooper & Turner, 2000; Damiano, Reece, Reid, Atkins, & Patton, 2015; Hughes et al., 2006; Leung & Price, 2007; Leung et al., 1999; Luck, Waller, Meyer, Ussher, & Lacey, 2005; Unoka, Tölgyes, & Czobor, 2007; Vitousek & Hollon, 1990; Waller, Ohanian, Meyer, & Osman, 2000). Even obese adults were shown to have significantly elevated levels of EMSs when compared with normal weight controls (Anderson, Riegers, & Caterson, 2006). Where research has indicted greater levels of EMSs in EDs groups compared to dieters, even after controlling for depression and self-esteem (Gongora, Derksen, & van der Staak, 2004; Leung & Price, 2007), it is likely that dieting, depression, or low self-esteem, alone, are insufficient causal factors for EDs and that the presence of EMSs is required for significant ED pathology to emerge. However, Pugh (2015) has cautioned against such generalisations, given the numerous methodological problems associated with longitudinal data and the criteria for defining “dieters” and “symptomatic dieting”. While numerous studies have indicated that the severity of negative core beliefs carried by patients with EDs is positively correlated with the severity of their ED pathology (Cooper, Rose, & Turner, 2005; Damiano, et al. 2015; Dingemans, Spinhoven & van Furth, 2005; Harrison, Sullivan, Tchanturia, & Treasure, 2010 ; Haynos & Fruzzetti, 2011; Leung & Price, 2007; Waller et al., 2000), there is little consistency in the literature of a relationship between schema content and the symptomatology of the various ED subtypes (Cooper et al., 1998; Dingemans et al., 2005; Leung, Waller, & Thomas, 1999). Even the five schema domains, each of which contains EMSs conceptualised around the failure of a related group of core unmet childhood needs, do not appear to be associated with specific ED diagnostic profiles. Table 11 on the next page, which outlines the results of 13 studies that have sought to identify a correlational relationship between the 18 EMSs and the different EDs profiles, confirms the observation that no discernible link between the two exists.

In fact, the literature even reflects inconsistency in the commonly held notion that patients with AN display higher levels of perfectionism (Unrelenting Standards EMS) (Lampard, Tasca, Balfour, & Bissada, 2013; Unoka et al., 2007) and lower levels of impulsivity (Leung et al., 1999; Unoka et al., 2007) when compared with patients with BN (Lampard et al., 2013; Unoka et al., 2007). The same can be said for the relationship between the severity of EMSs and the response to treatment. The study conducted by Leung, Waller, and Thomas (1999b) that provided a 10-week CBT group therapy for patients with AN demonstrated no correlation between the pre-treatment severity of EMSs and treatment response. While the treatment proved to be ineffective, no conclusion could be drawn regarding the effectiveness of schema-related therapies in the treatment of EDs due to the short duration of the intervention and absence of schema interventions. The study conducted by McFarlane, MacDonald, Royal, and Olmstead (2013) on a broad spectrum of inpatients with EDs also showed no relationship between the severity of

pre-treatment EMSs and the speed of response to treatment. In fact, the severity of EDs symptomatology was the only predictive variable for speed of response to treatment. While a few studies have claimed a positive

Table 11: The Relationship between Early Maladaptive Schemas and Eating Disorder profiles

Study Target Populations	Top EMSs In all EDs	Severe AN or Low BMI				AN > BN		Increased Bingeing				Bingeing > Restricting		Increased Vomiting			
Study (see key below)	1	2	3	9	13#	3	4	1	7	8	9	5	6	8	10	11	12
Early Maladaptive Schemas																	
Abandonment/Instability				●	●								●				
Mistrust/Abuse					●					●	●						
Emotional Deprivation	●			●	●												
Defectiveness/Shame			●		●					●				●	●		●
Social Isolation	●	●			●				●	●					●		
Dependency/Incompetence	●		●		●				●								
Vulnerability to Harm					●				●				●				
Enmeshment			●		●				●								
Failure			●		●					●						●	
Entitlement/Grandiosity												●					
Insufficient Self-control	●					●				●		●					
Subjugation			●		●												
Self-Sacrifice				●	●												
Approval-Seeking			●		●												
Pessimism																	
Emotional Inhibition	●	●				●		●			●						
Unrelenting Standards						●	●		●								
Self-Punitiveness																	

1 = Waller, Dickson, and Ohanian, 2002; 2 = Damiano et al., 2015; 3 = Unoka et al., 2007; 4 = Lampard, Tasca, Balfour, & Bissada, 2013; 5 = Leung et al., 1999; 6 = Jones, Harris, and Leung, 2005; 7 = Waller, 2003; 8 = Waller et al., 2001; 9 = Hughes et al., 2006; 10 = Leung et al., 2000; 11 = Waller et al., 2000; 12 = Waller et al., 2001; 13# = Dingermans et al., 2006, which only investigated the link between schema domains and ED, and not individual EMSs and EDs.

correlation between pre-treatment severity of EMSs and response to treatment (Cullum, 2009; Leung, Waller, & Thomas, 2000), the study by Jones, Leung, and Harris (2007) noted that the dampening of EMSs post-treatment was more indicative of a good outcome than the severity of EMSs measured pre-treatment. While it is plausible that the maintenance of EDs is linked to schema content, and that remission is, at least, partially attributable to schema change, one has to also consider that recovery may merely reflect less schema triggering or activation, but not, necessarily, schema change.

Whilst it is widely recognised that the vast majority of patients with EDs carry an array of elevated EMSs, the challenge remains for clinicians and researchers to develop a comprehensive treatment model that will address the eating and personality pathology as well as other presenting problems in an intensive, integrated, and focused manner for the purpose of enhancing treatment efficacy and achieving sustained remission (Bruce & Steiger, 2006; Munro, Thomson, Corr, Randell, Davies, Gittoes, Honeyman, & Freeman, 2014; Hinrichsen & Waller, 2006; Leung, et al., 1999, McIntosh et al., 2016). The only RCT study to have been completed that investigated the efficacy of ST for the treatment for the EDs was conducted by McIntosh et al. (2016). The sample comprised 112 adult women with a diagnosis of either BN or BED. Participants in the three equally sized cohorts received either ST, Appetite-Focused CBT (CBT-A), or traditional CBT. CBT-A was developed for the study and based on an aetiological model in which diminished hunger recognition and the insensitivity to satiety cues are fundamental in the precipitation and perpetuation of BED (Hetherington, Altemus, Nelson, Bernat, & Gold, 1994; Tanaka et al., 2003). The treatment emphasises the importance of monitoring appetite by registering and responding to cues for hunger and satiety rather than the traditional monitoring of food intake to reduce binge-eating (Allen & Craighead, 1999). Participants received a once-weekly one-hour therapy session for six months, after which they received a once-monthly one-hour therapy session for a further six months. No significant differences were found in the efficacy between the three different treatment groups, suggesting ST as a suitable alternative treatment, especially since it was as effective as the traditional CBT that has demonstrated itself to be the most efficacious treatment for BN (McIntosh et al., 2016).

Other studies have involved group ST (Simpson, Morrow, van Vreeswijk, & Reid, 2010) and individual case studies, while other research has explored the efficacy of specific ST interventions. For instance, Ohanian (2002) demonstrated one session of imagery rescripting for a young woman with BN to be far more effective than traditional CBT treatment, suggesting that such an experiential intervention was a favourable adjunct to the existing evidence-based treatments. While there remains paucity in the investigation of the efficacy of ST for these challenging conditions, many of the techniques and therapeutic strategies that have been integrated into the ST model have already been demonstrated to be very effective. While ongoing research is still indicated, what follows is a summary of existing research, including some schema-based models for the treatment of the EDs. While Leung et al. (2000) have demonstrated that the presence of EMSs influences the outcome of CBT treatment for patients with BN and BED, there are, as yet, no comparable studies that have looked at AN. Luck et al., (2005) have, thus, posed the question that if such schema activation can demonstrate evidence for AN and poor outcomes to treatment, that ST (Young, 1999, Young, et al., 2003) is potentially an appropriate and useful treatment modality for the full spectrum of ED pathology.

4.2. Schema Therapy Models for the Treatment of Eating Disorders

4.2.1. Waller's Schema-Focused CBT Model

In order to improve treatment outcomes with EDs, Waller et al. (2007) proposed the use of schema-focused cognitive-behavioural therapy (SFCBT) in the management of EDs to augment rather than replace the most effective existing treatment models. Where conventional CBT treatments appear to only address cognitions at a superficial level, Young and colleagues were concerned for the need to address early developed schema-level cognitions and the processes that maintain them to fully appreciate the root causes of ED pathology (Young, 1999; Young et al., 2003). This schema-based model is based on case evidence that indicates that restrictive and bulimic eating pathology arise from different schema processes (Luck, et al., 2005), with the former sharing cognitive features with other compulsive disorders, while the latter shares elements in common with other impulsive pathological conditions. This is supported by the findings of adjunct conditions amongst patients with EDs. As previously discussed in section 2.7.2c, AN is often associated with obsessive compulsive PD, with perfectionistic tendencies (Anderluh et al., 2003; Sansone et al., 2006; Shafran & Mansell, 2001), and with avoidant PD (Sansone et al., 2003). By contrast, ED pathology associated with binge-eating and purging are strongly associated with disorders featuring impulse regulation problems, found commonly amongst patients with BPD (Herzog, Keller, Lavori, Kenny, & Sacks, 1992; Sansone et al., 2003). Luck et al. (2005) argue that, in the presence of schema processes that can give rise to a wide spectrum of psychiatric conditions, what leads to the manifestation of an ED as opposed to another psychiatric presentation is the presence of the already identified environmental risk factors associated with EDs (see section 2.7.).

The model by Waller et al. (2007) also explains how restrictive eating pathology is associated with schema compensation, while bulimic pathology is explained to schema avoidance (Waller et al., 2007). As there is no distinction between restrictive and bulimic individuals with regards to surrender maladaptive coping styles, this does not feature in the model. They make the distinction between primary and secondary affect avoidance in such maladaptive coping responses. Primary avoidance refers to coping that reduces the risk of any aversive affect being experienced, while secondary avoidance refers to coping that dampens the already activated distress. As an example of primary avoidance, perfectionistic coping has the effect of reducing the risk of activating of cognitions associated with the Failure EMS. Similarly, restrictive eating serves to reduce the risk of onset of negative affect associated with body dissatisfaction, while simultaneously cultivating an (illusory) sense of control to ensure a calm emotional state. There is clinical evidence supporting this theory with a number of researchers having described the persistent, high-achieving and perfectionistic behaviour of patients with AN-r, who often carry strong underlying beliefs of defectiveness and failure (Brewerton, Hand, and Bishop, 1993; Bruch, 1973, Cooper et al., 1998; Shafran et al., 2002). Similarly, Serpell (2000) provides evidence that patients with AN-r, who typically have a minimal display of emotion, are aware that their dietary restriction serves as an overcontrolling means of

minimizing their experience of emotions. This is supported by George, Thornton, Touyz, Waller, and Beumont, (2004) who found a strong presence of the Emotional Inhibition EMS amongst patients with AN. Of course, dietary restriction can also serve as a secondary avoidance of affect by dulling already activated negative emotion. There is also evidence that bulimic eating pathology results from secondary avoidance of affect in which an individual attempts to reduce negative affect that has already been activated. In such cases, the impulsive, self-soothing behaviours of binge-eating and/or vomiting, serves to reduce, block or detach the sufferer from powerfully triggered and intolerable negative affect. In line with this, Spranger, Waller, and Bryant-Waugh (2001) demonstrated that BN is associated with elevated levels of schema avoidance responses. Cooper et al. (1998, 2004) have also demonstrated how bulimic behaviour serves to reduce negative affect.

Although Young (1999) does not distinguish between primary and secondary avoidance of affect in schema coping processes, his measures for schema compensation and schema avoidance reflect the distinction made in Waller's schema-based model. The Young Compensation Inventory (YCI; 1998), for instance, includes items that reflect complete avoidance of adverse situations in order to avoid schema activation and the experience of subsequent negative affect. By contrast, the Young-Rygh Avoidance Inventory (YAI; 1994) contains numerous items relating to behavioural reactions in response to the experience of negative affect - essentially the secondary avoidance of affect. The study by Luck et al. (2005) that utilised the YCI and YAI validates the hypothesis that patients with AN present with both primary and secondary affect avoidance processes, while patients with BN only utilize secondary affect avoidance processes.

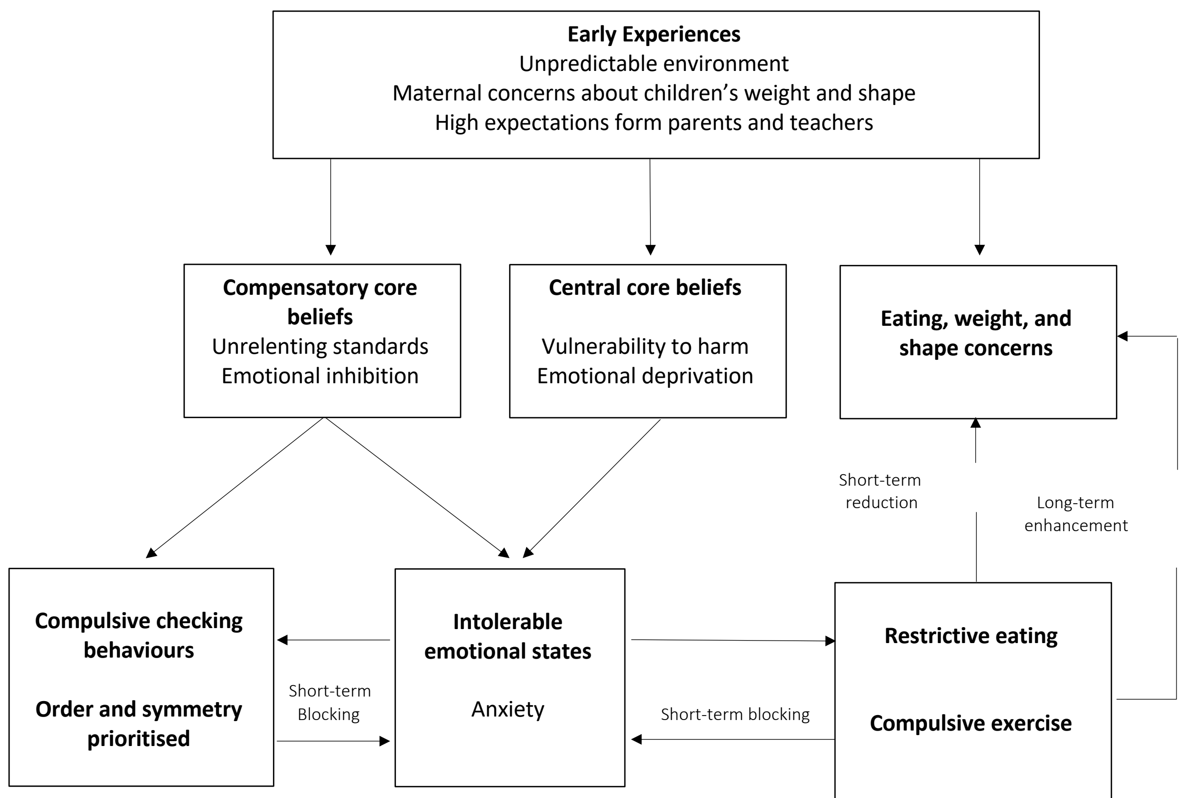
Waller et al. (2007) stress the importance of keeping the eating pathology and its associated distress in clear focus as critical targets of change. Besides physiological data such as body mass index (BMI) and relevant blood results to establish a baseline, structured and semi-structured interviews like the Eating Disorders Examination (EDE; Cooper & Fairburn, 1987) and behavioural recordings, like a food diary, are all very useful alongside reliable and robust measures of eating attitudes and behaviours like the Eating Disorders Inventory-2 (EDI-2; Garner, 1991) or the Eating Disorder Belief Questionnaire (EDBQ; Cooper, Cohen-Tovee, Todd, Wells, & Tovee, 1997).

With regards to schema-based tools in the assessment of patients with EDs, it is recommended that various questionnaires be used in identifying the relevant schemas and the evaluating of relevant goals for therapy in bringing about meaningful change. Here, Young's measures, namely, the Young Schema Questionnaire (YSQ), YCI, YAI, and the Young Parenting Inventory (YPI) are all clinically robust and useful, while the self-help guides, *Reinventing your Life* (Young & Klosko, 1993) and *Breaking Negative Thinking Patterns: A ST self-help and support book* (Jacob, van Genderen & Seebauer, 2011) are useful bibliotherapy resources to help patients recognise their most prominent EMSs and schema modes.

The processes outlined above are all useful in developing an individualized case conceptualisation for a patient with an ED. It should incorporate the experiences relevant to the patient's development, the central core beliefs,

the schema processes (both the primary and secondary avoidance of cognitions and emotion) that maintain the core belief, and how the coping gives rise to the particular pattern of ED behaviour (Waller et al., 2007). Figures 9 and 10 form two diagrammatic examples of SFCBT conceptualisations that Waller and colleagues have created for patients with restrictive and bulimic eating pathology respectively (Waller et al., 2007). Of course, the majority of patients with EDs are not exclusively restrictive or bulimic, though one mode of coping may predominate.

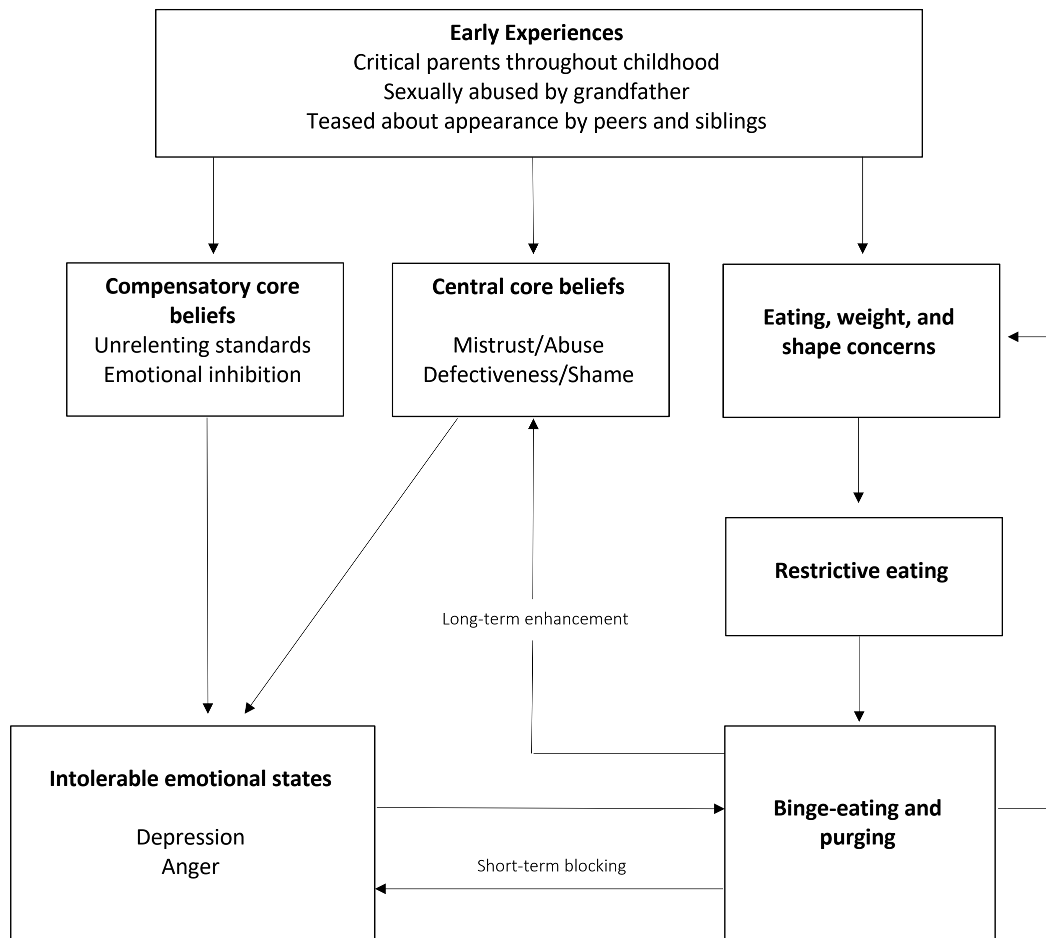
Figure 9: Example of an Individual ST Formulation for a Patient with a Restrictive Eating Pathology (Waller et al., 2007)



The presence of both primary and secondary avoidance of negative affect shows the importance of a transdiagnostic approach. As Waller and colleagues point out, the specific schema process that is used will depend on the nature of the trigger, the strength of the core belief laid down by the early experience, and the nature and frequency with which the "hot" cognitions are activated by the interaction of the trigger and the core belief. This is very valuable when building an individualized schema conceptualisation, where the patient can use different coping strategies in response to different matches between specific triggers and core beliefs (Waller at al., 2007). Treatment relies on this generation of a working set of hypotheses during the assessment phase of treatment, rather than on a diagnostic label, per se. Of course, the conceptualisation is provisional and will require regular review as new evidence emerges in therapy. While the therapist is building a broader picture of the

conceptualisation, Waller et al. (2007) advise that they help patients focus on one aspect of the conceptualisation while they hold the broader picture of the conceptualisation in mind to share at the appropriate time.

Figure 10: Example of an Individual ST Formulation for a Patient with a Bulimic Eating Pathology
(Waller et al., 2007)



Waller et al. (2007) have stated that SFCBT will be more effective than traditional CBT treatment in cases that are more complex in nature and involve more deeply rooted cognitive and behavioural elements. The early stages primarily focus on engagement, the building of a collaborative therapeutic relationship and the identification of cognitive and behavioural tasks. The therapist should aim towards dismantling the unconditional core beliefs and reducing overcompensatory behaviour in order to more effectively and directly challenge cognitions and implement behavioural experiments. Conventional CBT techniques can be used to directly address the more disorder-specific cognitions relating to weight, shape, and body image. Patients should be assisted towards viewing relapse more realistically as something to manage, rather than completely prevent, with lapses being normalized in a non-judgmental way, each one providing additional and valuable insight into the nature and challenges of the particular case. Identifying the triggers and hot spots that are conducive to binge-eating,

purging, and/or excessive exercise are as important as planning alternative functional and healthy coping strategies.

In summary, Waller and colleagues encourage patients with EDs receiving SFCBT to identify their schemas and cognitive distortions and develop specific challenges. They also recognise the importance of utilizing written tools like schema diaries, logbooks, and flash cards. With regards to eating habits they strongly recommend medical monitoring and psychoeducation that encourages patients to follow a well-planned and clearly defined meal plan that is flexible enough to adjust when required. Patients are trained to identify situations that lend to problematic eating and/or the activation of schemas that need to be healed. Patients are also encouraged to acknowledge their own progress and reward their achievements in replacing destructive eating habits with healthy responses. They are also urged to acknowledge their setbacks timeously and, without personal judgment, to learn from them. Patients are also encouraged to build a supportive network of new healthy relationships, to engage in the recommended bibliotherapy, and to engage with their therapist in the negotiated way outside of sessions for more urgent support (Waller et al., 2007).

Waller et al. (2007) have suggested that their SFCBT model and the transdiagnostic model of the EDs developed by Fairburn et al. (2003) (see section 3.2.2.) are very compatible and can, very suitably, complement one another. Although the latter is proposed as a maintenance model and does not address the factors that contribute to the origins of those cognitions and behaviours that maintain the ED, many of the model's features can be reframed within the context of the schema model. Waller et al. (2007) point to how the description of core poor self-esteem and clinical perfectionism in the transdiagnostic model is almost synonymous with the Defectiveness and Unrelenting Standards EMSs respectively, the latter being an example of primary avoidance of emotion (schema compensation), and that affect regulation in the transdiagnostic model is similar to the secondary avoidance of affect (schema avoidance) outlined in Waller's schema-based model. This prompted Waller et al. (2007) to consider that an integration of a schema-based model and the Fairburn approach might provide a fuller and more complementary treatment design.

Another trial conducted by George, Thornton, Touyz, Waller, and Beumont (2004) involved eight chronic EDs patients being provided with group therapy during a day-patient programme over a 6-month period that augmented ST and motivational enhancement therapy (MET). All participants had a prior or current history of AN and had been unresponsive to multiple prior inpatient and outpatient treatments. The group had an average length of illness of 18 years and an average BMI was 16.53. The Anorexia Nervosa Stages of Change Questionnaire (ANSOCQ; Rieger, Touyz, & Beumont, 2002) confirmed that all participants were either in the "pre-contemplation" or "early contemplation" stage of change according to the Prochaska and DiClemente (1992) model of change. The treatment priorities, thus, sought to increase motivation for change, minimize the drop-out rate, assist participants in understanding the barriers to relinquishing their ED, and explore the barriers to change. While MET

was predicted to be helpful in increasing motivation for change for this very ego-syntonic condition, the supposition was that the main barrier for change amongst patients with chronic EDs was due to the presence of EMSs. While no participants dropped out of the study, results revealed an increased motivation for change from the “early contemplation” to “late contemplation”, as measured on the ANSOCQ. While the five highest scoring YSQ subscales pre-treatment were Unrelenting Standards, Defectiveness/Shame, Emotional Deprivation, Emotional Inhibition, and Social Isolation, no significant changes in the sub-scores of the YSQ were detected at the end of the 6-month trial. However, this might be explained by the participants’ increased awareness of EMSs. The study did indicate that the tone of MET very usefully augmented the SFCBT component of treatment, prompting a recommendation that this study be repeated over a longer duration.

4.2.2. The Emergence of the Mode Model for the Treatment of Eating Disorders

While modes are implicit in the Waller model, it was only with the advent of the ST mode model developed by Young et al. (2003) and elaborated upon by Lobbestael et al. (2007) that researchers have been able to venture beyond clinical theory and utilise mode inventories to quantify and more fully contextualise the role of EDs within the mode model of treatment. However, there remains a dearth of studies that have explored schema modes in EDs.

Preliminary research indicates that maladaptive modes are more pronounced amongst patients with EDs compared with controls, whilst the healthy modes are significantly under-developed for the same group (Nesci, J., Redston, S., Snell, M, Kaplan, A, Newton, R, & Cleeve, S., 2014). The study conducted by Nesci et al. (2014) on a cohort of inpatients with AN observed elevated scores for the VuCh, CoSu, DePr, DeSS, PuPa, and DePa modes, none of which, with the exception of the PuPa, were related to weight. Prior to that, Voderholzer et al. (2013) found significantly elevated levels of the DePr and DeSS coping modes in their sample of patients with EDs compared with patients with other Axis I diagnoses and normal controls. While Jenkins (2009) also observed significantly elevated DeSS levels in the EDs cohort compared to controls, there was little evidence for the DePr coping mode. Masley (2012) observed significantly elevated scores for the UnCh and AnCh modes and, similarly to Nesci et al. (2014), found elevated levels of both the PuPa and DePa in her cohort of patients with a broad spectrum of EDs. While Bond (2014) demonstrated that the Overcontroller and DePr modes mediate the relationship between perceived negative parenting and EDs symptoms, a subsequent study more specifically observed that the Overcontroller was a complementary mediator between perceived negative parenting and restrictive eating, while the DePr was a full mediator for binge-eating and a complementary mediator for purging (Brown, Selth, Stretton, & Simpson, 2016). Although the Overcontroller mode is not included in the SMI (Lobbestael et al., 2010), it was incorporated into this study due to its well documented role in Cluster C PDs – the avoidant, dependent, and obsessive-compulsive PDs (Arntz, 2012; Bamelis, Renner, Heidkamp, & Arntz, 2011), and its perceived regularity amongst patients with EDs (Simpson, 2012). This has been subsequently confirmed in a

new Schema Mode Inventory for the EDs population (SMI-ED; Simpson et al., 2018). These fairly consistent findings suggest that the schema mode model might be an effective alternative or adjunct to the more recognised existing treatment models that look to explain the maintenance cycle of EDs. What follows is a broad overview of the application of the ST mode model in the treatment of patients with EDs, including two single case studies to demonstrate the application of the mode model.

(a) Simpson's Schema Therapy Mode Model for the Eating Disorders

In light of the complexity and chronicity of EDs, and the still unsatisfactory remission rate amongst the most recognised and effective models of treatment, Simpson (2012) has reiterated the stance held by many clinicians and researchers (Bruce & Steiger, 2006; Hinrichsen &Waller, 2006; Leung et al., 2000; Simpson, et al., 2010; Simpson & Slowey, 2011) that patients with EDs who hold deeply entrenched schema-level beliefs require a specialised treatment that addresses both the pathological eating behaviours and the personality pathology in a focused and intensive way. In light of the many personality, interpersonal, and other adjunct psychological problems experienced amongst patients with EDs, Simpson (2012) has proposed using the ST mode model (Young et al., 2003) to explicitly address EMSs, the interplay and sequences of child, adult, and select coping modes, while still maintaining the centrality of the therapeutic relationship to bring about change. While the model and its techniques especially confront deeply entrenched belief systems and the elevated levels of avoidance that typify patients with EDs and PDs (Leung et al., 2000; Mountford & Waller, 2006; Sansone et al., 2004; Waller et al., 2002; Waller et al., 2007), Simpson (2012) echoes the view held by others (Lavender & Schmidt, 2006; Vitousek et al., 1998; Waller et al., 2007; Wildes, Ringham, & Marcus, 2010) of the value this conceptualisation-driven model holds in addressing the complexity of EDs. Adapting the original mode model developed by Young et al. (2003), Simpson's initial schema mode model for EDs identifies 11 distinct modes linked to EDs. Two DPMs are outlined, namely the "Critical mode" and the "Demanding mode" (synonymous with the PuPa and DePa respectively). Often operating in alliance to shame and humiliate the Child modes at a bodily level, these modes place insurmountable pressure upon the Child to perform, while still depriving, attacking, and punishing him/her. These DPMs are disdainful of emotional neediness and induce shame in the subset of the VuCh she calls the "Shamed/Deprived Child". As this Child mode becomes more intensely distressed, they inevitably flip into a coping mode. For example, the DeSS might attempt to extinguish this distress through coping behaviour such as binge-eating, vomiting, alcohol consumption, or sleeping pills. While such behaviour might temporarily block or soothingly detach the distress residing in the Shamed/Deprived Child, the "Needy" Child feels deprived and may seek nurturance in impulsive and entitled ways. However, this only serves to incur further messages of disdain and disgust from the DPMs (Simpson, 2012).

The "Perfectionistic Controller" mode, on the other hand, serves as a mode of primary avoidance by reducing the perceived risk of schema triggering in the Child and sparing them shame and humiliation. For patients with EDs,

this compulsive overcompensatory coping mode will express itself through restrictive and ritualistic eating habits, body-checking rituals, label-watching, and excessive physical exercise in an attempt to harness a sense of control and refinement to body shape and size. However, the same mode will impact on other general domains, including general appearance, superior study and work performance, or compulsive tidying and cleaning. It compensates for the activation of one or more of the Failure, Defectiveness/Shame, Emotional Deprivation, Unrelenting Standards and/or Subjugation EMSs. This mode does elicit temporary feelings of achievement and pride when the self-imposed conditions, like having a thin body, are fulfilled. In an illusory way, this coping mode invariably lends to such patients believing that they are "healthy" and "in control" of their daily lives, which only serves to further minimize the detrimental effects of the ED. The CoSu coping mode, typically reflective of an underlying Defectiveness/Shame EMS, serves to avoid rejection and/or seeks acceptance from others by accommodating the needs of others or handing them control and decision making through subjugation or sacrifice of their own needs. Paradoxically, this relinquishing to others only serves to exacerbate fears associated with a "loss of control" in the Child. This might result in binge-eating in the context of self-punishment imposed by Critical (Parent) mode or a soothing to avoid or dampen emotional pain through the DeSS coping mode. While their needs are not being met and they feel controlled or deprived by others, the "Needy" Child (perhaps a combination of the Impulsive and Rebellious Child modes) may be triggered and act impulsively to fulfil such needs (Simpson, 2012).

Simpson's (2012) case study of "Nicki" fluently illustrates her adoption of the original ST mode model developed by Young et al. (2003) a decade earlier. The case study describes treatment over 60 sessions of a female adult with longstanding BN and a prior history of AN. Divided into five phases of therapy, the first involved a thorough assessment, particularly of the developmental trajectory of her ED and its links to childhood and current difficulties and relationships, where the ED was conceptualised as an adaptive mechanism to deal with a childhood filled with emotional deprivation. The second phase strongly emphasised the use of CBT-BN, but with the quality of the therapeutic relationship being a priority. For instance, adherence to the behavioural strategy of keeping food records was suspended due to the reporting of binge-eating evoked powerful EMSs and overwhelming feelings of shame and humiliation for the patient. While the standard CBT-BN techniques (Fairburn et al., 1993; Wilson & Fairburn, 1998) evoked dissonance as cognitive distortions and core beliefs associated with the ED were identified, Nicki also recognised the adaptive role the ED fulfilled as coping strategies to not only dampen her deflated mood but also mask her deep loneliness and empty life. Despite the provision of psychoeducation possibly contributing to the stabilising of a normal weight, the CBT-BN was substituted for ST due to sustained and significant level of binge-eating. Results of the YSQ-L2 (Young & Brown, 1990) helped to identify the origins and maintenance of Nicki's main EMSs, while ST strategies such as schema dialogues provided her with the insight into the multiplicity of parts of self that were distinctly healthy or dysfunctional. Keeping a schema dairy assisted her in recognising how a myriad of food and non-food related events triggered EMSs and negative emotions, while imagery work

helped to identify particular individuals that lay at the source of her emotional injury, including the shame associated with her body (Simpson, 2012).

The third phase of treatment was marked by the introduction of the schema mode concept, where the existing history and the SMI (Young et al., 2007) provided the basis for an individualised mode map which continually evolved as new evidence emerged through the therapy process. While the DPMs were strongly associated with her parents' frequent criticisms of her, these introjects manifested in internal voices that were derogatory of her body shape and size and powerful in demanding weight loss. Sessions focused on identifying the source of her various coping modes, whether it be her DePr to dampen negative feelings and avoid being vulnerable to others, or the Perfectionistic Controller that echoed the demands of her DePa mode through overcompensatory efforts to aspire to a certain body ideal and whose ego-syntonic nature helped her to feel special or superior to others. Of course, the schema mode diary helped her to see the sequences in which coping modes inevitably failed her as she flipped back into the subset of VuCh modes. Drawing her various modes and a "safe place" brought a vivid and graphically helpful "felt sense" to her modes (Simpson, 2012).

The penultimate phase of therapy saw the challenge of bypassing the coping modes in order to gain access to and reparent the Shamed/Deprived Child mode. While the Perfectionistic Controller was tasked with preserving the ED by "reasoning" its value, the therapist gently persisted in gaining access to the vulnerability residing in the Child. However, this inevitably lent to further mode flipping in which other coping modes like the Detached Protector (DePr), Angry Protector (AnPr), and Attention and Approval Seeker (AASe) were activated in order to block or soften the distress residing in the Child. This is where Simpson (2012) sees value in the use of empathic confrontation so as to not overwhelm the patient and to never lose sight of appreciating the adaptive role that coping modes play. Simpson (2016a) also cautions therapists to proceed cautiously with limited reparenting when the patient has a prominent mode of self-criticism because, as Gilbert (2009) explains, they will be particularly wary of receiving nurturance, empathy, and compassion. As such, the therapist made good use of imagery work to identify the source of her detachment from expressing distress, which was shamed by her parents during childhood. Mindfulness was introduced to help Nicki become more tolerant of and aware of the distress residing in the Child instead of flipping into various coping behaviours to dampen the emotion. Limited reparenting formed the blueprint for building the HeAd mode, while email contact with the therapist, flashcards, therapeutic letters, and craftwork provided opportunities for the healing process outside of the therapy room. Imagery mode dialogues were successfully utilised during sessions to gain access to the Child and even help in desensitising bodily-felt discomfort by introducing imagined physically demonstrative care. While, for an extended time, the therapist fulfilled the guardianship role in the corrective imagery rescripting, Nicki was eventually able to substitute her own HeAd into such scripts to meet the Child's needs. Nicki's Critical mode, most prominently an introject of her critical father, was addressed via the ST tools of imagery rescripting and chair work with the

assistance of clay work and drawing to provide a more graphic representation of her father, the primary source of this destructive introjection. This case study also illustrates the value of a patient being able to listen to the audio recording of their session in order to reflect and make notes on pertinent aspects to enhance the recovery process (Simpson, 2012).

The final phase of treatment overlapped considerably with the fourth phase but delineated where insights gained through the therapy very directly reinforced behavioural change. The therapist used standard CBT techniques to further dismantle pathological ED behaviour, while mindfulness was incorporated into mealtimes to enhance the patient's conscious awareness of the modes that would threaten healthy and normal eating behaviour. Body image work helped to elicit commentary from the Critical mode, which was then challenged to allow her to become more self-accepting. Simpson (2016a) has provided a useful imagery restructuring sequence in order to challenge the negatively internalized "felt sense" of the body at a visceral level (see Figure 11 in Appendix 10). Exposure work and behavioural experiments ultimately helped Nicki to become less self-conscious of her appearance, where various schema tools and preparatory imagery work was used to successfully help her feel more comfortable in public (Simpson, 2012). Modes identified within the therapeutic relationship, like the CoSu, were directly addressed, while various therapeutic techniques and psychoeducation helped her to cultivate the necessary skills in order to become more attuned in her relationship with her family and significant others.

Nicki made significant progress across a number of domains, gaining full remission from her ED by the termination of treatment. While the ST mode model provided invaluable insight into the multiplicity of her personality structure, conceptualising her ED as a coping mode and protective mechanism lent to her being considerably more responsive to the CBT-BN tools than she was prior to the introduction of ST. The compatibility of the various behavioural and mindfulness interventions with the ST model and its experiential techniques demonstrated the value of a highly integrative approach to addressing the complexity of an ED and its source amidst numerous deeply embedded and unresolved emotional issues in her younger life. The therapeutic relationship was pivotal towards instilling compassion in the HeAd to heal the Shamed/Deprived Child and block any intrusion from the DPMs. The therapist, as researcher, demonstrated the value of the ST mode model for the manner in which it facilitated a patient's capacity to conceptualise her challenges and significantly dissolve the shame associated with having an ED (Simpson, 2012). The same author reported similar success in a naturalistic single case study with an obese woman diagnosed with an atypical ED and co-morbid depression and somatization. Despite the ST being implemented in an online video context, chair work and imagery rescripting proved very beneficial in deflating dysfunctional schema modes and resolving the ED pathology (Simpson & Slowey, 2011).

Simpson's (2016b) subsequent and updated schema mode model for EDs included additional modes. For instance, she added the "Aggrieved Surrenderer" (AgSu), which is very similar to the Self-Pity/Victim (SPVi) coping mode developed by Edwards (2015) (see section 1.5.). The AgSu serves to hint that there is insufficient help, feels

victimized, and seeks attention in passive ways by, for instance, complaining. Often with an underlying subjugation EMS, the motive behind this surrender coping mode is to draw attention without explicitly reaching out for support. With regards to overcompensatory coping modes, she included a "Superior Overcompensator" (akin to the Self Aggrandiser) as a specialised ED coping mode that dulls feelings of defectiveness for a sense of worth and achievement when the patient succeeds in the arenas of dieting and weight loss. Thinness and the aspiration for physical perfection serve to boost self-esteem, exhibit qualities of self-control and discipline, and avoid the risk of being criticised or shamed. No longer the exclusive coping mode to the ED, the PeOv belongs to a subset of the Overcontroller mode and sets distinct rules about dieting and weight-related matters in order to blunt a sense of failure and instil a sense of control and predictability in an otherwise chaotic world. The "Flagellating Overcontroller" (FlOv), like an executioner, engages in personal attacks and self-inflicted harm, and is self-depriving, critical, and shaming as a means to achieve self-improvement or avoid condemnation from others and/or the Self-Critical Punitive Parent mode. It functions as a 'tight rein' and has a masochistic quality in which pleasure is derived from personal harm for being inadequate. Satisfaction is also derived from being the one that controls the punishment and deprivation. It is ego-syntonic as opposed to the DPM that is ego-dystonic. There is also a Scolding Overcontroller (ScOv) element to this mode, where others are condemned for not conforming to expectations. The "Invincible Overcontroller" seeks to be autonomous and avoid feeling dependent by feeling indomitable, indestructible, and powerful. The mode seeks to eliminate or dissolve all emotional needs, where vulnerability is felt to be synonymous with weakness. The individual seeks a sense of omnipotence based on their moral superiority by denying basic human urges and instincts (like hunger). This mode shares elements of the Self-Aggrandiser coping mode. The Suspicious Overcontroller is triggered in situations where others are afforded control over eating habits or when institutional care is applied in order to neutralize the ED. There is a general distrust and scrutinizing of others. Figure 12 outlines Simpson's (2016b) revised ST mode model for the EDs.

Simpson (2016b) also describes the Self-Critical (Punitive and Demanding) mode that inevitably triggers the Defectiveness/Shame and Emotional Deprivation EMSs in the Child. For patients with EDs, there is often a deeply internalized sense of shame felt at a bodily level. This mode is ego-syntonic at the outset of therapy and stems from many sources, including negative parental influences, societal pressures, religious indoctrination, and adverse traumas. The mode manifests by way of self-neglect and a lack of motivation to make progress or recover, as well as self-harm, self-deprivation, and a neglect to meet physical and emotional needs. Figure 13 outlines the origins of this Self-Critical Mode[5].

[5] What Simpson (2020) has subsequently labelled the "Inner Critic"

Figure 12: Simpson's 13 Mode Schema Therapy Mode Model for the Eating Disorders

(adapted from Simpson, 2016b)

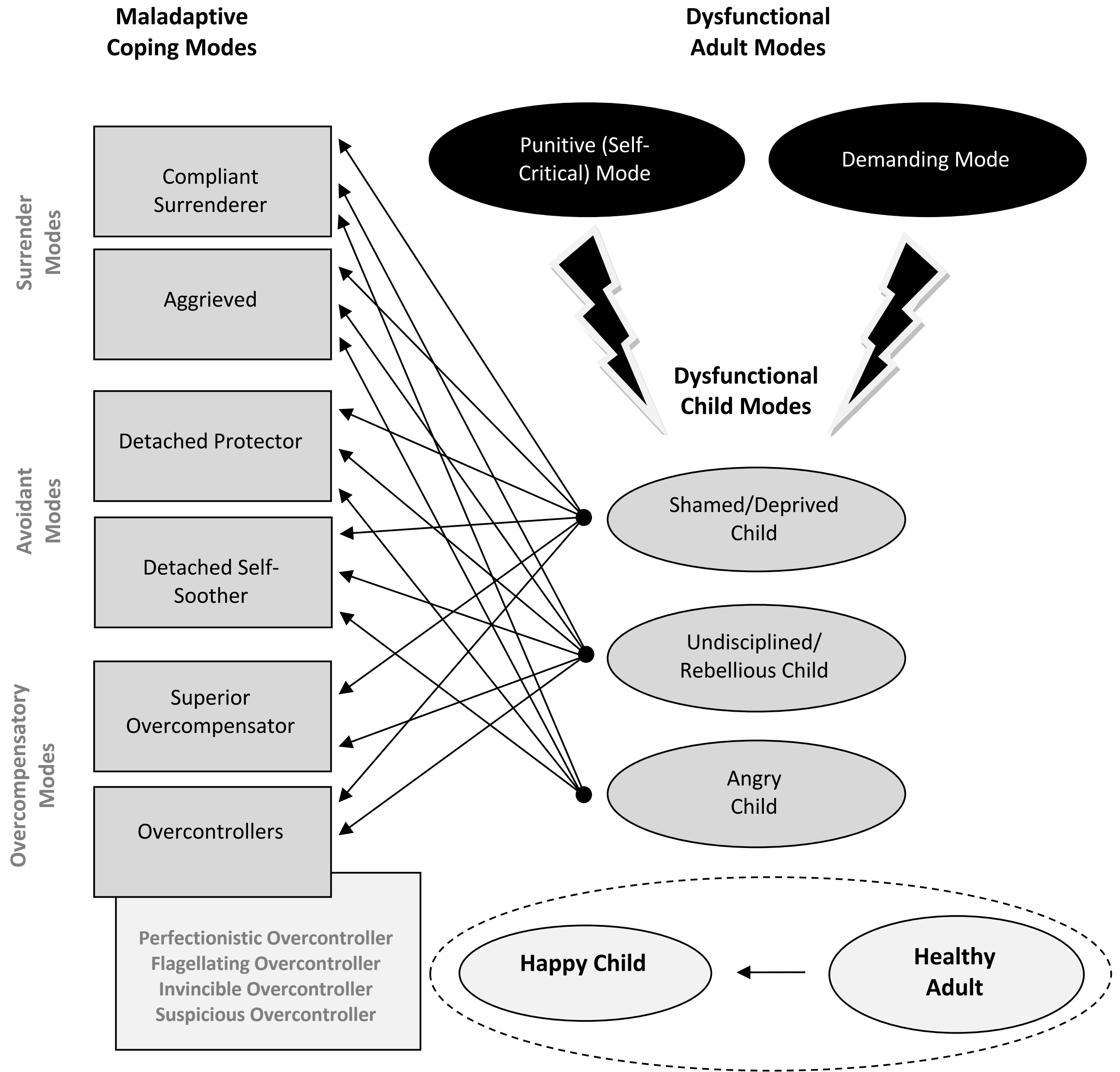
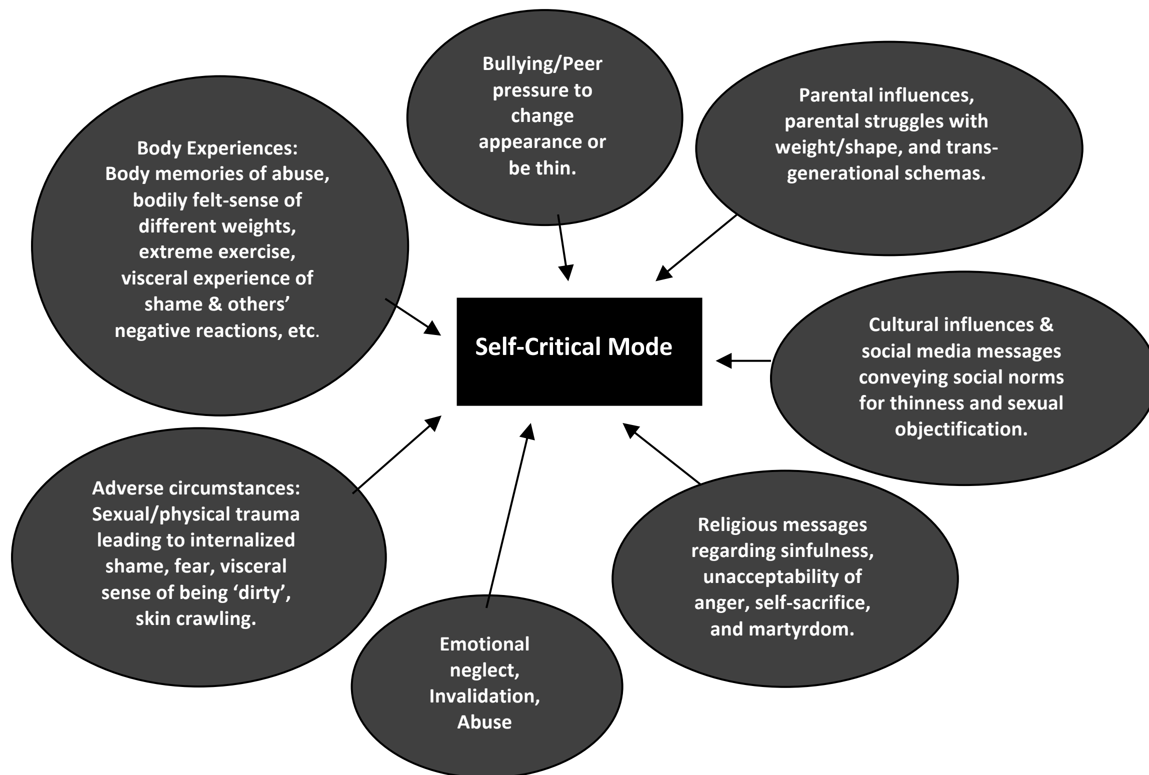


Figure 13: Origins of the Self-Critical Mode (Simpson, 2016b)



In the recently published book *Schema Therapy for Eating Disorders*, edited by Simpson and Smith (2020), Simpson provides her most recent schema mode model conceptualisation of EDs. In it, she explains the manner in which different modes work in tandem, something that Edwards (2020) reiterates when he speaks of the "complexities of the underlying mode structure in an eating disorder" (p.262). As an example, Simpson (2020) describes how the DeSS joins forces with the Rebellious Child (ReCh) mode to counter the demands and rules of the Demanding Mode (DePa) and/or the ED coping mode. Simpson (2020) also highlights the importance of differentiating modes where, for instance, parent and coping modes can manifest in similar ways, making the distinctions difficult to see. She reminds that the parent modes are an echo of long ago and harmful introjected messages, while coping modes have an ego syntonic quality about them, which is in contrast to the coping modes that are experienced as an inviting urge, a way of being, or an imperative that fulfils a function. For example, the Inner Critic echoes the notion of "I deserve to be punished", while the Overcontroller will impose restricted eating to create a sense of predictability, achievement, or protection.

In her model, the "Overcontroller" is defined as the main overcompensatory mode prominent in ED (Brown, Selth, Stretton & Simpson, 2016), manifesting by way of surrendering to the "Inner Critic" (essentially, the DPM), or as an overcompensation for underlying EMSs in the disconnection and rejection domain. It operates by way of counter-dependence – a primary avoidance mechanism to prevent EMSs from being triggered in the first place. Simpson

(2020) goes on to explain how this specialised ED mode uses restriction as a means of creating body-based rules which can create the illusory notion of pseudo-empowerment, mastery, and pride. The creation of an "idealised self" sets rules to provide a means of invulnerability and invincibility that allows the sufferer to bypass having to deal with complexity of real interpersonal relationships.

Simpson (2020) goes on to outline the functions and behaviour patterns of the "Overcontroller". First, it serves to protect one from potential rejection, shame and humiliation. Second, it serves as a buffer from introjected critical and demanding voices (the Inner Critic), and a protective guilt associated with realising needs or enjoying life. Third, this specialised coping mode provides a sense of hope, protection, and guidance in an otherwise confusing and unpredictable outside world. The fourth function that Simpson (2020) identifies is a sense of certainty or being right through superstitious or magical thinking, while the fifth function is the sense of illusory control that compensates for underlying uncertainty, anxiety, shame, and powerlessness. The sixth function is that of the ED coping mode serving as a pseudo-identity or "socially acceptable self". The seventh and last function identified by Simpson (2020) is the manner in which the Overcontroller serves as a mechanism for managing unprocessed and what are believed to be unacceptable emotions towards others, like anger, by turning them inwards towards oneself.

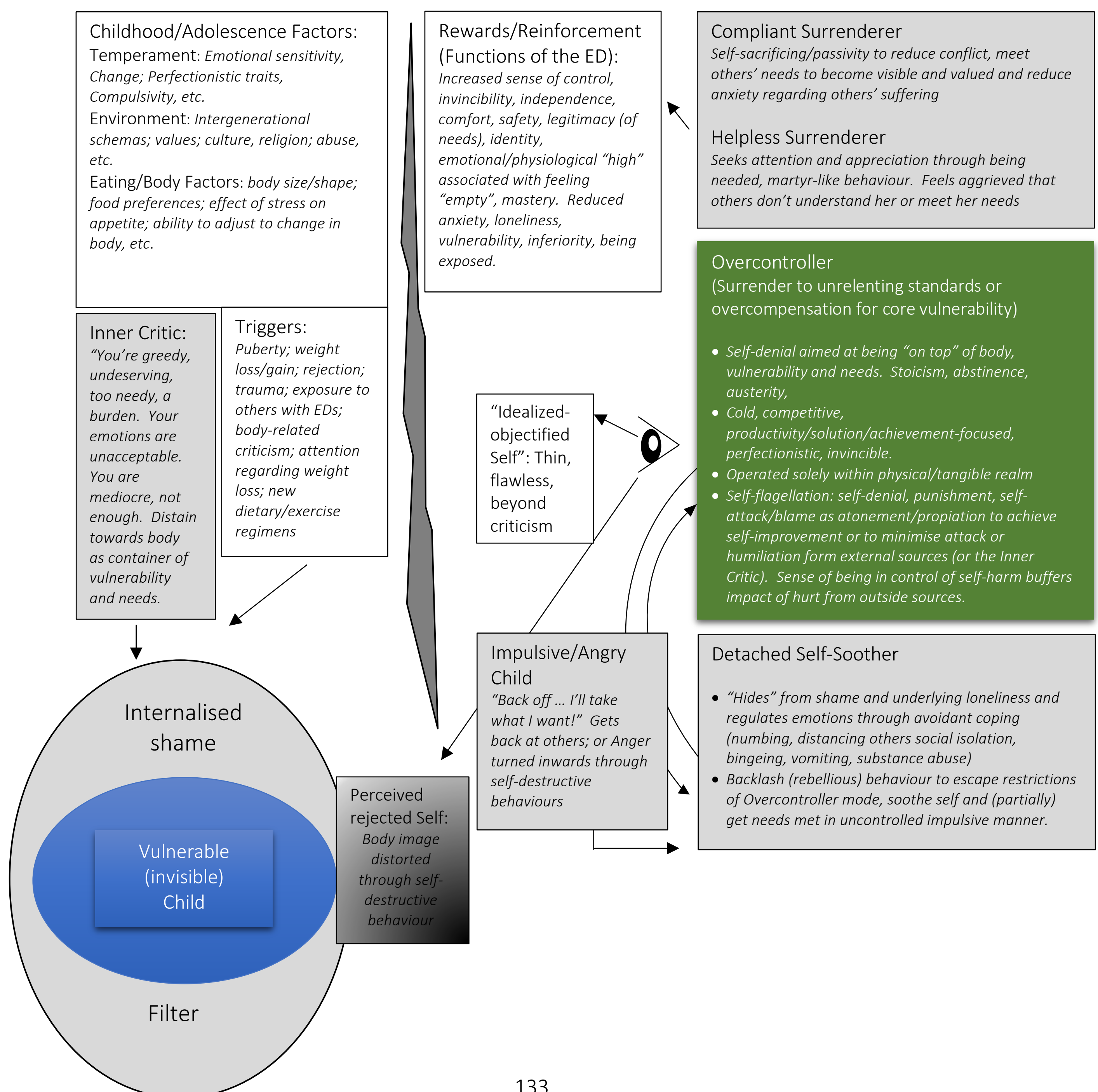
Simpson (2020) goes on to explain how the VuCh feels attached to the Overcontroller mode, seeing it functioning as a reliable and consistent self-made inner guardian that must be preserved at all costs. The Overcontroller views life as an ordeal that has to be endured – constantly avoiding criticism or blame. The carefully controlled and measured relationship with food is central. Furthermore, the Overcontroller is a slave to the Inner Critic by constantly trying to meet the expectations of introjected demands and avoid criticism or punishment. While this mode does not meet the authentic needs of the VuCh, both the Overcontroller and the Inner Critic sadly do aspire to some of the warped expectations of the Western world. Of course, this results in only deeper loneliness and despair for the Child.

Another overcompensator added to the new model is the Pollyanna mode – a mode that overcompensates for underlying pessimism or negativity by denying vulnerability and creates a silver lining to even the direst circumstances. Similar to the Overcontroller, it creates an illusory sense of invincibility. Within the context of AN, this mode can mask the legitimate medical concerns that are unfolding with weight loss and weight-related overcompensatory behaviour. Many of the modes in Simpson's (2016b) earlier model are retained in this latest version, whether the Compliant Surrenderer or the Helpless Surrenderer which is a relabelling of the previous AgSu.

Simpson (2020) emphasises how body image and body avoidance is the focal point of an ED – the body serving as a physical realm where intolerable or unmanageable emotion and a felt-sense experience is stored (Seijo, 2016). With the body containing all this intolerable emotion, "felt sense", and the unmet needs of the rejected VuCh, it is

perceived as "defective". The VuCh then feels to be the problem after being infused with the onslaught of introjected messages emanating from the Inner Critic. All of this falls upon the Child's existing shame and the trauma of early unmet needs. Subsequent cognitive and emotional processes directed on the body are then distorted when viewed through the damaged filter of a shamed Child. This is why Simpson (2020) reasons that body image distortion can be conceptualised as a mechanism for dissociating from the VuCh – the body becoming the container for the VuCh's "past self" that needs to be repeatedly avoided. This explains the limited success of cognitive strategies in therapy for such patients, and how the source of such distortions can only be accessed at a deep schema level. It is for this reason that Simpson (2020) persists in refining her ST conceptualisation for EDs,

Figure 14: Generic Eating Disorder Case Conceptualisation (Simpson, 2020)



given that coping modes play a key role in ED cognitions and behaviour and need to be defined within an individualised conceptualisation for there to be a real and lasting prospect of remission and authentic healing in the Child.

(b) Edwards' single case study of Linda, an individual with Anorexia Nervosa

Similar to Simpson's (2012) case-study of Nicki, Edwards' (2015) single case-study of "Linda", a young woman with AN-b/p and depression, was unresponsive to traditional CBT, which prompted the introduction of ST. Edwards (2015) described how the development of medical complications in her formative years was associated with a resultant emotional neglect, inconsistency, and lack of validation. As a consequence, she became overly responsible and developed a PeOv coping mode. With the subsequent development of diabetes mellitus, this PeOv transformed into a specialised ED mode aptly called the "Anorexic Overcontroller" (AnOv) – the sole purpose of which is to impose rigid control and special demands relating to weight loss, food rules and body shape. Similar to what some authors have described as an "anorexic identity" (see section 2.7.3a) (Bruch, 1978; Cruzat-Mandich et al., 2015; Levenkron, 1983), Edwards (2015, p.10) describes the AnOv's creating a "resultant experience of being strong and in control, and overcompensating for the VuCh experience of being invisible, unlovable, worthless, and a failure." Dream and imagery work enhanced and enriched the specific identity of the AnOv, who took on the appearance of a stern and dictatorial woman that suppressed all emotion residing in the VuCh. While such qualities might easily be mistaken as emanating from the DPMs, Edwards (2015) is specific that this mode is not the introjected echo of the criticism or demands of significant others, but the dialogue of an internally constructed overcompensatory coping mode. The persistence of this coping mode on restrictive intake and weight loss varies between individuals, as does the scorn and disgust of criticism and body image distortion that is an integral part of the anorexic profile. The determination to feel strong, powerful, and in control through vigilant manipulation of weight was very effectively displayed through chair work. Edwards (2015) identified another feature of the AnOv in the illusive and empty promise of a happier and more content life in which Linda would feel "pretty or beautiful or acceptable," provided she aspired to the prescribed weight and appearance.

While the AnOv was Linda's central overcompensatory coping mode, the case conceptualisation included other coping modes within this domain, with the broader PeOv still applying to many other areas of Linda's life. Edwards conceptualised another overcompensatory coping mode in which Linda learned from a young age to suppress the anger evoked by her mother. Despite this "Protector Child" (PrCh) having an avoidant aspect, it is conceptualised as an overcompensatory coping mode that "creates the illusion that the child is happy" (Edwards, 2015, p.12). This mode countered the raw, negative emotion residing in Linda's VuCh with false bravado but, as is the case with all coping behaviour, it had the effect of only reiterating the invalidating experiences evoked by Linda's parents. Of the avoidant coping modes, the comfort eating of Linda's DeSS dampened the loneliness and anxiety that would ordinarily be banished by the AnOv. In addition to having a CoSu within the surrender coping mode domain,

Edwards (2015) also identified the SPVi mode, which echoed how she felt in the face of others' responses when she was first diagnosed with diabetes mellitus. Linda was consciously aware of her self-pitying attitude, essentially using it to shut down. Similarly, in Flanagan's (2014) matrix of modes, she describes how the "Follower", an adaptive, but passive/resting mode that is devoid of behaviour, thoughts, and feelings, becomes the "Victim" – a decidedly passive and subjugated mode in which affect is flat, detached, or depressed. While such "victims" need connection, stability, and personal validation, shutting down actually has the effect of making such needs even more inaccessible. Despite this mode being noticeably absent from the commonly recognised list of schema modes (see Table 4 in Appendix 3), Flanagan (2014) and Edwards (2015) provide a legitimate and valuable coping mode that should not be mistaken for the legitimate pain residing in the VuCh mode.

(c) Munro's Schema Mode Model for the Intensive Treatment for Anorexia Nervosa (ANITT)

While there is little evidence for the efficacy of institutional care and outpatient psychotherapy models for the treatment of patients with AN (Berkman, Lohr, & Bulik, 2007; Bulik, et al., 2007; Meads, Gold, & Burls, 2001), this is especially the case for the subgroup of patients with severe AN (sAN). This has prompted Munro et al. (2014) to develop an institutional setting model for the biopsychosocial treatment of patients with sAN (BMI ≤ 13 or BMI ≤ 15 with weight loss ≥ 1kg/week). The Scottish-based service, named the Anorexia Nervosa Intensive Treatment Team (ANITT), provides a tiered level of treatment. With safety as a priority and a thorough multidisciplinary assessment being mandatory, this conceptualisation-driven ST treatment also has as its core the conceptualisation of AN as a coping mode – avoiding or relieving the Child's vulnerability through a vigilant control of food and weight. Rather than focussing on extinguishing the symptomatology associated with this debilitating condition, the emphasis of this flexible and manualised ST intervention lies in exchanging the dysfunctional nature of coping behaviour with healthy means of meeting the Child's needs.

Munro et al. (2014) conceptualise the maladaptive modes into four main types. The first of these involves the "striving for control," where the patient's "Self-Critical Mode" (SeCr) and the "Overcontroller Mode" (OvCo) ensure that the patient avoids the vulnerability of interpersonal contact. These seem synonymous with aspects of the DPMs and PeOv that inevitably leave the Child striving in the face of failure to assume "control" of their own thoughts and feelings, and the world around them. The second type serves to "sever and detach", and includes the DePr, the AnPr, and the CoSu. Munro et al. (2014) categorises all three as avoidance coping modes, serving the function of shutting down and detaching from vulnerable feelings, describing the purpose of starvation as creating "a state of numbed detachment" (p.4). The third type, "pulling others in," is defined by the "Complaining-Protector Mode" (CoPr), as described by Bernstein and van den Broek (2009). While part of their description of this mode has the notion of "poor me," it closely resembles the SPVi outlined by Edwards (2015). While this coping mode involves coercing others into meeting their needs, they are inevitably not met, which leads to them invariably lashing out at others and ultimately feeling ashamed of their unreasonable behaviour. The fourth

grouping, “giving in,” is defined by the “Hopeless-Resigned Mode” (HoRe). Although this surrender coping mode can be interpersonal, it predominantly involves an internal submission to the intrapersonal modes, leaving the individual feeling a sense of failure and resignation. It is a depressing, hopeless, and powerless way to be (Munro et al., 2014).

A central concept to this model is the existence of the “Feared Self”, which is akin to the ImCh. This is an identity that the sufferer anxiously evades by sustaining the polar opposite – the “Anorexic Self,” which is synonymous with the AnOv described by Edwards (2015). While the Anorexic Self appears extremely controlled and thin to others, the Feared Self is extremely reckless, fat, and chaotically out of control. While the Anorexic Self is self-critical (active SeCr) and self-punishing (PuPa if an introjection), the Feared Self is greedy, self-righteous, and entitled. Similarly, while the Anorexic Self is self-sacrificing and kind to others (CoSu), the Feared Self is perceived to be critical, demanding, unreasonable, and nasty. Another polarity sees the Anorexic Self being detached (DePr) and self-protective (possibly from the PrCh or any number of avoidant coping modes like, for example, the AnPr), while the Feared Self appears open, naïve, and susceptible to exploitation by others. Between the polar contrasting “Anorexic Self” and the “Feared Self”, Munro et al. (2014) place the “Healthy Self” which, synonymous with the HeAd, provides balance and integration and has a good enough sense of self. This is graphically outlined in Figure 15.

Figure 15: Munro’s Schema Therapy Mode Model for Anorexia Nervosa (adapted from Munro, 2014)

Munro et al. (2014) recognises various maintenance or “vicious” cycles that hinder the therapy of patients with AN. While this is synonymous with what Edwards (2015) describes as “mode sequences” (see section 5.1), Munro et al. (2014) has identified some distinct metaphors to highlight the frequent and prominent vicious mode cycles amongst patients with AN. For example, the “Super-Hero” maintenance cycle is central to the perceived reward of AN-r. Such patients constantly evade their vulnerability, needs, and reliance upon others. While the SeCr mode is critical of any perceived weakness, the OvCr mode accounts for the obsessive need for control and the pursuit of unattainably high standards. The patient is rewarded with feeling invincible and superior, and never being reliant on anyone else. However, this notion of being an absolutely autonomous super-hero inevitably collapses. While

the VuCh seeks power and invincibility through restrictive eating, self-condemnation, and the pursuit of perfection, the vicious cycle inevitably sees a return to the lonely and vulnerable child in despair. "The Dictator" describes the patients who, despite being aware of the negative consequences of their ED, persists with ever-increasing harsh rules and controls over their eating behaviour. The strict rigidity by which they live their life inevitably lends to biopsychosocial retardation. The "dictator" concept is reflected in a harsh, but simple solution to problems being imposed on the Child. The sequence of modes sees the vulnerable mode passing through the SeCr, the OvCr, and the HoRe modes before a return to the vulnerable mode. In line with the ST model, Munro et al. (2014) conceptualises healing as the interruption of these vicious cycles, with the Healthy (Adult) Mode increasingly meeting the Vulnerable (Child) Mode's core needs, while maladaptive modes become increasingly neutralised or obsolete. Munro et al. (2014) also provides metaphors for various AN profiles that map the progressive stages of recovery of the transtheoretical stages of change model developed by Prochaska and DiClemente (1992). Table 12 in Appendix 11 outlines these stages.

Contrary to the commonly held contention that significantly emaciated patients with AN are unresponsive to psychotherapy, ANITT have observed that once these patients have established a sufficiently trusting therapeutic relationship, they are able to adequately engage in the therapy. The framework central to ST of addressing unmet core emotional, physical, and social needs is utilized with the intention of mobilizing the patient towards a more functional existence. The therapy should equally provide increasing insight and awareness of the means by which their ED restricts and imposes on their daily lives. Response by patients to the ANITT post-treatment evaluation revealed a refreshing sense that clinicians were perceived as supportive, caring, and authentic. Patients valued the individualised nature of the treatment in meeting core needs and the holistic psychological approach that did not focus exclusively on weight. While the authors have not yet published data regarding symptomatic outcomes, this treatment did result in significant weight restoration (Munro, Burdon-Cooper, Allot, & Hannon, 2014). Furthermore, drop-out rates were very low, mortality rates were comparable to less severe cases receiving inpatient care and, importantly, treatment costs were reduced by approximately 27% (Munro et al., 2014). While it is inconclusive whether cognitive and perceptual deficits in pre-treatment patients with AN has a physiological basis, it is a very plausible explanation for the observed "fall-off" in such patients to their emotionally detached and defensive state and the vulnerability they experience in the face of a challenging therapeutic relationship.

(d) Group Schema Therapy Mode Model for the Eating Disorders

Results of the pilot study conducted by Simpson, Morrow, van Vreeswijk, and Reid (2010) appear to demonstrate improvements on the ST group design conducted by George et al. (2004) (see section 4.2.1.). This outpatient group intervention, facilitated by two psychologists, was provided for eight patients with chronic EDs and high levels of adjunct psychiatric conditions like PDs, anxiety and mood disorders. The study, which involved 20

manualised group sessions over a six-month period, was based on the group ST model developed by van Vreeswijk and Broersen (2006) for patients with BPD.

With an emphasis on behavioural change, ST strategies specifically focused on the bodily felt-sense, body-image, and the cultivation of emotional regulation skills. With both therapists providing limited reparenting, the patients were encouraged to cultivate and share in the parenting role with each other as the group progressed. Emphasis was placed on linking pathological eating behaviour with identifiable schema modes in order for patients to recognise and understand the origin of the coping function of their pathological behaviour. Whenever the DePr, a prominent avoidant coping mode in the group, was present, it was essential that either a fellow patient or one of the therapists addressed and labelled its presence. A culture of empathy and emotional transparency was encouraged to replace the familiar reflex of inhibiting or blocking the expression of emotions. Expressing personal needs was strongly encouraged, while mindfulness meditation (Kristeller et al., 2006) was integrated into the treatment to facilitate emotional regulation and to improve awareness of the urge to engage in disordered eating behaviour. Patients were assisted in identifying the source of their negative and distorted body-image and linking it with the emergence of particular modes. Similar to imagery rescripting, the "historic role-play exercise" (Young 1984, cited in Simpson et al., 2010) was used to play out an early experience, after which it was repeated with a re-structured meaning. The HeAd was deliberately incorporated into body-image work in order to establish a compassionate and nurturing attitude towards body weight and shape. Mode dialogues were also used to banish dysfunctional modes that were critical of body weight and shape. In this way, patients had the opportunity to cultivate the HeAd actions, first for their fellow patients and, eventually, for themselves.

Although two patients dropped out mid-treatment, the remaining patients who completed the group therapy experienced significant reduction in ED severity and global EMS severity, as well as reduced levels of shame and anxiety. Quality of life scores also improved significantly. It appeared that the group members were only able to modify their eating behaviour once they had engaged in the main task of the group of challenging and healing the underlying EMSs. Group factors, especially the credibility of peer support and the de-stigmatising of having an ED, appeared to enhance the change process, much as it did in the RCT for group ST for patients with BPD conducted by Farrell et al. (2009) (see section 1.1.2.) Importantly, participants reported a 60% reduction in schema severity and eating pathology at the 6-month follow-up. Despite their small sample size, the authors have called for a RCT to more rigorously test the efficacy of this promising form of ST treatment for this patient population.

4.3. A Call for Further Research

As will shortly be outlined in the methodology chapter, drawing generalisations from a single case study is not possible. However, the two cases discussed above, together with other similar case studies, do provide the building blocks towards constructing clinical theory. These case studies, as well as the preliminary studies looking

at severe AN, and studies designing group ST for EDs have provided a valuable platform upon which to explore the therapeutic response to ST for this difficult-to-treat population. This is especially the case when they have been unresponsive to the most recommended of the existing models of treatment available. While earlier models became more useful in shifting the emphasis from schema content to schema processes (Waller et al., 2007), it was with the advent of the ST mode model that an increasing number of clinicians and researchers have been able to more effectively conceptualise ED behaviour within an individual's constellation of schema modes. The utilization of this model, with its multiplicity of modes and EMSs, facilitates the building of an integrated and individualised conceptualisation for the complex and heterogeneous nature of this patient population. A core feature of the model is the conceptual understanding that coping modes serve as survival strategies that, although "functional" in childhood, deny the fulfilment of emotional needs as an individual matures into adulthood. As such, the ST mode model of treatment facilitates the identification and confrontation of the ED as a coping mode with a specific "identity" which can only be made redundant once the DPMs have been banished and the HeAd sufficiently established to provide the Child with the guardianship to foster authentic and spontaneous development. While CBT techniques often help patients gain an intellectual and superficial understanding of their EDs and unmet childhood needs, it is with the rich array of techniques and tools available to schema therapists that patients can ultimately engage at a deeper emotional level in order to identify, explore, and dismantle EMSs and, thus, liberate the Child within. There is value in Pugh's (2015) calls for RCT to provide robust quantifiable evidence for the efficacy of ST for EDs. However, it is no less imperative that systematic case studies contribute to an accumulating knowledge base because, as Hilliard (1993) explains, only this method of research allows a spotlight to be cast upon the delicate therapeutic process that sets a bearing for personal authenticity and liberation.

CHAPTER 5: METHODOLOGY

5.1. Research Objectives

The ST mode model of treatment is a relatively new development (Lobbestael et al., 2007; Young et al, 2003) and, furthermore, its application to the treatment of patients with EDs is still in its infancy. The most valuable means of exploring the application of this highly integrative and flexible model of treatment to this notoriously difficult-to-treat patient population would thus require readers, especially practitioners, to be privy to the most accessible means of observing the fine details of this interface. Through the analysis of the individual case in the form of the systematic case study method, this study aimed to provide a comprehensive account of the complexities and challenges faced in applying this model of treatment to the broad spectrum of patients with EDs. The first aim was to provide a phenomenological element by way of a rich and thickly detailed case narrative and additional case vignettes as a basis for the interpretative element. A central hermeneutic element of this study was an expansion of the theoretical understanding of this model for treating ED patients. Reading questions were constructed that would highlight and address key concepts and processes in ST and identify significant challenges in the implementation of this treatment model.

In order for this study to meet the research objectives, the following was required:

1. The recruitment of 10 patients across the EDs diagnostic spectrum to receive individual therapy using the ST mode model of treatment. These would either be new patients to my practice or existing patients within my practice who were not responding favourably to the existing CBT treatment.
2. The documenting, analysing and measuring of response to treatment for all ten participants over a maximum of eighteen months or 100 sessions.
3. Taking into account the volume of material gathered during the study, identifying which case or cases to write up that would best exemplify and richly illustrate the application of ST for EDs.
4. The writing up of one of more systematic case studies to contribute to an existing evidence base of case studies that can serve as an "explicit public reference point" (Edwards et al., 2004, p.593) for clinicians treating patients with eating disorders.

5.2. Distinguishing Research Methodology from Clinical Methodology

Edwards (2007; 2011) draws a distinction between research methodology and clinical methodology in case study research. The former describes a systematic framework upon which the therapist/researcher plans and investigates the raw material of their case for the purpose of examining useful questions and arguing for

conclusions based on the experience of working the case. It ensures that sound scientific principles are systematically applied to the processes involved in the collection, condensation, and interpretation of the data collected. Here, the strategies for ensuring reliability and rigour in qualitative research are a priority. Clinical methodology, on the other hand, refers to the actual methods adopted by therapists to formulate cases and plan their approach to a therapeutic intervention. It usually takes the form of a set of standardised procedures for the assessment, treatment planning and the ongoing decision-making in the implementation of their interventions (Edwards, 2007). In the case of CBT-E (Fairburn et al., 2012) for BN, for example, a strictly manualised treatment protocol is used through the assessment, conceptualisation, as well as the stepwise treatment plan for each session, with the only variation being the additional individualised components that reflect the patient's particular psychopathology profile and core issues. Issues pertaining to qualitative research design will first be outlined, with a particular emphasis on the systematic case study method research, after which issues regarding clinical methodology will be addressed.

5.3. Research Paradigms

5.3.1. Nomothetic and Idiographic Research Methodology Perspectives

Nomothetic and idiographic are terms that describe two distinct approaches to knowledge, each corresponding to a contrasting intellectual tendency, and each to a different branch of academia. Although the distinction of these two approaches was taught by Socrates in bygone millennia and comprehensively documented by Windelband (1894) more than a century ago, controversy still surrounds the preference for and relative strengths of these two research methods (Hermans, 1988). While there are many examples of the idiographic approach to research in the natural sciences (e.g., the research explorations undertaken by Charles Darwin or the design of a suspension bridge for a specifically unstable terrain), the natural sciences are generally more concerned with the formulation of laws and the generation of general statements. The social sciences/humanities, however, require the ability to be very specific, produce full description of events and hold preference for particular statements. Even within the social and behavioural sciences, however, the challenge of choosing between the nomothetic or idiographic approaches has been a contentious debate. Introduced as psychological terms in his studies into personality theory during the 1930s, Allport (1937) courageously developed novel research methods to embrace the richness and complexity of human personality; those regularities in which individuals think, feel, and behave in a unique manner. He called for the use of idiographic methods, the purpose of which is to identify patterns of behaviour, thought/cognition, and emotion within the individual over time and across contexts, rather than strictly identifying patterns of differences between individuals that exemplifies the nomothetic approach (Conner, Tennen, Fleeson, & Barrett, 2009).

Within the social and behavioural sciences, the nomothetic perspective has remained dominant for an extended period of time (Barker, Pistrang, & Elliott, 2015). It reveres the notion of an objective reality; one being associated

with elaborate logical designs to achieve experimental control that is independent of the subjective human mind. As such, it is concerned with the quantifiable and experimental methods of inquiry prominent within the natural sciences domain, where the collection of such data is generally expressed mathematically by means of descriptive or inferential statistical analysis in the form of discrete, normative and quantitative measure of specific variables (Barker et al., 2002). Concerned with the search for general laws, the fidelity to therapy manuals/protocols and the extensive statistical analysis of the therapeutic outcomes of groups of patients, it has been granted much scientific legitimacy within the psychotherapy research community, where the RCT is frequently recognised as the metaphorical "gold standard" (Fishman, Messer, Edwards, & Dattilio, 2017, p.1). This is despite the fact that many researchers have pointed to their numerous limitations (Eells, 2007; Hollon, 2006; Sackett & Oxman, 2003; Westen, Novotny & Thompson-Brenner, 2004). For one, such studies typically only evaluate a single diagnostic problem, which is very simplistic when one considers that the vast majority of psychiatric patients have a complex diagnostic profile. RCTs also do not inform us of the extremely complex mechanisms through which treatment works. And, very importantly, such studies do not account for the idiographic nature of both patients and therapists. This creates uncertainty of the extent to which a specific treatment is appropriately suited to a specific individual. RCTs that require rigorous conformity to manualised treatment, what Wilson et al. (1997) refer to as the method-orientated treatment strategy, fail to do justice to the context-specific and patient or therapist-related aspects that are encountered in everyday clinical settings. This is where the value lies in studies that accommodate the therapist being flexible in adapting treatment to an individualised way; what is known as the process or patient-oriented treatment strategy (Schulte & Eifert, 2002). This is what many have termed "therapist responsiveness" (Kramer & Stiles, 2015; Norcross, 2011; Stiles, Barkham, Connell, & Mellor- Clark, 2008).

By contrast, the idiographic perspective is typified by a focus on qualitatively rich patterns of human transactions, and one that focusses specifically on a particular case, place or phenomenon. The approach is designed to derive meanings that are particular to the research target rather than extrapolating generalizations. The systematic therapy case study serves as a good example in the application of this research approach, with emphasis being placed upon the provision of a rich and thickly detailed microcosm of the therapy from both the patient's and therapist's perspectives. From a phenomenological stance, this would include the unfolding narrative within an emotionally significant relationship between therapist and patient, as well as a detailed and evolving case conceptualisation and treatment plan that emerges from the complex interplay of the patient's personality, life history, presenting symptoms and present life circumstances (Fishman & Edwards, 2017; McLeod, 2010). The guidelines published by the United Kingdom NHS Centre for Reviews and Dissemination in 2001 and the Cochrane Qualitative Research Methods Group (CQRMG) are just two examples of the efforts that have convincingly argued for the credibility and relevance of qualitative research. This has led to resurgence in the use of such research methods in clinical psychology, psychotherapy and mental health practice (Barker, Pistrang, & Elliot, 1994; Edwards, 1996, 1998; Hilliard, 1993; Jackson, 2015; Shaw, 2012; Stiles, 2003).

Since Allport's (1937) invaluable contribution to research methodology eight decades ago, the tides of methodological argument in the social sciences, particularly in clinical psychology, have persisted. Much derision has been expressed across the boundary wall dividing those researchers committed to the nomothetic approach and those showing preference in presenting the idiographic nature of their work (Barlow, 1981; Safran, Greenberg, & Rice, 1988). For instance, critics have historically marginalised qualitative research, arguing that the private nature of psychotherapy practice makes for a process that is inaccessible to critical evaluation, leaves clinicians unaccountable and uncritical of their work, and lacks objective and definitive data for evaluating the effectiveness of their work.

While the significant contrast in the underlying epistemological principles of these two paradigms resulted in decades of futile conflicts, many have argued that such territoriality has distracted the proponents of these contrasting camps from realising a valuable synergy through their complementarity. While, in short, the nomothetic paradigm focusses on "numbers about variables within groups …" and the idiographic on "… words about patterns within specific persons" (Fishman et al., 2017, p.ix), it is increasingly recognised that the respective strengths of quantitative and qualitative research methods are both perfectly valid approaches to the cultivation of research, yield rich understanding and are well positioned to answer equally valuable, albeit different, research questions (Bates, 2015; Creswell, Fetters, & Ivankova, 2004; Davies & Dodd, 2002; Fishman et al., 2017; Johnson, Onwuegbuzie, & Turner, 2007). This is where Nathan and Gorman (2002) have argued for the creation of highly structured manuals of "treatments that work", which allow clinicians to benefit in the arena of managed care (Cummings, Pallak, & Cummings, 1996).

Reflecting this complementarity, Theodore Millon, for instance, outlines how for the identification and diagnosis of PDs, one would initially engage with the nomothetic perspective in seeking various general scientific laws. Once a diagnosis has been made, the shift should be made towards the idiographic perspective to focus more on the specific individual and their unique personality traits (Millon & David, 1996). So, too, does Salkovskis (2002) argue that the most comprehensive knowledge base that informs clinical practice is achieved via a multidimensional approach in which contrasting research methods complement one another rather than being used in isolation. The mixed-methods research movement (e.g., Barkham, Hardy, & Mellor- Clark, 2010; Clark & Creswell, 2008; Creswell & Clark, 2006, Green, 2007; Dattilio, Edwards, & Fishman, 2010; Fishman et al., 2017; Goodheart, Kazdin, & Sternberg, 2006; Norcross, Beutler, & Levant, 2006; Wolfe, 2012), for instance, has expanded on the traditional gold standard of what constitutes best-practice psychotherapy research. This "Cases within Trials" model seeks to integrate knowledge gathered from RCT with that from systematic case studies strategically drawn from the same RCT study (Fishman & Edwards, 2017, p.3). Fast gathering momentum, this synergistic marriage of two complementary research paradigms has, for more than a decade now, been recognised as a third stand-alone research paradigm (Fishman & Edwards, 2017; Johnson & Onwuegbuzie, 2004). Fishman (2005) explains how the

creation of this integrative pragmatic alternative discipline provides a rediscovered and complementary method for gaining new and valuable knowledge in applied and professional psychology.

Such integration and evaluation of evidence from these various methods of inquiry is what leads to the development of "empirically grounded clinical evidence" (Salkovskis, 2002). This is reiterated by others (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996), with Edwards et al. (2004) arguing that idiographic research that reflects clinical practice, rather than being viewed as a poor relation to more formalised settings of most nomothetic research, be recognised as a vital component in the research process that has led to the development of clinical theory and treatment models in cognitive therapy.

5.3.2. Different Qualitative Methodological Approaches to Research

Creswell and Poth's (2017) recent publication provides a useful categorisation of qualitative design methods under five distinctive headings, namely: ethnography, narrative, phenomenological, grounded theory and case study. While each uses similar data collection techniques, the purpose of the study is what differentiates them. However, they also acknowledge that most researchers make use of a combination of these approaches in a particular study. While this study is case study-based, it does draw on each of the other four approaches. Rooted in anthropology, ethnography means "portrait of a people" (Hancock, Ockleford, & Windridge, 2009, p.5). Providing descriptive studies of cultures and people and helping provide health care professionals to develop cross-cultural awareness and sensitivity, this methodology requires researchers to immerse themselves in the target participants' environment in order to understand the goals, cultures, challenges, motivations and themes that emerge. The researcher attempts to interpret data from the perspective of target population, with results being expressed as if from the subjects themselves, using their local language and terminology (Creswell & Poth, 2017; Hancock et al., 2009). The narrative approach weaves together a sequence of events to form their cohesive story. Researchers conduct in-depth interviews (therapy sessions would be applicable), read documents and collateral, and look for themes in individual stories that illustrate the larger life influences that created them. Findings are presented as a story (or narrative) with themes and can resolve conflicting stories and highlight tensions and challenges as opportunities for innovation or change (Creswell & Poth, 2017; Hancock et al., 2009). Phenomenology studies conscious experience as experienced from the subjective or first-person point of view (Allen, Nodelman & Zalta, 2003). We often do not fully understand these experiences because they have not been overtly described and explained, or our understanding of the experiences may be unclear. For example, what might it actually be like to live with the anorexic condition? What is the impact on family members, and how does the condition impact on the sufferer's broader social network? A phenomenological study would, thus, explore the detailed impact of the ED on family relationships, the sufferer's broader friendship circle, as well as the impact of the condition on the sufferer's emotional, cognitive and physical well-being. While not starting with a well-formed hypothesis, such research acknowledges that there is a gap in our understanding and that clarification will be of benefit. Although

such research will not necessarily provide definitive explanation, it does raise awareness and increase insight (Creswell & Poth, 2017). What phenomenological studies describe, grounded theory provides an explanation for through the collection and analysis of data about a phenomenon. Extending beyond phenomenology, the explanations that emerge from grounded studies provide genuinely new knowledge and are used in the development of new theories to enable us to approach existing problems and challenges in new ways. A good example of grounded theory is the model of the grieving process described by Kübler-Ross (2009), by which individuals pass through a series of stages - each typified by certain responses; denial, anger, depression, acceptance and resolution. It has often been documented how a grieving individual does not, necessarily, pass through all these stages or in the neat order laid out in the model. A key feature of grounded theory is the simultaneous collection and analysis of data using a process known as constant comparative analysis. Here, data are transcribed and examined for content immediately following data collection, and new theory is conceived as researchers recognise the emergence of new ideas and themes from what is observed of the subjects. In this sense, the theory is grounded in the data. While case study research can take a qualitative or quantitative stance, it is through its use in the former domain that is pertinent to this research study; the in-depth analysis of a single or small series of individual cases. Whereas most quantitative research has very little to teach the practicing clinician, it is essential that idiographic research rightfully receives legitimate status within the research literature as a means of reflecting and enhancing clinical practice. Fishman (2005) illustrates how the case is the basic unit of psychological research, and that working with it, the clinician needs to view it holistically, looking in context at the problems and goals, the situations and events, as well as the procedures, interactions and the outcomes associated with the case (Fishman, 1999a; 2005). Supported by numerous other authors working from diverse perspectives (Bromley, 1977, 1986; Edelson, 1988; Edwards, 1996, 1998; Fishman & Peterson, 1987; Fishman, 1999a, 2000a; Hoshmand & Polkinghorne, 1992; Klumpner & Frank, 1991; Levine, 1974; 1980; Runyan, 1982; Sechrest, Stewart, Stickle, & Sidani, 1996; Spence, 1992, 1993; Yin, 1989) Fishman (2005, p.2) argues for the revival and legitimacy of case studies "as a vehicle for systematically reporting and evaluating clinical observations, exploring theory and documenting advances in professional effectiveness." The central aim of this study is to use the systematic case study method to provide practicing therapists and the developers of therapy models with the opportunity to critically observe the intricacies of working with a broad spectrum of patients with EDs using the ST mode model of therapy.

5.4. The Systematic Case Study Method

5.4.1. Defining Case Study Research

Yin (1994, p.23) has defined the case study research method as "an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used". It involves the systematic and

detailed gathering and presentation of information regarding a particular patient-participant and/or treatment process. It differs from other research methods by its intensive analysis and description of the particular phenomena under investigation within its real-life context (Yin, 1994). Here, Edwards et al. (2004) remind us that this method of inquiry often has better external validity (transferability) in light of the ability to preserve the complexity of a real-life environment than a multivariate study.

5.4.2. The Benefit of Case Study Research to the Practicing Therapist

There are several ways in which case-based research provides practical value to practising therapists. The first of these is that they take into account the contextual realities of therapeutic practice. Patients seen in practice tend to differ in terms of their personality, socio-cultural and historical background. Furthermore, many patients have complex diagnostic profiles and frequently contend with complicated social and personal circumstances. Therapists also tend to differ in terms of their own socio-cultural and historical background and vary with respects to the therapeutic modalities and the techniques they use or the particular profile of patients they see. These contextual variables not only influence the therapy process beyond the implementation of a particular treatment model, but also shape the quality of a therapeutic alliance, the patients' expectations and commitment to treatment, as well as their motivation for change. Because these kinds of variables are highly pertinent to practicing therapists, the case study serves as a very valuable research method in providing insight as to how best to respond to the unique characteristics of specific patients, their circumstances and the presenting problems (Dattilio et al., 2010; Eells, 2007; Fishman, 2005, 2007; Flyvbjerg, 2006). Furthermore, the design of the systematic case study provides the opportunity for the refining of clinical treatment models, as well as the testing and refining of the theory on which such models are based, thus, providing a deeper understanding of how treatments work and how they need to be adapted to new situations.

A further strength of the case study is how it provides insight regarding therapist responsiveness; a central factor in the delivery of psychotherapy. This refers to the manner in which therapists monitor their patients' understanding or engagement with the treatment, and how therapists adjust or adapt their responses to meet the needs and circumstances of each of their patients (Edwards, 2009, Norcross, 2011). As such, therapists are required to be flexible and individualise their treatment approach. Case-based research can illuminate the manner in which therapists use flexibility to apply the appropriate intervention and tailor their responses to suit the moment-to-moment needs of their patients. This kind of information is particularly useful in providing practicing therapists with the necessary guidelines to integrate specific elements into the treatment of their patients' unique circumstances.

Edwards et al. (2004) as well as Stewart and Chambless (2007) have identified as a concern the fact that practising therapists frequently neglect to keep abreast of current publications, due largely to the ongoing prevalence of multivariate studies in the journals not sufficiently inspiring practitioners to broaden their knowledge base. In fact,

it has been demonstrated that practicing therapists are enticed more by qualitative than quantitative studies, with various researchers specifically identifying how case studies are significantly more captivating to the reader due to their ability to provide insight into the sometimes subtle utility of specific clinical models, and the rich phenomenology of experiences for both patients and therapists (Finlay, 2011; Goodheart, 2005; Stewart & Chambless, 2007). In fact, it should be remembered that significant psychotherapeutic approaches such as psychoanalysis, cognitive and behavioural therapy, the humanistic therapies, CBT, as well as existential therapy have all gained considerable credibility through detailed idiographic case studies (Ponterotto, Kuriokose, & Granovskaya, 2008). A study conducted by Stewart and Chambless (2007), for instance, demonstrated that therapists' exposure to such research was far more influential in guiding their clinical practice than the exposure to RCTs and other quantitative research. Their study had registered clinical psychologists randomly assigned to receive either a research review of data from RCTs of CBT for BN or a case study demonstrating the application of CBT for BN. Irrespective of the therapists' years of experience or their particular training orientation towards research or a particular model of treatment, the therapists experienced the case study material to be significantly more relevant to their practice, in light of such research typically "striving to capture real-world human complexity and its narrative meanings on its own terms, using words rather than numbers" (Fishman & Edwards, 2017, p.6).

5.4.3. The Coexisting Roles of Therapist, Researcher and Author

I fulfilled the coexisting roles of therapist, researcher and author throughout this research study.

There is substantial literature that focuses on the interface between research and treatment. Particularly more recently, practicing primary health care clinicians have been urged to involve themselves in research, for which there are numerous benefits at all stages of the research process. One of the main advantages of being a clinician-researcher is that an experienced clinician is far more likely to identify with or be inspired by phenomena worthy of exploration that is relevant to routine clinical practice in real-world settings, and that is meaningful and accessible to fellow therapists (Goodheart, 2005; McNair et al., 2008; Yanos & Ziedonis, 2006). Another advantage of maintaining such coexisting roles is because it is the ideal position in which to be able to integrate implicit and procedural clinical knowledge into both the analysis and interpretation of the data (McNair et al., 2008). Clinicians also have readily available access to research settings, whether a private practice setting or an institutionally based setting. Related to this is the clinician's ease of access to the clinical field and population. Furthermore, experienced clinicians have tacit clinical knowledge to apply to the patient population being investigated. For instance, schema therapists are not only encouraged to be flexible and spontaneous by tailoring their treatment design to best pursue the most pertinent goals that have been jointly identified, but also to track the often subtle processes in therapy, whether it be that of the patient's, their own, or that of the therapeutic relationship that is recognised as central in ST (McNair et al., 2008; Yanos & Ziedonis, 2006). Finally, clinician-researchers are often in a position to be able to provide continued treatment when required beyond the confines of the research time

frame. Being the author of a study has the advantage of being able to accurately and thoroughly document all the findings from the clinician's and researcher's perspective. The therapist-researcher is also uniquely poised to anticipate problems that arise within the therapeutic setting (Yanos & Ziedonis, 2006).

While this is an arena that poses the greatest potential for the patient-orientated clinician-researcher to make a meaningful contribution, it also poses a significant risk for ethical conflict and practical dilemmas (Dickson-Swift, James, Kippen, & Liamputtong, 2006; McNair, Taft, & Hegarty, 2008; Scerri, Abela, & Vetere, 2012; Yanos & Zeidonis, 2006). The most glaring challenge involves the internal clash between the clinician's responsibility to do best for their patient (beneficence), and the researcher's directive to exercise scientific autonomy in the pursuit of truth (Pellegrino, 1992). Pertinent to this study, this dual role can create misconception for the participant, where the investigators are not only associated with their roles as clinicians, but also carry the dual responsibility of maintaining methodological rigour in their interaction. This problem can be addressed by the clinician-researchers having limited or no research contact with the participants. For instance, it can be useful to have a clinician other than the one with whom participants have therapeutic contact to recruit, collect data, or conduct interviews with participants for the purpose of reflecting upon the therapeutic process (Sales & Folkman, 2000). Where this is not possible, it is important that a clinician-researcher clearly and fully disclose their possible conflicts to potential participants (Roberts, 2002). For the most comprehensive means of balancing and prioritising ethical issues and promoting sound ethical judgment, Miller et al. (1998) advocate that the clinician-researcher seek to integrate their dual roles by what they call a "coherent moral identity". This stance requires the clinician-researcher to be thoroughly self-reflective and to make sound judgments in order to avoid the possibility of exploiting participants in the study. They should be very conscious in developing a therapeutic relationship with their participants that minimises the risk for therapeutic misconception. Equally, the clinician-researcher should be extremely cautious to not overidentify with specific participants, the whole participant population, or even the treatment model at the expense of the scientific value or rigour of the research study.

Clinicians as researchers also face practical challenges, where the dual nature of their roles poses the threat of what Polasky and Holahan (1998) have called "inter-role conflict". The dual roles need to be clearly defined and delineated without compromising the efforts in one domain by overextending the efforts in the other. While the development of an integrated identity requires the clinician-researcher to be diligently introspective, it is a mechanism by which science and practice can remain balanced. With due responsibility, both beneficence and scientific integrity can exist in harmony, rather than in conflict (Yanos & Ziedonis, 2006).

5.4.4. McLeod's Typology of Psychotherapy Case Studies

McLeod (2010) outlines a typology of five prominent and different types of psychotherapy case studies. The first of these is the pragmatic case study which is defined by its comprehensive nature and serves as an exemplar of best practice. The primary purpose of the theory-building case study is to create and revise general theories of

psychotherapy process and outcome. The adjudicational case study focuses on the intensive, "hermeneutic" evaluation of the case's process and outcome via multiple types of data, and its analysis by multiple judges to determine the authenticity of claims about the therapy. The narrative case study primarily focusses on capturing the personal meaning of the therapy experience for both the patient and the therapist. Finally, the single-case experimental design observes quantitative changes over time in response to controlled variations in therapeutic conditions (Fishman, 2012, 2013). While Fishman (2012) explains how all five of these models of case studies draw on the same qualitative and quantitative data reflected in the observed psychotherapy, they vary in the scope and kind of data they focus on and analyse. Yet, it is the pragmatic case study method that he claims is the most comprehensive due to its very broad and descriptive focus, while still including the various components of best practice and their inter-relationships. This model, due to it being fully utilised in this study, will now be discussed in detail.

5.4.5. Pragmatic Case Study Model

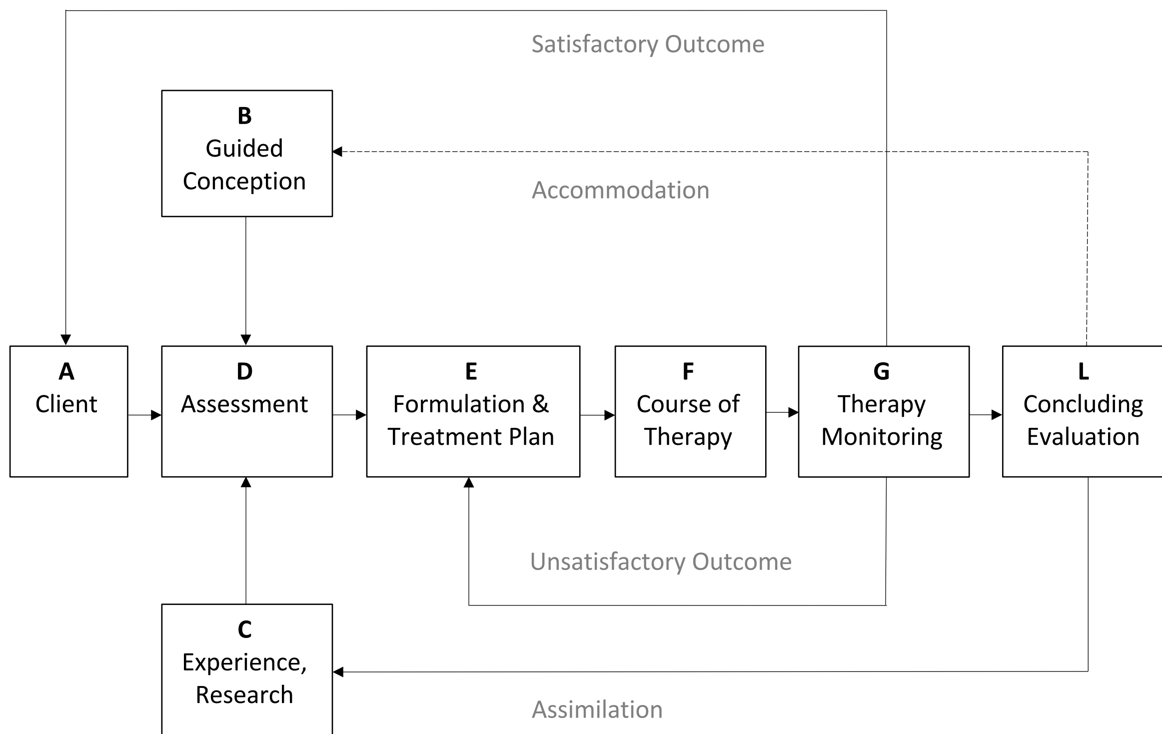
The majority of published therapy case studies reflect the therapists' descriptive accounts of their work with patients in routine everyday practice; what Aveline (2005, p.138) describes as "a vehicle by which clinicians can inform and receive feedback about the potential value of the specific ways in which they work with different groups of patients". However, it is important that methodological guidelines are followed to ensure that such case studies are written up in a rigorous, systematic and critically informed manner (Messer, 2007). Here, Daniel Fishman (1999, 2005) has provided a major contribution to case study research design through his book "The Case for Pragmatic Psychology" as well as the e-journal of which he is the chief editor, "Pragmatic Case Studies in Psychotherapy" (PCSP). The methodological guidelines he devised hold immense practical value in terms of the required steps to ensure the construction of a systematic and rigorous case report of everyday practice. However, such guidelines also ensure conceptual and philosophical coherence in reflecting a perspective on knowledge building that is informed by current debates in the philosophy of science, psychology and the social sciences. While the merits and drawbacks of an objective and nomothetic approach to research were outlined earlier (see section 5.3.1.), there are many researchers, influenced by postmodern ideas, who argue against the notion of a purely objective and knowable external reality, and maintain that all knowledge is socially constructed and shaped by the interests and stances of individuals and groups who are culturally advantaged to make knowledge claims. Yet neither of these positions can singularly build a knowledge base that is optimal for everyday practice. Experimental studies get lost in translation due to the complexities of everyday practice, while the critical stance of postmodern enquiry "deconstructs" everyday practice by virtue of not supposedly providing tangible solutions about how to practically improve treatment (McLeod, 2010).

Fishman's (1999) resolution to this dilemma is his development of what McLeod (2010) calls a "postmodern pragmatism" (p.94), in which the implications for therapy research involve the adoption of an interpretive

paradigm that “focuses on case studies that address particular practical problems in local and time-specific contexts, rather than on the abstract, universal and quantitative knowledge of timeless laws and principles” (Fishman, 1999, p.131). In building a bridge between the philosophical stance of postmodern pragmatism and the practical realities of therapeutic practice, Fishman’s (1999) model of the pragmatic case study is based on a sequence of steps drawn from Donald Peterson’s (1991) “Disciplined Inquiry” epistemological model. This model, utilised in this study and diagrammatically outlined in Figure 16 on the next page, begins with an information gathering phase by way of a thorough and systematic assessment of the patient’s presenting problems, personality, history and life circumstances. This forms part of any normal clinical practice; a flexible, organic and ongoing assessment phase, that is well-described by Edwards and Young (2013). The initial assessment is orchestrated by a “guiding conception” of the process being studied, which includes the clinician’s assumptions about theory, epistemology, intervention programme goals and ethics, in addition to knowledge of relevant existing empirical research and their recollection of examples of similar completed cases. Knowledge gained from the assessment is used as a basis for the next two steps: constructing an individualised case conceptualisation and a resultant treatment plan thus define the next two steps. The treatment plan is then implemented during a course of therapy. With the therapist’s accumulation of new information and the ongoing monitoring of data and treatment, it is typical for the case conceptualisation to be repeatedly modified. Feedback loops will see the necessary adjustments being made to the treatment and the methods employed by the therapist to achieve the goals set out. When the feedback loops that stimulate recycling through earlier phases of the case are complete, termination is indicated, and the final results are contained in a concluding evaluation. Confirmation of the original guiding conception describes the assimilation process, while the need for the revision of theory is reflected in an accommodation feedback loop. The discussion section of the write-up of the case presents the overall analysis of, and reflections upon, the study. It is important that the manner in which the presentation of descriptive clinical information (e.g., case history and case narrative) and the subsequent interpretation are separated (Fishman, 2000; 2005; 2013; Elliott, Fischer, & Rennie, 1999).

One of the reasons for Fishman’s (2012, 2013) claim that the pragmatic case study model is the most comprehensive of the five case study models outlined by McLeod (2010) (see section 5.4.4.) is because it includes the case study content of the other four models. In this respect, the pragmatic case study model includes theory-building through the guiding conception component (B), while the adjudication-related search for particular conclusions about the nature and influence of therapy are reflected in the concluding evaluation component (L) of the model.

Figure 16 Professional Activity as Disciplined Inquiry (Adapted from Peterson, 1991)



A description of the narrative experiences, for both the patient and the therapist, documents the course of therapy component (F). Finally, the quantitative data that reveals the effect of different therapy conditions reflects the therapy monitoring component (G). Of course, each of the four other case study models each possess a design that provides an opportunity to "zoom in" with greater detail and conceptual elaboration on particular aspects of the case study (Fishman, 2013).

5.4.6. Interpretative Phenomenological Analysis as a Methodological Framework

This study makes use of the interpretative phenomenological analysis (IPA) methodological framework. While initially applied to problems in the health psychology field, it is very applicable in the examination of the psychotherapy process. The primary goal of this framework requires that the researcher investigate how individuals make sense of their own experiences (Gill, 2014). It is assumed that individuals are self-interpreting, which essentially means that they are actively engaged in interpreting events, objects and others in their lives. In examining this process, IPA draws upon the three fundamental principles of phenomenology, hermeneutics and idiography (Larkin & Thompson, 2012; Pietkiewicz & Smith, 2014). As outlined earlier, phenomenology is concerned with identifying the unique and special components of experiences from the stance of a particular individual. According to hermeneutics (from the Greek word meaning "to interpret" or "make clear"), one needs to comprehend the mind-set of the individual and the language which mediates their experiences of the world, in order to translate their messages (Freeman, 2008; Larkin & Thompson, 2012). The third theoretical orientation

which IPA relied upon is idiography (as outlined in section 5.3.1.), where the researcher focuses on the particular rather than the universal (Smith, Harré, & Van Langenhove, 1994); making specific statements about the participant in the case study due to the analysis being based upon a detailed case exploration. The aim of IPA is thus to produce an in-depth examination of certain phenomena, rather than generating a theory to be generalized over the whole population.

A thoroughly detailed examination of one case is widely accepted as a legitimate study in itself, with Smith (2004) arguing that a detailed analysis of a single case may well be justified if rich and meaningful data has been collected. This allows the researcher to present original problems, mechanisms or experiences through that single case. It provides an opportunity to learn much about the patients, their responses to specific situations, and consider connections between different aspects of the patients' experiences. Pietkiewicz & Smith (2014, p.9) reiterate this point, explaining how IPA researchers "should concentrate more on the depth rather than breadth of a study". These views guided my ultimate decision to present one of ten case studies for this thesis. When working with a series of cases in a single study, IPA researchers should aim to work with a fairly homogenous sample by selecting participants purposely in order to analyse psychological similarities and contrasts within the sample group. Comparing a series of cases or separate IPA studies within the same context may provide insights into universal patterns or mechanisms and contribute towards the development of what Bromley (1986) terms "case law". This comprehensive stepwise process allows for a theoretical structure of distinctions, principles and hypotheses to be formulated and progressively refined in explaining a broad range of phenomena observed across all cases (Miles & Huberman, 1994). This understanding of the epistemology of knowledge building is synonymous with Fishman's (1999) concept of "pragmatic psychology" or Strauss and Corbin's (1990) notion of "grounded theory".

For a patient undergoing psychotherapy, the IPA researcher would thus seek to understand the entire therapy experience from the patient's perspective and, through interpretative activity, make sense of the patient's entire experience. Their primary concern is to elicit rich, detailed and first-hand accounts of the subject's experiences and the phenomena under investigation. While IPA is typically associated with semi-structured interviews, it is equally suited to the session-by-session unfolding of the psychotherapy process. As such, the building of rapport and trust within the therapy and the research relationship is important to consider.

Pietkiewicz & Smith (2014) express how the analysis of data should be an "inspiring activity" (p.11) for the researcher; whether listening to audio-recordings, writing detailed summaries, making use of verbatim transcripts of individual therapy sessions or sifting through the data gathered from semi-structured interviews that evaluate the entire therapy process. Researchers should, to the best of their ability, immerse themselves in the data as though through the lens of the patient's experience of the unfolding therapy process. As such, the analytic process in IPA is often described in terms of a "double hermeneutic" process, firstly, because the subjects make sense of their experiences and, secondly, the therapist-researcher attempts to decode that meaning to make sense of the

patients' meaning-making (Smith & Osborne, 2008). Here, the therapist-researchers are required to be reflexive by carefully considering their personal lived experiences, biases, motives, assumptions and the manner in which their own perspectives relate to the material being investigated. In this way, IPA synthesizes ideas from phenomenology and hermeneutics. This results in a method which is descriptive due to it being concerned with how things appear and letting things speak for themselves, but also interpretative considering that there is essentially no such thing as a completely non-interpreted phenomenon.

IPA researchers should employ techniques that are flexible enough to allow unanticipated topics or themes to emerge during analysis. Repeated interrogation and condensation of the available data and the addition of the researcher's own notes help in the identification of significant themes. The researcher should then look for connections between the emerging themes to form an emerging structure, but never lose site of the participant's experience by referencing relevant short extracts from audio-recordings or transcripts. In a typical IPA project, the case narrative provides a strong reflection of the unfolding therapy process by highlighting pertinent aspects, while the final discussion relates the identified themes to the existing literature. Reflections on the research are usually included here, as are comments on the implications of the study, its limitations and suggestions for future development (Pietkiewicz & Smith, 2014).

5.4.7. Reliability and Rigour in Case Study Research

In the field of psychotherapy research, much scepticism has been directed at the authors of case studies for being biased towards demonstrating or supporting their pre-existing assumptions; what amounts to "smoothing" the narrative in order to shape the data towards their preferred conclusions (Spence, 1986). However, Edwards et al. (2004) argue that such criticism is only appropriate for some poorly argued case studies. More pertinent is that case-based research can be conducted rigorously by implementing strategies to safeguard accuracy, checking replicability and ensuring the validity of arguments (Barker et al., 2016; Edwards et al., 2004; Petermann & Müller, 2001; Safran, Crocker, McMain, & Murray, 1990). As such, a growing number of well-known case study researchers have developed criteria and associated methods of a rigorous standard to ensure that a sound body of trustworthy clinical knowledge occupies the published literature (Dattilio, 2006; Edwards et al., 2004; Fishman, 2005; Iwakabe & Gazzola, 2009; Lincoln & Guba, 1985; Simons, 2009; Stake, 1978, 1995; Stiles, 2009; Yin, 2013). For instance, the aims of PCSP are "to generate a growing database of systematic, rigorous, and peer-reviewed therapy case studies across a variety of theoretical approaches" (Fishman, 2013). The specific measures required by all publications in this journal thus ensure that their case studies are robust and credible additions to the psychotherapy research literature.

Davies and Dodd (2002) explain rigour in quantitative research to be associated with "detachment, objectivity, replication, reliability, validity, exactitude, measurability, containment, standardisation and rule" (p.280). From Latin, the term "rigour" literally means "stiffness," and implies "strict precision, harshness, rigidity, inflexibility and

a strict enforcement of rules" (Sykes, 1985, p.898). As was outlined earlier, both nomothetic and idiographic methodologies are of value (see section 5.3.1.), but it is important to recognise that rigour is achieved in different ways within each framework. It is important to avoid imposing the definitions of rigour from quantitative research onto qualitative case study research. For instance, Davies and Dodd (2002) and Shenton (2004) challenge the notion of these supposedly "universally standard" criteria for rigour being applied to qualitative research because they obscure the importance of qualitative research methodology, already mentioned earlier, requiring flexibility. Haraway (2003) urges that we reconceptualise what has often been understood as weaknesses within qualitative research and begin to recognise the strength and rigour of qualitative research. Where Thomas and Magilvy (2011) regard qualitative rigour as the means by which trust or confidence is established in the findings of such research studies, Davies and Dodd (2002) remind us that qualitative rigour still describes a strict enforcement of rules. This is in keeping with the Oxford College Dictionary (2007) defining of "rigour" as something having the quality of being exhaustively thorough and accurate. There is, thus, consensus that there needs to be a systematised, ordered and visible approach to research methods that is consistent in the methods employed, insulated from unexamined bias, and reliable in analysis and conclusions to ensure an accurate representation of the participant population being studied (Elliott et al., 2009; Elliott et al., 1999; Fishman, 2013; Stiles, 2009).

In their classic work on naturalistic inquiry, Lincoln and Guba (1985) explained the basic question of qualitative research rigour by asking: "How can an inquirer persuade their audience (and themselves) that the findings of an inquiry are worth paying attention to and worth taking account of?" (p.290). Of course, we essentially know that a single, generalizable, external "truth" held and perceived universally is not possible, as each individual holds their own personal perspective; seen through the lens of culture, experiential, environmental and other contextual influences (Thomas & Magilvy, 2011). However, researchers and their audiences need to be confident and trusting of the research findings presented. As such, what follows is a discussion of the important elements that safeguard the rigour and reliability of qualitative research, and more specifically, case study research.

(a) Subjectivity

As is the case with all research methods, it is important to maintain a balanced stance when thinking about the alleged subjectivity and bias of research in this domain. McLeod (2010) identifies strategies for limiting subjectivity and bias in order to ensure the neutrality of evidence. The first of these is through researcher reflexivity which requires the researcher to maintain a self-critical attitude and note how their own preconceptions, personal feelings, biases and insights impact on the research. For qualitative research, this is grounded in the epistemological assumption that it is not possible for the researcher to remain completely "outside" or "apart" from that which is being researched (Angen, 2000). As such, researchers not only describe the research process, but also carefully assess the impact of their role and presence. Further to the researcher outlining their professional background, allegiances, pre-existing assumptions and experience in the field being studied, they

should declare the values and theoretical orientation that have guided their research, and how this influences, acts upon and informs the study (Nightingale & Cromby, 1999). Such transparency about potential sources of bias might be further enhanced by the disclosure of unexpected findings that emerge, for instance, where pre-existing assumptions were not supported (Etherington, 2004; Finlay & Gough, 2008). While my research benefitted from close research supervision, I also attended regular individual and weekly group supervision meetings which ensured that my research cases were being monitored for issues pertaining to subjectivity and bias.

Secondly, the researcher should make use of independent and objective evidence in order to limit subjective bias. A case study that draws on sources of evidence that can be replicated by the reader is less prone to being biased compared to, for instance, the researcher's notes. Having the participant in this study complete questionnaires and inventories like the Young Schema Questionnaire (YSQ-S3; Young, 2005) or Eating Disorder Examination–Questionnaire (EDE-Q; Fairburn & Beglin, 1994), for example, provided verifiable evidence that alludes to prominent EMSs or an ED diagnosis respectively, rather than relying solely on my role as therapist or the perception of the patients. While such inventories are not necessarily conclusive (or even more reliable than the therapist's view), they do provide a clear evidence-trail to something tangible that the patients did at a particular time. The availability of verbatim transcription and the detailed summaries of audio-recordings of each session provided a good source of objective evidence in this study.

Thirdly, the use of multiple researchers is another strategy to transcend the personal or biased agenda of a single researcher. The involvement of third parties in the collection, analysis and interpretation of gathered data helps to prevent the wholly subjective construct that would be made by a single researcher working in isolation. While financial constraints limited the employment of additional researchers/research assistants in this study, an independent clinical psychologist[6] was used to conduct a post-treatment evaluation interview with each research participant. These were then transcribed and only made available to me for analysis once the therapy research cut-off date was reached. Even the invitation for participants to, themselves, confirm the accuracy of the researcher's interpretations of their therapy experiences is a recognised avenue to enhancing the credibility of the research. As such, I requested that Alison as a "co-researcher" evaluate how accurate and comprehensive the next chapter (Chapter 6) was. This chapter includes a summary biographical, her mode map and the full therapy narrative that also includes brief discussions following the outline of each session covered. The completed evaluation form appears as Form 1 in Appendix 12 and responses appear in Section 7.7 of the Results Chapter. Member checking describes the process whereby peers or consultants who are experienced in the qualitative research process are asked to review and provide feedback on the coding process (Holloway, 1997). This is where

[6] So inspired was the psychologist by the material that emerged from the post-treatment evaluation interviews that she decided to commence ST training herself and now predominately conducts therapy within this model.

my supervisor, Professor David Edwards[7], fulfilled an important role throughout all forms of supervision in scrutinising and evaluating both the research material and the clinical methodologies employed.

(b) Generalisation

Traditionally, generalisability denotes the ability to apply the results of research conducted on a population sample to a broader population (Babbie, 2000). This familiar notion of generalisability is what Yin (2003) has termed "statistical generalisation". Of course, one cannot make broad generalisations from one single case study that exists in a vacuum. Such a case in isolation that demonstrates the effectiveness of a specific model of psychotherapy for a particular condition cannot be generalised to say that all patients with that condition will be effectively treated with that specific therapy model. Developed by Stake and Trumbull (1982), naturalistic generalisation is a process whereby readers develop insight by reflecting on the details and natural, in-depth description presented in case study material. It is what Yin (2010) calls analytic generalisation and is, essentially, another way of describing case law or grounded theory. As clinicians identify similarities in the case study details that they read and also recognise descriptions that resonate with their own personal context, they are called to consider whether their situations are similar enough to warrant generalisation. Unlike objective scientific generalisations, naturalistic generalisation generates the potential for transferring knowledge more privately from the richly subjective accounts expressed through case study material (Melrose, 2009). Stake and Trumbull (1982) suggest that individuals can learn from the generalisations they make from their everyday experiences in addition to published works and teachers in their lives. Such naturalistic generalisation emphasizes the practical, functional application of research findings that "intuitive fall naturally in line with the readers' ordinary experiences" (Melrose, 2009, p.2). Lincoln and Guba (1985) noted that this form of generalisation builds on the readers' implicit knowledge – permitting detailed probing of an instance in question, rather than mere surface descriptions.

Extending on this, Lincoln and Guba (1985) established two particularly interpretive concepts of generalisation that rely on researchers providing their readers with the thick description and vicarious experiential accounts required to determine if and how they will use the information responsibly in their own lives. The first of these is transferability, whereby a hypothesis developed in one particular context can be transferred to another context, while the other, the concept of fittingness, describes how a hypothesis from one context is adequately congruent or "fits" in another. Where naturalistic generalisation is embedded in the reader's own unique experiences, small sample sizes and even a single case can inform and enlighten (Melrose, 2009). This is why Stake (1995) emphasises that case study researchers need to provide opportunity for vicarious experience through rich narratives – their accounts of the therapy being deeply personal, describing phenomena at a sensory level, and being curious. While

[7] Professor David Edwards served two terms as chairperson of the ISST between 2016 and 2020 and has advanced certification as a schema therapist and ST trainer. He is also an experienced case study researcher, has numerous published case studies and academic publications on case study methodology, and is on the editorial board of the PCSP e-journal.

Stake (1995) emphasises that the case study researcher is not personally responsible for directing the readers' naturalistic generalisation, it is a responsibility that researchers must not ignore.

A pivotal motive behind Fishman's PCSP e-journal is the manner in which a growing number of case studies are assembled and organised into large, accessible databases. As cases in the databases grow, this widens the variety of contextually different patient populations, conditions and situations. As such, the probability increases that specific cases in the database that closely resemble a new target case will exist. One of the important considerations that Fishman (2005) identifies in the design of a case study database is to provide methods to "match" a new, ongoing target case with completed cases in the database that will be directly relevant and helpful to the target case – synonymous with Lincoln and Guba's (1985) concept of fittingness. A collection of pragmatic case studies has the empirical potential of inductively generalising to the treatment of certain conditions or a particular patient profile. The extent of the generalisation to a new situation is determined by how much the context and the focus of the collection of completed cases correspond with the context and focus of the new, ongoing case. As Fishman (2005, p.10) says: "we learn from experience."

McLeod (2010) identifies strategies that case study researchers can employ to establish what he refers to as a "matrix of generalisability" (p.37). From a larger series of cases, one can identify a "typical" case that inevitably reflects the majority of cases within a larger sample (Parry, Shapiro, & Firth, 1986), or one that is "exceptional" in some way that demonstrated unusual, but valuable elements. Another approach would be for the researcher to choose cases that are either "good" or "poor" in their outcome (Watson, Goldman, & Greenberg, 2007). Respectively, this strategy would provide the opportunity to highlight aspects of the case that contribute to the favourable outcome, or aspects to identify that are conducive to a lack of progress in treatment. Seawright and Gerring (2008) have identified seven distinct methods or strategies for case selection, namely: "typical", "diverse", "extreme", deviant", "influential" (typically not representative), "most similar" and "most different"; each one emphasises the importance of carefully considered sampling choices and the caution to merely use random sampling for cases. Another strategy is to conduct a case series. The cases need a variable that allows for comparison, for instance, the specifics of the participant profile or a shared condition/pathology. In this respect, my study chose participants who were all suffering with an ED, and all received a consistent treatment approach. The number of cases in the series needs to be relatively small, given that all the cases may be utilised for comparison and analysed in depth. Here, tentative generalisations can be based on the consistency of conclusions or trends drawn across the series as a whole, or what is referred to as a cross-case comparison. The third strategy involves the inclusion of standardised and norm-based process and outcome measures to collect data on the case. Measures such as the YSQ-S3 (Young, 2005) or Clinical Outcomes in Routine Evaluation (CORE-OM; Evans et al., 2009) can be used to compare pre- and post-therapy severity levels, or the magnitude of change. Similarly, if

inventories like the Working Alliance Inventory (WAI; Horvath & Greenberg, 1989) are used between studies to assess the quality of the therapy relationship, then cross-study comparisons can be made.

The strategies outlined above provide significant evidence for the manner in which a small sample of cases and even a rich and thickly detailed single case study can contribute to generalisability, thus ensuring that each completed case study added to a growing database of cases helps towards theory building, case law (grounded theory) and a wealth of accessible information for clinicians to apply towards enhancing the quality of their own work with patients.

(c) Causality

The issue of causality is another challenge facing case study researchers – the notion of "what causes what". Many critics claim that only an experimental study of psychotherapy, such as an RCT, can draw well-founded conclusions around causality (or internal validity), given the manner in which a number of factors are controlled. Despite the relative confidence with which causal statements can be made in such RCT studies, they are, nevertheless, unable to provide a comprehensive causal account of how and why a particular psychotherapy is effective (or ineffective) for a particular sample. In an RCT study, there will typically be some subjects in the control condition that do as well as, if not better than, some subjects receiving therapy in the experimental group, or some in this latter group that do not appear to respond to the therapy. This suggests that there are always some causal factors other than the therapy intervention at play. A further problem with RCTs of psychotherapy is that they only allow causal mechanisms to be specified at a global level (McLeod, 2010), this being the reason why Elliott (2002) regards such studies as "causally empty" (p.2) – failing to provide insight to the fine-grained causal processes taking place within the therapy.

While some case study evaluations may be limited to descriptive or exploratory objectives, it is those that fill an explanatory role that provide the greatest challenges. The documenting and interpreting of a set of outcomes and the subsequent attempt to explain how those outcomes came about does, in effect, examine causal relationships. Edelson (1986) explains how a carefully designed case study can play a vital role in identifying and analysing causal factors in therapy. If conducted in a systematic fashion, such "intensive" case studies that collect a large amount of data around a relatively restricted set of events can make causal links more accessible. Conducting and documenting direct observations of the events and actions, as they actually occur in a local setting as a critical part of the case study's data collection, is an approach that is used by many researchers (Erickson, 2012; Maxwell, 2004, 2012; Miles & Huberman, 1994).

(d) Analysis of Data

Rigour and reliability are equally important considerations in the analysis of case study data. Detailed therapy notes are very valuable, but the availability of verbatim transcripts or detailed summary notes of the audio-

recording of individual sessions are invaluable in the analysing process. Transcripts of the audio-recordings of sessions are particularly helpful in capturing the complexity and richness of a session. There will always be segments of a transcript that are highly “quotable” for the purpose of illustrating key concepts and processes. Besides transcription, however, there are a number of well-established guidelines for the systematic analysis of transcripts; whether, for example, the assimilation of problematic experiences (Stiles, 2002), narrative processes (McLeod & Balamoutsou, 2001), or the depth of emotional experiencing (Klein, Mathieu-Coughlan, & Kiesler, 1986). For a case study that covers therapy over an extended time period, as was the case in this study, it is not feasible to analyse every session. As such, it is best to use therapy notes, session summaries, and/or measuring instruments to identify those sessions (or segments thereof) that are theoretically interesting or clinically significant. Whatever amount of detailed information is available to the researcher to utilise, the reader of a case study should be able to recognise exactly what treatment model was implemented. Saying that a therapist used CBT or psychodynamic therapy is not sufficient, given that each of these has a wide variety of schools of thought and that most therapists are responsive to their individual patients in tailoring the therapy to meet their specific needs (Stiles, Honos-Webb, & Surko, 1998). Knowing which model of treatment was implemented is less important than knowing how the particular model of therapy was delivered in that specific case (McLeod, 2010).

(e) Triangulation

Some of the abovementioned techniques that draw on multiple sources of information about the patient, the therapist, or the process, outcome and analysis of data demonstrate the value of triangulation; a technique of cross comparison that can significantly bolster the rigour and reliability of case study research. Of the different types of triangulation, Patton (1999) singles out the data source and method types of triangulation that particularly enhance the validation of a case study evaluation. A therapist-researcher’s own perception of the outcome and analysis of a case is not sufficiently convincing or reliable, whether it is subject to bias or lacking objectivity. However, a post-intervention interview with the patient-participant that is preferably conducted by an objective and neutral third party provides valuable adjunct information, whether to find out more about their experience of the therapy, how and why they did or did not benefit from it, or to voice their opinion on the specifics of the model of treatment they received. This additional source of information provides a good example of data source triangulation, adding credibility to the therapist’s stance and the overall case study evaluation. Further data sources have the potential to open up additional perspectives on the case, which can also result in a more differentiated and detailed analysis of the case (McLeod, 2010, Noor, 2008; Yin, 2011, 2013). Increasing interest in the mixed methods research (see section 5.3.1.) that combines quantitative and qualitative data has highlighted the way in which triangulation can increase confidence in the findings of a case study (Creswell & Plano Clark, 2007; Teddlie & Tashakkori, 2009). A good example here would be to compare the information gleaned from a post-treatment interview and the post-treatment results of questionnaires and inventories submitted to the patient.

While the broad range of accessible information for the researcher to draw on also includes, amongst other things, referral letters and professional collateral, patients' weekly diary entries, as well as other artefacts like drawings, sculptures, poems and photographs, the researcher should be cautious to not over-burden the patient-participant or swamp themselves with excessive information gathering instruments. Yin (2013) acknowledges the role triangulation holds in enhancing the validity of a case study evaluation, but he also cautions that the operational procedures for this technique remain underdeveloped and, hence, require ongoing investigation to enhance its potential.

(f) Concluding Comments on Reliability and Rigour in Case Study Research

In response to the many objections that have been levelled at case study research methods for psychotherapy over the years, case study researchers have given considerable attention to finding effective solutions and answers to these methodological concerns. It is quite clear that much of the opposition that has been aimed at case study methods is grounded in an outdated view of case study methodology and a biased stance in comparing and applying the guidelines for quantitative research rigour to qualitative research. Yin (2013) is optimistic that the momentum gathering amongst case study researchers to develop more specific and relevant tools and techniques for rigour will cement the credibility of this worthy and invaluable method of research.

5.4.8. Ethical and Moral Considerations in Case Study Research Design

An essential and much written about component of rigorous research is ethics (Miller, 2012; Yin, 2013), which is more than just a set of principles or abstract rules that sit as a principal entity guiding a research project. They are about the issues or potential problems that each research situation presents (Charlesworth, 1996), are always in progress and exist in all actions, and the ways of doing and practicing research. Not to be treated as a separate part of the research, Davies and Dodd (2002) understand ethics to involve trustfulness, openness, transparency, honesty, respectfulness, carefulness, and consistent attentiveness. In psychotherapy research these are therapist qualities that should govern all interactions with patients during sessions. It is important that they are not, under any circumstances, compromised and are maintained in the way that we reflect on the material following the intervention.

The consideration of ethical challenges in case study research is an arena that faces a higher degree of moral risk compared with other research methodologies. Unlike in RCTs where the individual identity is hidden amidst large sample numbers and statistical data, case studies involve a deep examination of one individual's life that is presented in the form of a rich and thickly detailed write-up. Furthermore, it is likely the individual's troubling or shameful aspects are being scrutinised under the lens of the researcher. In reading the case study, the participant may be confronted by personal truths and experiences they would have preferred to set aside, possible distortions of their personal truth, and come to realise what their therapist really thinks about them that touches an inner

wound. Furthermore, all of this is embodied in a document that is fully available in the public domain, which by some readers may be misinterpreted. While the therapist is, to some extent, also exposed in a therapy case study, it is the patient-participant's life that is most exposed. According to McLeod (2010), these and other ethical considerations are an important aspect of therapy case study research in creating a safe and moral space within which to make effective enquiry to expand knowledge and understanding.

Guillemin and Gillam (2004) make the distinction between procedural ethics and micro-ethics, the former pertaining to the procedures in the research design and protocol that are required by an institutional ethics committee or board in order to minimise harm (non-maleficence) and optimise the benefits and well-being (beneficence) of the participant. The concept of micro-ethics, on the other hand, pertains to the moment-to-moment ethical considerations in the interaction between the therapist-researcher and the patient-participant. These sometimes difficult, subtle, and unpredictable issues that arise in the research process will be elaborated on within the clinical methodology section later in the chapter.

While there is no means by which procedural ethics can fully secure every aspect of ethics pertaining to case study research, it is essential that every step taken in such research is conducted within a structure that ensures that the potentially vulnerable participant is safeguarded by an externally verifiable set of guidelines (McLeod, 2010). In this respect, the ethics committee in the Department of Psychology at Rhodes University approved this study and were satisfied that all the ethical elements of a research study were adhered to, whether they pertained to participant autonomy, confidentiality or non-maleficence. The specifics pertaining to these ethical issues are addressed within the relevant sections later in the chapter.

5.5. Research Sample Selection

Details of the criteria used in participant selection, the recruitment method, the process involved in the selection of patients and the characteristics of the participant sample are outlined below.

5.5.1. Inclusion Criteria

The inclusion criteria for this research study required prospective participants to be above the age of 16 years; meet the full criteria for an ED; be psychologically and medically suitable to commence or continue treatment on an outpatient basis; have no prior exposure to ST or the ST mode model of treatment; be fluent in English. Patients with an ED in my existing practice who were responding well to traditional CBT treatment for EDs were not considered for the study as there was no reason to change the treatment approach due to their good response to treatment. The only other exclusion criterion for participants in the research study would have been patients with a diagnosis of a psychosis or mental retardation, or any other condition or circumstance that made them a poor candidate to receive ST.

5.5.2. Recruitment Method

Participants for the study were recruited from within my private practice - a practice that comprises approximately 50 individual patients, of which approximately 80 percent have an ED diagnosis. Those that I considered for the study were either existing patients with an ED diagnosis who had not responded adequately to therapy mostly grounded in the CBT-E model of treatment of EDs (Fairburn, 2008), or new patients with an ED diagnosis that I considered good candidates to receive ST. Two of the ten participants that I identified for the study were referrals from within the bariatric surgery clinic, for which I am the consultant psychologist. While most candidates for surgery only require a once-off psychological assessment as part of a comprehensive multidisciplinary team assessment for surgery, there are some candidates that request or are recommended to receive regular psychotherapy in preparation for and qualification for surgery. It is from this group of bariatric surgery patients that individuals were considered for the study. All ten individuals who I invited to participate in the study expressed a willingness to be considered, at which time I provided them with the participant information package in a lever-arch file, the contents of which are outlined in the next section.

5.5.3. Screening Interview

I personally met with each prospective participant that I identified for the study and explained to them the nature of the research process and the purpose of the research project. All invitees agreed to consider participation, at which point an individual 1-hour screening interview was arranged for the purpose of discussing the details and purpose of the study.

Together, we went through the participant information package which included, amongst other documents, three consent forms. The first of these was a contractual agreement between researcher and the research participant (See Form 2 in Appendix 13). This contract briefly outlined the purpose and motivation for the research study, and also provided a brief description of the treatment. The form also outlined features pertaining to the research, including: the electronic recording of all sessions; disclosure of information to supervisor; participant responsibilities in completing questionnaires/inventories and attending interviews; information pertaining to reduced or waivered fees; the preparation of a publicly accessible or subsequent published material; issues of anonymity, confidentiality and the security of information/data; the reassurance of the maintenance of professional parameters for clinical psychologists laid out by the Health Professions Council of South Africa (HPCSA); and the participant's right to terminate participation upon request. Of course, many of these aspects pertained to sound ethical considerations of the research, especially surrounding patient autonomy.

In order to ensure participant anonymity for this study, names were changed, while details pertaining to biographical information were marginally disguised in order to ensure that third parties reading a case report do not identify the patient-participant and, hence, learn information about them that could prejudice them in any

number of social or work contexts (Algozzine & Hancock, Darke, Shanks & Broadbent, 1998; 2016; Stake, 1995). The second contract was a release form to authorise the electronic recording of all sessions (see Form 3 in Appendix 13), while the third one pertained to the use of research assistants (see Form 4 in Appendix 13). These contracts served to secure the confidentiality of sensitive material and the access to information and participant identity to specified individuals. After all, confidentiality is a particularly important consideration in therapy case study research, given the depth of information that is revealed in the case report of this research format (Lewis, 2013; Stake, 1995).

All of the prospective participants agreed to participate in the study following the 1-hour screening interview and duly signed the relevant contracts. Due to all the participants being above the age of 18 years, no co-signatories were required. Informed consent ensured that each patient's choice to participate in the study was autonomous, as it was important that no participant felt coerced or obligated to participate in a study. After all, it has been demonstrated in various studies (Gavey & Braun, 1977; Kantrowitz, 2006) that a significant proportion of participants feel uncomfortable to decline. While there was minimal risk of this for new patients participating in the study, I had to be particularly alert to the risk that my existing patients would feel obligated (in CoSu coping behaviour) to join the study. This issue was explored in detail with each of them. This is where Winship (2007) makes the distinction between prospective and reflective case studies, the former being where the research study is planned before the therapy commences and the latter being where the idea of the case study arises either during therapy or following the termination of therapy. New patients in the study, thus, fell into the prospective category, while all existing patients fell into the reflective category due to having already started therapy with me before it was conceived. McLeod (2010) highlights the importance of researchers needing to be particularly careful in the latter to not unduly influence an existing therapy relationship, but he also mentions that even for prospective case studies there should be no inducement or pressure involved in the consent (McLeod, 2010).

All prospective participants were informed of the right to voice any queries or concerns with either me or my supervisor at any time during the study. Also included in the package were two introductory guides to ST, "A Client's Guide to Schema Therapy" (Bricker & Young, 2012) (see Form 5 in Appendix 14), and "Using schemas and schema modes as a basis for formulating and treatment planning in schema therapy" (Edwards, 2013) (see Form 6 in Appendix 14). Each participant was also provided with a complimentary copy of the self-help book, "Reinventing Your Life" (Young & Klosko, 1993). The details of the surveys, questionnaires, and scales included in the participant information package for baseline measures are outlined later in the chapter.

One of the benefits for participants was a reduction in fees. Participants received a minimum 25% reduction in fees from either the medical aid tariff rate or the reduced rate already agreed upon with existing patients. Further reductions were negotiated and even a waiving of fees was granted for those individuals who struggled to afford the fees notwithstanding the default 25% fee reduction. There were two reasons for including a fee in the study.

Not only did the participants form a significant portion of my existing income, but they were also charged a fee in order to maintain the naturalistic nature of the therapy environment.

5.5.4. Sample of Participants

A total of ten participants were recruited for the study. One participant terminated participation in the study during the assessment phase due to her decision to return to live with her parents in a city 2000km away from Cape Town. Another participant was unable to continue attending sessions into the second year due to the long travel distance to sessions and the associated high cost of transportation. The remaining 8 participants remained in the study for the minimum duration of 18 months and/or 100 sessions. Many of the participants continued in individual therapy with me beyond the study period, but data was no longer collected for the purpose of the study at 18 months.

According to DSM-IV-TR (APA, 2000) criteria, five participants, including Alison, met the criteria for AN (4 = AN-r; 1 = AN-b/p), one for BN, three met the criteria for BED, albeit not a stand-alone diagnostic entity until the release of the DSM-5 (APA, 2013), while one participant met the criteria for EDNOS. A summary of the details of the participants' demographics appears in Table 13 of Appendix 15.

5.5.5 The Selection of the Case of Alison[8]

Due to the significant volume of material that was collected from all participants over the approximately two-year period, at approximately the one-year mark of providing treatment I identified three cases that would most likely illustrate the application of the ST across three distinct diagnostic profiles. When the study began, the diagnoses for EDs were based on the criteria outlines in the DSM-IV-TR (APA, 2000). However, during the study, the DSM-5 (APA, 2013) was published, for which the new criteria were adopted for the remainder of the study. This did not affect Alison's diagnosis.

At the two-year mark when all analysis of the cases was completed, however, it became further evident that even these three cases would still provide an immense volume of material that would be difficult to document within the confines of the limits of the thesis. I, thus, decided to focus exclusively on a single case study for the thesis. Both my supervisor and I agreed that Alison, a woman in her 60s with an extensive history of AN-r, would comprehensively highlight key concepts and processes in ST. As was the case with the majority of the participants, Alison's response to the treatment was very positive. Despite it elegantly reflecting the effectiveness of ST, the therapy with Alison also possessed numerous difficulties that well-illustrated the typical challenges in ST. The decision to limit the thesis to one single case study not only afforded me space to provide a richly detailed therapy narrative (Chapter 6), but it afforded me the opportunity to comprehensively address three key reading questions

[8] Pseudonym in order to assure anonymity

in Chapters 8, 9, and 10 that cover a broad spectrum of the elements of ST. All data for the other seven participants that completed the ST will be stored for the possibility of further research or publishing.

5.6. Clinical Methodology

The application of the schema mode model for the individual treatment of the broad spectrum of patients with EDs was the basis of the initial clinical methodology for this research study. This has already been detailed earlier. The literature and clinical approach of ST for EDs has grown considerably during the course of the treatment, which was initiated in 2012, but the central features were already well established.

5.6.1. Assessment and Education Phase

The assessment and education phase for Alison was completed in six 1-hour consultations that were structured, without being formulaic. Although she had received CBT-E therapy with me before the study began, I still followed the standard form of this phase with a re-evaluation to assess her presenting problems and goals for therapy, as well as her suitability for ST. The completion of a battery of surveys, questionnaires and inventories all contributed towards making a provisional diagnosis and the compiling of an evolving and individualised case conceptualisation which determined the direction of treatment. Select questionnaires and inventories (outlined in 5.7.6.) were also used for the purpose of obtaining baseline measurements. The provision of select written material specifically developed to familiarise Alison with the treatment model (see Appendix 14) was also discussed and clarified during this phase of the treatment. Other details of the standardised assessment and education phase that were carried out with Alison have already been outlined in Chapter 1 (see section 1.7.1.).

5.6.2. Case Conceptualisation

Information obtained from the assessment was used to build Alison's case conceptualisation. A hypothesis of the aetiology of her illness and presenting problems was used as a basis for the ongoing treatment (Kuyken, Padesky, & Dudley, 2009). It is essential for schema therapists to thoroughly map out the presenting problems and integrate these with the existing theory and research before designing and commencing with the treatment plan (Arntz & van Genderen, 2012; van Genderen, 2012; Young et al., 2003). In keeping with the collaborative nature of ST, Alison and I jointly formulated an understanding of the problems by identifying the prominent schemas and modes at play. This normalised and validated the presenting problems. The goal was to generate curiosity, interest and a sense of mastery. Through a collaborative effort, case conceptualisation also helped to make the complexity of problems seem more manageable and it helped guide the selection, focus, and sequence of interventions. It was also very useful in identifying Alison's strengths and the means by which to build resilience. Furthermore, the case conceptualisation helped towards anticipating and addressing problems that emerged in therapy and assisted in forging alternative pathways for therapy when she was either being unresponsive or resistant to change. From a

more practical perspective, case conceptualisation often suggests the most cost-effective interventions to use and, for me, enabled high-quality supervision in which I could address treatment plans, progress, response to particular interventions, therapeutic impasses or ruptures, as well as the patient's own thoughts, feelings and responses during therapy (Kuyken et al., 2009).

It is usual practice for a schema therapist to use all information gathered from the assessment to compile a standardised case conceptualisation, using the form outlined by the ISST or the one modified by Edwards (2016). Due to space constraints, I compiled an abridged case conceptualisation, but the full one, which was submitted for independent evaluation as part of the process of my applying for and obtaining my standard ISST certification can be viewed as Form 7 in Appendix 16. Rather than presenting Alison with an abridged or even fully completed case conceptualisation, she received an individualised mode map which we jointly constructed on a whiteboard® using laminated and magnetised schema mode and EMSs labels. This was a collaborative effort, although I led the exercise. She did not disagree with any of the suggestions that I made, which meant that the version of the mode map on the whiteboard was then replicated in print form, laminated, and given to Alison to keep. In light of the flexibility of the ST model, as it is with the case conceptualisation, the mode map serves as a working model that is inevitably modified throughout the therapy process as new information and insights arise. This might include the addition of new EMSs and schema modes, including those that might have been initially refuted by the patient and subsequently accepted.

5.6.3. Treatment or Change Phase

Although elaborated on in Chapter 1, it is worth reiterating that the broad goals of the ST mode model of treatment, as defined by Young et al. (2003), involves the building of the HeAd, the healing of the VuCh and the giving of a voice to the AnCh, the ultimate banishment of the DPMs and the neutralizing or redundancy of the coping modes. Certainly not a brief therapy and often requiring a few years of regular weekly sessions, ST relies on a number of cognitive, emotion-focused, and behavioural techniques. The therapeutic relationship lies at the heart of ST, where the process of limited reparenting of the Child and the facilitation of change through empathic confrontation are the two cornerstones of this phase of the therapy process. These concepts and processes are comprehensively outlined in the therapy narrative (Chapter 6) and analysed in the reading questions of Chapters 8, 9, and 10.

5.6.4. Experience and Expertise of the Therapist

My interest in the treatment of EDs grew out of my clinical training and internship and was reinforced as a result of a 4-month placement in a state hospital psychiatric inpatient programme that predominantly treated patients with

EDs (predominantly AN-r). During my internship in 1994 my clinical mentor, Professor Daniel le Grange[9], (who also supervised my Masters' dissertation that explored the analogous nature of EDs and excessive exercise) invited me to participate in a multidisciplinary team to establish the first specialised ED unit (EDU) within the South African private psychiatric clinic sector. I joined the clinical staff in 1995, the year in which I qualified as a clinical psychologist from the University of Cape Town with the appropriate registration with the HPCSA. When Professor le Grange emigrated to the USA in 1996, I was made clinical director of the unit, a post I held until my resignation in 2015, primarily to allow me to concentrate on my research study. Throughout my years as clinical director, I was responsible for overseeing the development and management of the unit, which included a 6-bed inpatient facility staffed by a multidisciplinary team comprising approximately 12 psychiatric professionals. Adjunct to this, I have always maintained a private practice predominantly treating patients with EDs. Since its inception in 2005, I have also served as consultant clinical psychologist on a private hospital's multidisciplinary surgical team that provides morbidly obese patients with bariatric surgery. Here, my role has been to provide a comprehensive psychological assessment of candidates wishing to undergo weight loss surgery and also provide psychotherapy for such candidates, where indicated, whether prior to and/or post-surgically.

My interest in ST grew out of a wish to explore alternative and more effective treatment models for EDs besides the predominantly CBT-E model of treatment developed by Fairburn (2008) that I was primarily applying in my private practice. I was introduced to ST by Professor David Edwards and attended a number of his workshops. I also familiarised myself with the existing published work on ST, including a small number of articles and a book chapter on the application of ST in the treatment of EDs. To ensure the correct and appropriate application of the treatment model for this study, I was supervised by Professor David Edwards, who holds advanced certification by the International Society of Schema Therapy (ISST) as a schema therapist, is an ISST accredited trainer and held the position of chairperson for two consecutive terms of the ISST between 2016 and 2020. Besides attending the ISST conference in New York (USA) in 2012, I completed the required workshops facilitated by Professor Edwards to receive the South African Diploma in Schema Therapy. I also attended regular weekly (sometimes twice weekly) 90-minute ST group supervision sessions as well as individual supervision. This included the supervisor and peer supervisees listening to audio-recordings of various sessions held with research participants and having access to summary notes for the purpose of ensuring adequate application of the ST mode model of treatment. I also received regular weekly supervision from my supervisor to ensure that I was implementing the correct research methodology for the duration of the study. Where self-therapy is part of the ST supervision process, a number of sessions were provided by my supervisor in order to familiarise me with the ST mode model of treatment. During

[9] Professor Daniel le Grange holds a Ph.D. from the University of London, where he worked under Professor Gerald Russell at the Maudsley Institute of Psychiatry. Having always taken an interest in the treatment of EDs (specifically in family therapy for adolescent AN) he emigrated to the USA in 1996.He has since held academic posts at NYU, Stanford, and the University of Chicago, where he served as director of the EDs programme for many years until his recent relocation to UCSF to take up a full professorship position.

the completion of this dissertation, I received Standard Certification as a schema therapist through the ISST and was in the process of obtaining Advanced Certification (also with the ISST).

5.6.5. Ethical considerations in the Therapy Setting of Case Study Research

Guillemin and Gillam (2004) remind of the importance of researcher reflexivity; the researchers being vigilant in noting their own needs and motives during ethically important moments. This is where Ellis (2007) explains how the research should be governed by “relational ethics” that requires the researchers to be mindful of the responsibilities that arise from the relationship that develops between them and the patient-participants. One of the issues of non-maleficence pertaining to case study research is the consideration of how the research may impact on the therapy. Although Marshall et al. (2001) have evidence that a significant majority of participants feel that the research enhanced their experience of the therapy they received, a small minority might be particularly sensitive around any type of research. Another aspect that the therapist-researcher needs to consider is whether they are tempted to modify their behaviour and steer the therapy in a particular direction to prioritise the research goals rather than the patient’s needs. An example here might be the schema therapist’s excessive use of preferred techniques and tools, rather than following a therapy process and frequency of techniques that best suits the patient and optimises the therapy (Houghton, Casey, Shaw & Murphy, 2010; McLeod, 2010; Moll, 2012).

I was aware of my wish for the ST mode model to successfully demonstrate its positive impact in the treatment of EDs. However, neither my supervisor nor I detected any bias on my side to distort the therapy process or findings. On a few occasions during sessions, one of the other participants did express concern that she was compromising the research study by not making good progress in therapy. Therapy identified that this particular participant consciously avoided developing HeAd skills for fear that she would be abandoned if assumed by others to be capable of leading an independent and autonomous existence. There were a few occasions when various participants asked me how the research study was progressing. While I openly confirmed that it was going well, I did mention that the participants’ response to treatment was varied, and that this was expected and not jeopardising the study. While participants were occasionally conscious of the audio-recording of sessions and the completion of a weekly battery of questionnaires, I had no reason to suspect that their participation in the study impacted on the natural course of therapy. In fact, I routinely invite all my patients to the option of having their sessions audio-recorded, should they want to review the sessions afterwards in their home setting.

5.7. Data Collection

A substantial quantity of data was gathered for this study from a number of sources. This included audio-recordings of all sessions; session therapy notes; homework assignments and communication outside sessions; collateral from professional colleagues; transcriptions of select sessions; the completion of surveys, questionnaires, and inventories; as well as the audio-recording and transcription of interviews with all the research participants

that was conducted by an independent third-party clinical psychologist. The manner in which data was gathered for this study closely resembled the steps of the interview data management system[10] developed by Halcomb and Davidson (2005).

5.7.1. Audio-Recordings of Sessions

All audio-recording of all 106 sessions with Alison (6 assessment sessions and 100 therapy sessions) reflects the first step of data gathering outlined in Halcomb and Davidson's (2005) model. Being required to sign the relevant form, Alison consented to and understood the purpose for the recording of all therapy sessions (including assessment sessions) on a high-quality voice recorder. Sessions were transferred and securely stored onto a computer in my home office on a weekly basis, with an additional reserve copy of all sessions being safely stored on an external hard-drive in case my primary copy was damaged or destroyed.

Due to the substantial volume of sessions conducted across nine participants during the study, the resource intensive and financial costs of obtaining approximately ten weekly verbatim transcriptions had to be weighed up against the potential benefits of generating such transcriptions in the data management and analysis process of session data (Halcomb & Davidson, 2006). Not only has Britten (1995) determined that it requires 6-7 hours to generate a verbatim transcript of one hour of taped therapy, but others have voiced concern that verbatim transcribing is also a complex process (especially pertaining to interpretation of spoken word) and fraught with technical dilemmas (Fasick, 2001; MacLean, Meyer, & Estable, 2004; Wellard & McKenna, 2001). In fact, the use of written notes taken either during or immediately afterwards has been reported to be superior to the exclusive use of audio-recordings that are subsequently transcribed verbatim (Fasick, 2001; Wengraf, 2001). Furthermore, ardent qualitative researchers have emphasised the importance of taking memos and therapy notes (the equivalent of field notes) in order to capture the researcher-clinician's thoughts and interpretations during the process of listening to audio-recordings; something that is easily lost in the process of generating verbatim transcriptions (Wengraf, 2001). Despite the benefits of therapy notes, Fasick (2001) still reminds us of the important reasons for audio-recording sessions in both data management and analysis. For instance, audio-recordings allow for a review of material by the clinician-researchers and their supervisors. Listening to audio-recordings of sessions also benefits the clinician-researchers in filling the blank spaces left in their therapy notes. This potentially reduces bias by providing opportunity for the clinician-researcher to reflect on sessions to ensure that the true meaning conveyed by the participants is accurately represented. The presence of audio-recordings also permits supervisors or independent assessors to verify that sessions were conducted, and that the data recorded by the therapist-researcher is accurately reflected in the condensation of data. The audio-recordings also

[10] Although the model developed by Halcomb and Davidson (2005) relates to research interviews, it is equally applicable to the therapy setting.

provide the opportunity for clinician-researchers to recreate the sometimes-subtle nuances of the sessions, such as voice, tone and intonation, and the specific language of participants, which assists in more complex analysis.

5.7.2. Therapy Notes

While there is always the risk that note-taking can disrupt the flow of therapy sessions, such notetaking is something that I have been accustomed to doing throughout my years of practice. As such, I continued doing so during sessions throughout this study. As each audio-recording was listened to as part of the data condensation process, my notetaking focused less on content and more on documenting non-verbal elements and tracking the therapy process (e.g., noting sequences of schema modes). While therapy notes reflect the second step in the data gathering process outlined by Halcomb and Davidson (2006), they also suggest that, while fresh in their minds, the therapist-researchers should make reflective notes immediately following the session to elaborate on their in-session therapy notes. They maintain that this should be done to allow for more considered elements that stood out in the session. Although I was frequently able to do this, it was not routinely done due to there often being a mere 10-minute break between consultations. However, there was opportunity to make such elaborations in the early data condensation stage when I listened to each audio-recorded session for the purpose of making session summaries. This process will be elaborated on in the upcoming section on data condensation.

5.7.3. Homework Assignments and Communication outside Sessions

Assigning homework tasks is a common feature of ST, as it is in many other therapy models, especially CBT. All such completed tasks were reviewed in sessions and then stored. All e-mail correspondence and telephonic text communication was stored in Alison's file. All pertinent telephonic contact was documented in the same file.

5.7.4. Collateral from Professional Colleagues

Referral letters and all correspondence from colleagues that is a familiar part of everyday practice also formed part of the data collection process. This was especially the case in the close communication that was maintained with Alison's dietician, who played a pivotal role in Alison's weight restoration and meal planning.

5.7.5. Transcriptions of Select Sessions

I listened to the audio-recording of all sessions for the purpose of making session summaries, a step-in data condensation that will be detailed in a later section of the chapter. In listening to the audio-recordings, I noted specific standout sessions that were selected for verbatim transcription. These were examples of significant processes for analysis or the session having excerpts of dialogue that were worthy for inclusion in the therapy narrative or the interpretation thereof.

5.7.6. Self-Report Surveys and Questionnaires

The research participant package included a number of self-report surveys and questionnaires that needed to be completed and returned to me within a fortnight. These provided additional information that formed part of the assessment and information phase, but also served as a baseline with which to compare follow-up scores upon completion of the study. Those measures marked with a single asterisk formed part of a weekly package that Alison was required to complete between each session, while those marked with two asterisks were used exclusively in the weekly package in order to monitor progress and provide a more sensitive impression of change through the therapy process. These self-report documents are briefly outlined below in the order in which they were administered:

(a). Clinical Assessment Self-Report

The Clinical Assessment Self-Report (CASR) is my adaptation of a survey developed by Professor David Edwards in order for patients to be able to provide a significant quantity of information to assist the assessment and education phase of treatment. Amongst other items, it enquires on the current presenting problem; goals for treatment; history and details of family of origin; intimate relationships, marriage(s), and children; other relationships, including intimate ones; developmental history; schooling and tertiary education; substance use, abuse history, as well as personal and family psychiatric/medical history.

(b). Eating Disorders Assessment Survey

I have developed the Eating Disorders Assessment Survey (EDAS) over the past 15 years for the specialised EDU of which I was the clinical director. Initial versions were largely an adaptation of sections of the Eating Disorders Questionnaire (EDQ) developed by Mitchell and Peterson (2005). However, I have regularly modified it and it no longer closely resembles the Mitchell and Peterson (2005) document. This assessment tool is designed for completion by a patient prior to or during the assessment phase to record important information pertaining to their biopsychosocial status and includes sections on weight history; body image and attitude; dieting behaviour; ED compensatory behaviours; sport and physical exercise; hormonal and menstruation history; abuse history, substance abuse; as well as psychiatric and medical history.

(c). Eating Disorder Examination – Questionnaire

The Eating Disorder Examination – Questionnaire (EDE-Q; Fairburn & Beglin, 1994) was adapted from the interview version of the Eating Disorder Examination (EDE; Fairburn & Cooper, 1993), a widely respected measure of ED symptom that has considerable reliability and validity data to support its use (Fairburn & Cooper, 1993). While both formats contain identical items, the interview version is still regarded by some researchers as the most comprehensively robust tool, especially when the ED includes binge-eating (Carter, Aimé, & Mills, 2001). However,

a review of the literature that compares the two formats demonstrates reliability of scores on both and that such scores correlate with the scores on measures of similar constructs (Berg, Peterson, Frazier & Crow, 2012). The EDE-Q focusses on ED symptoms and attitudes over the past four weeks and contains four subscales: Restraint, Eating Concerns, Shape Concerns and Weight Concerns. It is a tool recommended for use in research and clinical settings.

(d). The Body Image Quality of Life Inventory

The Body Image Quality of Life Inventory (BIQLI; Cash & Fleming, 2002) is a self-report questionnaire that quantifies both the positive and negative effects of body image on an individual's psychosocial quality of life. While it has demonstrated sound psychometric properties (Cash, Jakatdar, Fleming-Williams, 2004), the 19 items reflect specific domains that have been empirically established as consequences or correlates of body image, including: self-esteem, sexuality, social interest/avoidance, interpersonal relations, eating and exercise, grooming habits and general day-to-day emotions and levels of life satisfaction. The BIQLI is not a measure of body image, but assesses the impact of personal body image experiences on various psychosocial domains of life.

(e). Clinical Impairment Assessment Questionnaire

The Clinical Impairment Assessment Questionnaire (CIA 3.0; Bohn, Doll, Cooper, O'Connor, Palmer, & Fairburn, 2008; Bohn & Fairburn, 2008) is a 16-item self-report measure of the severity of psychosocial impairment due to ED behaviour within the past four weeks. Studies conducted by Bohn et al. (2008) confirm its reliability, validity, sensitivity to change, and ability to detect case status. The CIA covers impairment in the domains of life that are typically affected by ED psychopathology, including: mood and self-perception, cognitive functioning, functioning within interpersonal relationships, and work performance. With no subscale, it provides a single global score of the severity of psychosocial impairment secondary to ED behaviour and circumstances. Although used in epidemiological studies, it is mostly utilized in comparing the impact of treatment on psychosocial impairment (Bohn & Fairburn, 2008).

(f). Eating Disorder Quality of Life

The Eating Disorders Quality of Life (EDQoL; Engel, Wittrock, Crosby, Wonderlich, Mitchell, Kolotkin, 2006) is a 25-item self-report health related quality of life instrument designed specifically for the ED population. While this instrument reflects sound validity and reliability, it has also been demonstrated to be more sensitive than general health-related quality of life measures for this specific patient population. Questions are divided into four domains, namely: Psychological (thoughts and feelings about self and others), Physical/Cognitive (physical sensation or altered cognitions), Financial (financial status such as debt), and Work/School (work or studies performance). On a 5-point response ranging from "never" to "always", the patient is asked to assess the extent to which they view their ED affecting each of the four domains.

(g). The Eating Disorder Belief Questionnaire

The Eating Disorder Belief Questionnaire (EDBQ; Cooper, Cohen-Tovée, Todd, Wells, & Tovée, 1997) is a self-administered instrument designed to assess assumptions and beliefs associated with EDs. The four subscales pertain to negative self-beliefs, weight, and shape as a means to the acceptance by others, and weight and shape as a means to self-acceptance and control overeating. The subscales demonstrate good psychometric properties with significant correlations being found between the subscales and other measures of the specific and general psychopathology of EDs (Cooper et al., 1997; Rose, Cooper, & Turner, 2006).

(h). Mood Disorder Questionnaire*

The Mood Disorder Questionnaire (MDO; Hirschfeld et al., 2000) is a brief self-report screening instrument for identifying patients with bipolar disorder. With good sensitivity and excellent specificity, the instrument comprises 13 questions that assess clustering of symptoms and functional impairment (Hirschfeld et al., 2000).

(i). Depression Anxiety Stress Scale*

The Depression Anxiety Stress Scale (DASS; Lovibond, 1983; Lovibond & Lovibond, 1995) is a 42-item self-administered questionnaire designed to measure the magnitude of the three major negative emotional states of depression, anxiety and stress over the preceding week. Each of the three scales consists of 14 items which are responded to using a 4-point scale. DASS-depression detects low mood, motivation, and self-esteem; while DASS-anxiety measures for physiological arousal, perceived panic and fear, while DASS-stress focuses on reports of tension and irritability. Numerous evaluations of both general and clinical populations have consistently demonstrated its psychometric stability (Lovibond & Lovibond, 1995; Ng, Trauer, Dodd, Callaly, Campbell, & Berk, 2007; Taylor, Lovibond, Nicholas, Cayley, & Wilson, 2005).

(j). Experience of Shame Scale

Based on the interview measure (Andrews & Hunter, 1997), the Experience of Shame Scale (ESS; Andrews, Qian, & Valentine, 2002) assesses four areas of characterological shame (shame of personal habits, manner with others, sort of person you are, and personal ability); three areas of behavioural shame (shame about doing something wrong, saying something stupid, and failure in competitive situations) and bodily shame. For each of the eight shame areas covered, there are three related items that address the experiential, cognitive, and behavioural components. Participants respond according to how they have felt in the past year and each item is rated on a 4-point scale. Rigorous testing of both the scale and its subscales reveals it to be psychometrically sound (Andrews, Qian, & Valentine, 2002).

(k). Clinical Outcomes in Routine Evaluation*

The Clinical Outcomes in Routine Evaluation (CORE-OM; Evans et al., 2009) is a brief, user-friendly 34-item questionnaire that should be administered at the commencement of therapy and repeated at regular intervals through treatment in order to measure shifts in the severity of problems being experienced by patients. Due to a number of inadequately tested and developed measures, the developers of the CORE-OM were determined to challenge the damaging myth that the efficacy of psychotherapy was not measurable. The four domains covered by the measure include: well-being, social functioning, problems/symptoms, and risk to self and others. Since its development almost two decades ago, this measure has survived extensive clinical and non-clinical testing and is routinely used by a wide spectrum of researchers and therapists (Barkham, Mellor-Clark, Connell, Evans, Evans, & Margison, 2010).

(l). Personality Belief Questionnaire

Drawing from the beliefs identified by Beck & Freeman (1990), the Personality Belief Questionnaire (PBQ; Beck & Beck, 1991) was developed to assess the dysfunctional beliefs hypothesized to underlie the PDs as they were categorised in the existing diagnostic manuals (Beck & Beck, 1991). The instrument is a 126-item, self-administered measure that has demonstrated itself to be psychometrically robust in a clinical sample, where many of the subscales have differentiated patients diagnosed with different PDs (Beck, Butler, Brown, Dahlsgaard, Newman, & Beck, 2001). Such findings have reiterated the argument held by many that a systematic description of the dysfunctional beliefs endorsed by individuals with personality pathology will add credibility to any future psychiatric diagnostic systems (Fournier, DeRubeis, & Beck, 2012).

(m). Young Schema Questionnaire

This study utilised the Young Schema Questionnaire - short version 3 (YSQ-S3; Young, 2005), an 85-item scale, which is a subset of the original 205 items from the Young Schema Questionnaire; Long Form (YSQ-LF; Young 1994). Both have demonstrated psychometric robustness across a number of studies (Stopa, Thorne, Waters, & Preston, 2001; Waller, Meyer, & Ohanian, 2001; Welburn, Coristine, Dagg, Pontefract, & Jordan, 2002; Hoffart, et al., 2005; Baranoff, Oei, Cho, & Kwon, 2006). The items assess the presence of the 18 EMSs outlined by Young et al. (2003) outlined in Chapter 2; a useful measure of core beliefs (Sheffield & Waller, 2012). Each of the items requires a rating on a six-point Likert scale ranging from “completely untrue of me” to “describes me perfectly”. A higher score on a given subscale is indicative of the greater possibility of the presence of a particular EMS.

(n). Schema Mode Inventory (Version 1.1)

The presence of schema modes was measured using a shortened version of the Schema Mode Inventory (SMI V1.1; Young, et al., 2007) that comprises 124 items. Although no version of the SMI covers the full existing list of modes

recognised in the literature, this version still measures 14 modes, including: five dysfunctional Child modes (VuCh, AnCh, EnCh, ImCh, and UnCh); the two recognised dysfunctional parent modes (PuPa and DePa); five coping modes with at least one from each of the three coping processes of surrender, avoidance, and overcompensation (CoSu, DePr, DeSS, SeAn, BuAt); as well as the two adaptive modes (HeAd and HaCh). Each of the items requires a rating on a six-point Likert scale ranging from "never or almost never" to "all of the time". An overall score is calculated from the scale sum score divided by the number of items in that particular scale. A higher score reflects a more maladaptive schema mode. The study conducted by Lobbestael, van Vreeswijk, and Arntz (2008) confirmed its sound psychometric properties, confirming the tool as a valuable assessment of modes in ST. Unfortunately, the Overcontroller coping mode was not psychometrically robust enough to be included in the list and, hence, a shortcoming in the inventory. Sheffield and Waller (2012) caution that results of the SMI will reflect modes states, and that results of the measure will strongly emphasize the dominant and active modes at the time of administering the inventory.

(o). Young Parenting Inventory

The Young Parent Inventory (YPI; Young, 1999) was designed on the basis of clinical experience and intended to identify the potential origins of seventeen negative core beliefs. It is a self-report questionnaire consisting of 72 specific statements that individuals might use to describe their parents or substitute parent(s). Each of the items requires a rating on two six-point Likert scales ranging from "completely untrue" to "describes him/her perfectly". Each statement reflects the behaviour of parents/substitute parent(s) related to each of the EMSs outlined by Young et al. (2003), except for the Social Isolation EMS. With the exception of the Emotion Deprivation scale, which is reverse scored (1 being "completely untrue" and 6 "describing him/her perfectly"), high scores are indicative of the perception that the parent behaved/behaves in ways that were/are more likely to generate the related core beliefs (Sheffield, Waller, Emanuelli, Murray, & Meyer, 2003). The YPI has been validated in a study using a large student sample and shown to have sound psychometric properties (Sheffield et al., 2005).

(p). Session Bridging Form**

The linking of experiences between sessions and taking account of attempts to perform homework tasks is referred to as "bridging". The Session Bridging Form (SBF; adapted from Beck, 1995), which was developed by Judith Beck as a focus on the "within session" processes (Beck, 1995), can be benchmarked to a series of evidence-based competencies from the cognitive therapy scales (CTS; Young & Beck, 1980) and its revised version, the CTS-R (Blackburn et al., 2001). In a study conducted by Williams and Squires (2014), the use of the SBF facilitated in patients' compliance to homework and was conducive to building greater collaboration within the therapy relationship and the identification of potential barriers in the therapy process. The form comprises nine questions, divided into two parts. The first part, which the patient is expected to complete shortly after the session, addresses the usefulness and quality of the session and addresses ways in which material from the session can be

adapted to help them in the upcoming week. The second part of the form should be completed just prior to the subsequent session and enquires about pertinent issues to focus on in the upcoming session.

(q). Working Alliance Inventory**

The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), theoretically grounded in Bordin's (1979) trans-theoretical conception of the alliance (Horvath, 1994), is a 12-item measure of three key aspects of the therapeutic alliance. The first of these, the Bond scale, measures the therapeutic bond, which encompasses mutual liking, attachment, and interpersonal trust. The Task scale measures the mutual agreement between patient and therapist on joint tasks, including the strategies and techniques of treatment. Finally, the Goal Scale measures the level of agreement regarding treatment goals, including the areas targeted for change. Each of the twelve questions that reflect different ways the patient may think or feel about the therapist are answered along a 7-point Likert scale, ranging from "never" to "always". The study conducted by Horvath & Greenberg (1989) confirms the measure's psychometric rigour.

(r). Agnew Relationship Measure**

The Agnew Relationship Measure (ARM-12; Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998) is another self-report measure designed to assess the quality of the therapeutic alliance. The original 28-item ARM assesses five dimensions of the patient-therapist alliance, namely: bond, partnership, confidence, openness, and patient initiative. While the first two dimensions ("bond" and "partnership") reflect the classic dimensions outlined by Bordin (1979), "confidence" measures the confident collaboration dimension identified by Hatcher (1999) as a predictor of positive outcome, reflecting the therapist's and patient's joint sense of progress and investment. "Openness" measures the felt freedom of the patient to disclose personal material without fear of judgment, while "initiative" measures the patient's personal responsibility for the direction of therapy. This study made use of a short form of the measure, the ARM-12, which has been widely used as a pragmatic proxy for the full version and preserves the dimensional structure of the full ARM (Reynolds & Stiles, 2007; Reynolds, Stiles, & Grohol, 2006). This short version of the ARM selects 3 items from each of the ARM's scales for Bond, Partnership, Confidence and Openness. Both the full version (Agnew-Davis, et al., 1998) and the short form (Reynolds & Stiles, 2007; Reynolds, Stiles, & Grohol, 2006) have demonstrated sound psychometric properties. The fifth dimension of the full ARM, patient initiative, was dropped from the shorter version due to being psychometrically heterogeneous (Cahill et al., 2012). Reflecting on the session just completed, the 12 items are scored on a 7-point Likert scale ranging from "Strongly disagree" to "Strongly agree".

5.7.7. Therapy Evaluation Interview

Approximately 18 months into the treatment an independent clinical psychologist conducted an approximately 1-hour semi-structured interview with each patient-participant in the study. While the use of an independent

interviewer demonstrated triangulation to bolster the rigour and reliability of the findings of the study, the purpose of the interview was to explore each participant's experiences of the therapy, with a special emphasis on their experience of working within the ST mode model of treatment. The interviewer explored the changes each participant experienced through the therapy and what they believed contributed towards such changes. Aspects of the therapy that were deemed helpful or a hindrance were also explored. The interviewer was guided by a semi-structured interview developed by the researcher (see Form 7 in Appendix 17). All interviews were audio-recorded and then transcribed verbatim by an independent professional transcriber. The audio-recordings and transcriptions were only made available to the therapist-researcher for analysis upon completion of the research intervention so as to not interfere with the naturalistic quality of the therapy process.

5.8. Data Condensation

Within the context of the IPA methodological framework, various levels of data condensation were performed during the research study.

5.8.1. Session Summaries

A session summary was compiled for each therapy session conducted during the research study. While listening to the audio-recording of the session, I completed the session summary on a template that I designed specifically for this aspect of data condensation. Prior to listening to the audio-recording, I reviewed my in-session and post-session therapy notes to familiarise myself with the session and ensure that important information in the therapy notes could also be included in the session summary. This process of compiling a summary of the audio-recording of a session and the available therapy notes describes the next step in the data management system developed by Halcomb and Davidson (2006). At the head of the session summary template was space for the participant's name and the date of the consultation. With time references in the margin for the purpose of being able to revert to the audio-recording, the session summary included detailed descriptions of the therapy content and the therapeutic processes evident in the session. Where pertinent, passages were typed verbatim in parenthesis for the purpose of preserving detail for possible use in the final therapy narrative. All therapy summaries were compiled within 48 hours of the actual session for the purpose of recalling and recording as much detail as possible of events in the session. Session summaries also included detailed description of pertinent behaviour or gestures that were obviously not evident from the audio-recordings. For example, noteworthy actions performed during chair work, silent moments or non-verbal gestures and facial expressions made by Alison during the session were described in the session summaries. Observations, hypotheses and interpretations of events that I made in sessions were also noted in the session summaries. For example, I noted whether my use of experiential or emotion-focused work at specific times in the therapy was effective or not.

5.8.2. Summarising of Therapy Evaluation Interview

Upon completion of the study, I gained access to the verbatim transcripts and original audio-recordings of the nine therapy evaluation interviews. The first level of data condensation involved a summarising of the transcripts of each interview on the same template used to make session summaries. The content of these summaries reflected the responses that each participant made to each of the questions posed in the semi-structured interviews. The next level of data condensation involved the combining of the nine summaries into a single document that outlined the important and common findings of the interviews. For the final level of data condensation, a cross-case synoptic thematic analysis was conducted by identifying, analysing and reporting on the themes and patterns that emerged across the nine interviews. Prominent themes included the participants' experiences of receiving ST and, where relevant, a comparison of this to previous therapy they received; their experiences of the various therapeutic techniques undertaken in the treatment and the nature and influence of the therapeutic relationship. An analysis of the findings is discussed in section 11.9.

5.8.3. The Therapy Narrative

While any of the ten cases were worthy of being included in the thesis, I chose the case of Alison due to it comprehensively demonstrating the utility of the ST mode model of treatment for a patient with a longstanding history of AN. While it was a successful treatment, it still displayed many of the challenges that typically arise in therapy with a patient with AN. Besides the ED, there existed a broader diagnostic profile and an array of psychological issues preceding the onset of the ED that required therapeutic attention. The within-case analysis was idiographic in nature and concentrated on an understanding of the features of this single case. Written as a therapy narrative, it is phenomenological in the way it reflects both my own experiences of Alison and the treatment process, as well as her own experiences. With minimal interpretation, it provided a chronological account of the sequence of pertinent themes, events, and processes that unfolded across the 100 sessions of ST. In this descriptive narrative approach, I arranged the material into a story, I attempted to retain the phenomenology of the therapeutic process and allowed the narrative to speak for itself. While some summaries described individual sessions, others outlined concepts and processes that extended over a number of sessions. Some sessions were excluded from the therapy narrative for not demonstrate anything unique or for repeating a theme or process that was already addressed elsewhere in the therapy narrative. In this respect I was conducting Halcomb and Davidson's (2006) fourth step[11] of the interview data management system by way of a preliminary content analysis in eliciting common themes within the therapy process.

[11] Halcomb and Davidson's 5th step, which they call *secondary content analysis*, involves an independent third-party researcher not involved in the therapy process reviewing the primary content analysis as a measure of the rigour of the study. While my supervisor did review select excerpts of sessions, there was insufficient funding to employ anyone to independently listen to all audio-recordings and view therapy notes to form an independent content analysis.

5.8.4. Results of Questionnaires, Inventories and Surveys

A summary was compiled onto an Excel® spreadsheet of Alison's scores for questionnaires and inventories. This included the battery of tests provided before and upon completion of the study. Results of the weekly battery of tests were also summarised onto a spreadsheet. Given that Alison has continued to receive once weekly ST beyond the completion of the study period, I decided to re-administer the full battery of questionnaires and inventories exactly five years after completion of the study to serve as a follow-up. Scores across time were now readily available for interpretation.

Alison was provided with a copy of the therapy narrative to read. As a further exercise in triangulation to bolster the rigour and reliability of the research process, she was asked to complete a form (see Form 1 in Appendix 12) that I compiled in order for her to be able to evaluate the accuracy with which the data condensation of the session summaries reflected all the salient features of the 100 sessions of ST. Her responses to the form are discussed in the Quantitative Measures (Chapter 7).

5.9. Data Interpretation

The interpretative analysis of the case of Alison is central to the study and based on questions arising from the objectives of the study. As such, the therapy narrative was repeatedly interrogated in order to elicit pertinent questions: Was the ST model useful in treating Alison and was it discernibly different to the CBT-E therapy provided before the study began? Which aspects of the therapy process resulted in the most noticeable change? What challenges did we experience in therapy and how did we address these challenges? What components of ST most benefitted or hindered Alison's progress? Were there any personal patient-related aspects of contextual features that obstructed the implementation of the ST mode model? In what ways did the therapeutic relationship impact on the therapy? Three key reading questions emerged to form the basis of Chapters 8, 9, and 10. Chapter 8 explores how Alison responded to limited reparenting, and how this contributed towards the building of her HeAd mode and, finally, the formation of a strong HeAd/VuCh dyad. Given Alison's deeply suppressed anger, Chapter 9 reflects on the challenges in accessing Alison's AnCh, despite strong hinderance from the introjected messages of the DPM. Chapter 10 explores whether the identification and establishment of an ED-specific coping mode was achieved on the mode map. Its functions were identified and compared with those of ED-specific coping modes identified in the literature. Did this mode significantly contribute towards Alison's remission from AN, and did this mode provide the opportunity to more readily address other important therapeutic processes outside the direct influence of the ED? I reviewed literature in search of information that would confirm and further illustrate these features of Alison's therapy and the themes that emerged. Rigour and reliability of my interpretations of the treatment was enhanced by reviewing the results of questionnaires and inventories displayed in Chapter 7, and a

thorough review of the narrative and my observations in subsequent chapters by my supervisor. The final chapter of the thesis identifies the most salient features of the therapy process and a discussion of the clinical implications.

CHAPTER 6: THE THERAPY NARRATIVE

While the complete ISST-approved case conceptualisation can be viewed in Appendix 16, I first provide a brief biographical summary of Alison to familiarise the reader with the most pertinent aspects of her life. It was written at the conclusion of the 6-session assessment phase of ST. It outlines Alison's early life, her core relationships, the development of her eating disorder, her psychiatric treatment history, the course of her anorexic condition and, finally, her identified goals for therapy. This is followed by a DSM-5 (APA, 2013) diagnosis, after which I provide the mode map that Alison and I constructed together during the assessment phase of ST treatment. This material provides a context for the detailed therapy narrative that follows.

6.1. Alison's Summary Biographical

Alison is a 68-year-old married woman who completed a teachers' diploma after matriculating from a small, private Catholic school. She met her husband, Mike, at church while she was still completing her teacher training, but they had a very protracted engagement due to the disruptive effect of her ED. She and Mike, a 76-year-old retired engineer, have been married for 35 years and they have a 29-year-old son, Eric, who is currently studying in France. It was Eric who initially contacted me out of his growing concern for his mother's lack of response to her existing psychiatric treatment for a longstanding AN-r condition. After he repeatedly pleaded with his mother, she finally agreed to attend the initial assessment consultation with me in late October 2011. On initial presentation she was quietly spoken, very polite and neatly dressed. Her extremely fragile and severely emaciated frame gave the appearance of a woman many years older than the person who tentatively entered my office accompanied by her husband. She was visibly anxious with the uncertainty of what to expect in the consultation. Although she had already been under the care of a registered dietician for five years and was still consulting with the psychiatrist whom she first saw two decades earlier, she was clearly deeply entrenched in her anorexic state and making no progress. Her weight of 39.0 kg on presentation equated to a body mass index of 14.0, placing her within the "extreme" level of severity as outlined in the DSM-5 (APA, 2013). She dismissed the severity of her emaciated state, despite describing her frame as "thin". Although she acknowledged some concern about her condition at the time, she had a profoundly distorted body image and did not appreciate the short and long-term medical consequences of her ED state. She was very distressed at the prospect of the significantly required weight gain, but was willing to consider a small increase. With no prior history of binge-eating or bulimic compensatory weight loss behaviour, she fulfilled all the criteria for AN-r as outlined in the DSM-5 (APA, 2013). Her blunted affect and monotonous tone were clues to an adjunct depressive mood disorder.

Soon after Alison's parents married in 1936, they had their first son, Noel. Three years later their second son, Robin, was born. Her father, Eric, then served in the South African Army in North Africa, where he was captured in 1944 and sent to a prisoner-of-war camp in Italy until being liberated in 1945. He returned to Cape Town to

resume his career as a customs official in the postal service until his retirement. More than a decade younger than her oldest sibling, Alison was born in 1948 - supposedly a delight to her parents, who had always wished for a daughter. However, the unresolved trauma of her father's wartime experiences saw him turn to alcohol to sooth away his particularly traumatic prisoner-of-war experiences. He remained both physically and emotionally absent from family life and, according to Alison, was "an utter failure as a husband, father, family man, and provider." She saw him as a weak character, seldom sober, and incapable of engaging with the family in any positive manner. A significant portion of his modest income was spent on alcohol and compulsive gambling at the racecourse. He died at the age of 63 years due to cardiac complications, despite having complied with his doctor's instructions to abstain from alcohol in his last few years of life. Alison was 23 at the time.

Alison's very emotionally deprived relationship with her mother, Leonie, played a significant role in creating a childhood filled with loneliness, uncertainty, fear, inadequacy and an existence devoid of warmth and safety. Alison held an idealised notion that her mother always prioritised the needs of others and, while she admired her mother's very sanctimonious and "self-sacrificing nature", she was also very aware of her mother's very penitential, non-demonstrative, strictly disciplinarian and emotionally absent qualities. Rather than challenging her mother's attitudes and behaviour, Alison chose to emulate these extremely self-depriving and puritanical qualities throughout her own life. When her mother died of heart failure at the age of 75, Alison was 35 years old and had only been married for three years.

Alison believes that her mother was physically, socially, and emotionally healthy during her pregnancy. Infancy passed by without any notable complications, and she conformed with all the expected developmental milestones. As a toddler, she remembers engaging hesitantly with her peers and being both timid and shy. Although she described her formative years as "uneventful", she was very aware of the constantly tense home environment, mostly due to her father's addiction problems. In what she described as a "happy childhood" she had many friends who would frequently visit the family home to play. However, she has never forgotten her father's frequently intoxicated state, where his socially inappropriate antics were a great source of embarrassment to both her and her friends. Alison's mother was the disciplinarian. She was over-protective, denied her daughter the opportunities for autonomy, and only engaged in some very basic parental responsibilities. Although Alison seldom expressed emotion, when she was distressed her mother became anxious and ignored her daughter's fundamental need for support, comfort, and guidance.

While Alison was still at school, her brothers were already working in the insurance industry. They pampered their baby sister and fulfilled the parenting role that their own parents were incapable of providing. Noel abandoned his initial aspirations to be a Catholic priest to marry the woman with whom he subsequently had seven children. He has a history of depression, but has remained in remission for many years. Now an elderly man of 79 years, he is retired and lives in the same suburb as Alison and Mike. Her other brother, Robin, was very intelligent and

excelled as an athlete when he was young. He emigrated to England, where he met his wife and had a family. He also had a history of depression, but recovered with psychiatric intervention and remained in remission until his death last year.

Alison said that she enjoyed her school years. However, she recalls feeling very distressed on her first day at the Catholic convent when it came time to be separated from her mother, desperately holding onto her mother's arm. She still recalls holding back her tears after a nun ripped the hem of her blouse in an attempt to separate her from her mother. Alison denies that she is intelligent and is convinced that it was only her very diligent work ethic that helped her progress through her school years with relative ease. She related well with both peers and teachers, and engaged in both summer and winter team sports. She was voted head girl in her matriculation year, which required many extra time-absorbing responsibilities. She balanced these duties and her studies by completely withdrawing socially to spend entire weekends alone to keep abreast of her schoolwork. Alison reflected on the irony that her school testimonial described her as "a person with sound common-sense and an excellent sense of responsibility," yet this dramatically contrasted with the reality she has seen of her entire adult life spent under psychiatric care and being paralysed by her anorexic condition.

Although Alison completed her teacher diploma, she never applied for a teaching post due to the self-doubt instilled by her mother. Instead, she worked as a junior bank clerk for over a decade and avoided any progress to a more senior position in order to just "feel safe and secure." Immediately following her father's death, at the age of 23, she began losing significant weight and eventually become severely emaciated. When her colleagues at work voiced concern about her significant weight loss, it instilled in her "a sense of accomplishment and importance." Already engaged for 4 years at that time, it was due to her ED that it would be another six years before she and Michael married. They married in 1981 when she was 33 years old, but the impact of her AN resulted in her living very reclusively at home when she was not at work. Five years into the marriage she followed her gynaecologist's advice to gain enough weight in order to have the realistic prospect of falling pregnant. After giving birth to Eric when she was 39 years old, she immediately renewed her severely restrictive eating habits and returned to a severely entrenched anorexic state.

Alison does not believe that she has sufficient skills to engage socially, and she feels unworthy of the love and care from her friends and family. She also thinks that the only feeling she evokes in others is sympathy and concern for her ED condition. She said that she has always felt more comfortable in the company of those older than her, that she was always exhausted by what she perceived as the competitive nature of her peers, and has always avoided interpersonal conflict. She very seldom sees her current group of friends and she still generally avoids socializing for fear of judgment and condemnation. However, she still holds fond memories of engaging with young children and mixing with their parents at church social events during the more than three years when she taught catechism classes at her church in the 1990s. Although Alison's AN has lent to much social isolation, she has always sought

from it a sense of “importance and admiration,” as well as a distinct sense of identity. She believes that her ED has “protected” her from needing to acknowledge and emotionally embrace her sexuality, an arena that was shamed and tabooed by her parents – particularly her mother who was, herself, raised in a very authoritarian, oppressive and strictly Catholic culture. She feels that the self-deprivation of her AN state has provided an ideal platform upon which to demonstrate her need for “strength, discipline, and purity”, as well as a sense of “perfect control and order” in her life. Some earlier sessions were spent looking at the parallel between Alison’s AN and the medieval phenomenon of “anorexia mirabilis”, where Saint Catherine of Siena’s fasting, life-long virginity and self-flagellant behaviour denoted female holiness or humility and underscored purity. These discussions very effectively helped Alison to become aware of some of the distorted motives behind her eating disordered behaviour.

Alison’s earliest psychiatric treatment involved the attendance of day-patient treatment programmes at two different state hospitals between 1978 and 1980. She was unresponsive to the group therapy and dietetic advice. The following year, aged 31, she was forced to resign from her banking job to be admitted at her lowest weight of 32 kg (BMI=11.5) to a state facility specialist ED unit inpatient programme. While she remained in the facility for over a year, she received predominantly behaviour therapy that was facilitated by a multidisciplinary psychiatric team under the leadership of a specialist psychiatrist. Although the “privilege” system prioritised weight restoration, individual and group therapy was also provided for the purpose of exploring her condition and difficult life circumstances. She was eventually discharged at her designated goal weight of 56 kg, which placed her comfortably within the normal weight (BMI=20.1). As a result of immediate weight loss following her discharge from inpatient care, she was forced to attend regular weekly day-patient treatments from the same facility over the next twelve months.

Overcompensating for her parents’ neglect of her and her siblings, Alison was overly protective of her son, despite remaining emotionally blunted within her anorexic state. This required her to return into therapy with a new psychologist at the age of 44 to address her severe separation anxiety when Eric entered pre-primary school. She began consulting with her current psychiatrist at the same time for the management of her psychiatric medication. Although her separation anxiety was resolved in therapy, she ceased attending sessions before her ED could be challenged. She began consulting with her current dietician, Elliene, in 2006, but remained mostly unresponsive to treatment and defied all encouragement from her support system to adhere to a weight-restoring meal plan.

Having agreed to enter into therapy with me, Alison contracted to attend once weekly individual therapy sessions on an outpatient basis, making it clear that she was extremely reluctant to be admitted into the inpatient eating disorders unit for fear of relinquishing all control over her eating and general lifestyle. As such, we agreed to work on an outpatient level, provided her psychiatrist continued to monitor her medically and endorsed ongoing outpatient treatment. I employed a CBT model of individual psychotherapy that closely followed the one

developed by Christopher Fairburn (2008). She agreed to continue attending regular weekly consultations with her existing dietician for the purpose of dietary management and weight monitoring. She also continued with her existing antidepressant (fluoxetine), and anxiolytic (Alprazolam) medication prescribed by her psychiatrist many years earlier. Despite Alison's reluctance to fully comply with the meal plan of three daily meals and snacks, she did steadily restore weight, albeit with frequent fluctuations. Her main motive for following the meal plan was to sustain the acceptance and approval of her family and treating professionals and to avoid conflict situations. However, she was still making some progress in her therapy. Six months into treatment she had restored 7kg to reach 46 kg (BMI=16.5) and looked discernibly healthier and alert, and was engaging better at an emotional level. In her first consultation of 2013 she reached 50.0 kg, a milestone that saw her very close to reaching her prescribed goal weight range of 52kg to 54kg. She reached this goal the following month, something she had never achieved before on an outpatient basis.

Although proud of her accomplishment and sincere in her therapy efforts, Alison remained very ambivalent and frequently longed to return to her anorexic identity. Her weight still fluctuated between 49.0kg and 52.5kg over the next six months due to restricting her intake sufficiently to ensure that she remained marginally below the goal weight range. She had reached a plateau both physically and emotionally and she was beginning to feel resigned to the prospect of ever gaining full and lasting remission. Although only marginally below the expected weight range, she remained reluctant to restore the 2 kilograms necessary to reach the normal weight range. I therefore proposed a change in the treatment approach and invited her to participate in the research project. I provided her with a brief overview of ST and explained the fundamentals of the schema mode model. At the conclusion of a research study assessment session, Alison agreed to participate in the study and begin ST.

Alison's revised goals for treatment were to return to and maintain a normal weight. She also wished to relinquish the obsessional nature of the ED lifestyle and live life more spontaneously. Furthermore, she wanted to feel healthy and to develop a more meaningful social lifestyle as a friend, mother, and wife. Alison also wished to develop the ability to be more emotionally available and physically demonstrative – something that she had never experienced in her family of origin, and which she felt inhibited from exercising in her marriage. Alison also wished to grow spiritually and resume a more active and participatory role within the church community. Most importantly, she knew that she needed to develop an intrinsic sense of deserving to feel better, rather than defining and applying her life in a rigid, fearful, and obsessive way through her anorexic condition.

6.2. Diagnosis

AXIS I: Major Depressive Disorder (Mild) with Anxious Distress (296.21)

Anorexia Nervosa- restrictive type (Mild) (307.1)

Generalised Anxiety Disorder (300.02)

AXIS II: Avoidant Personality Disorder (301.82)

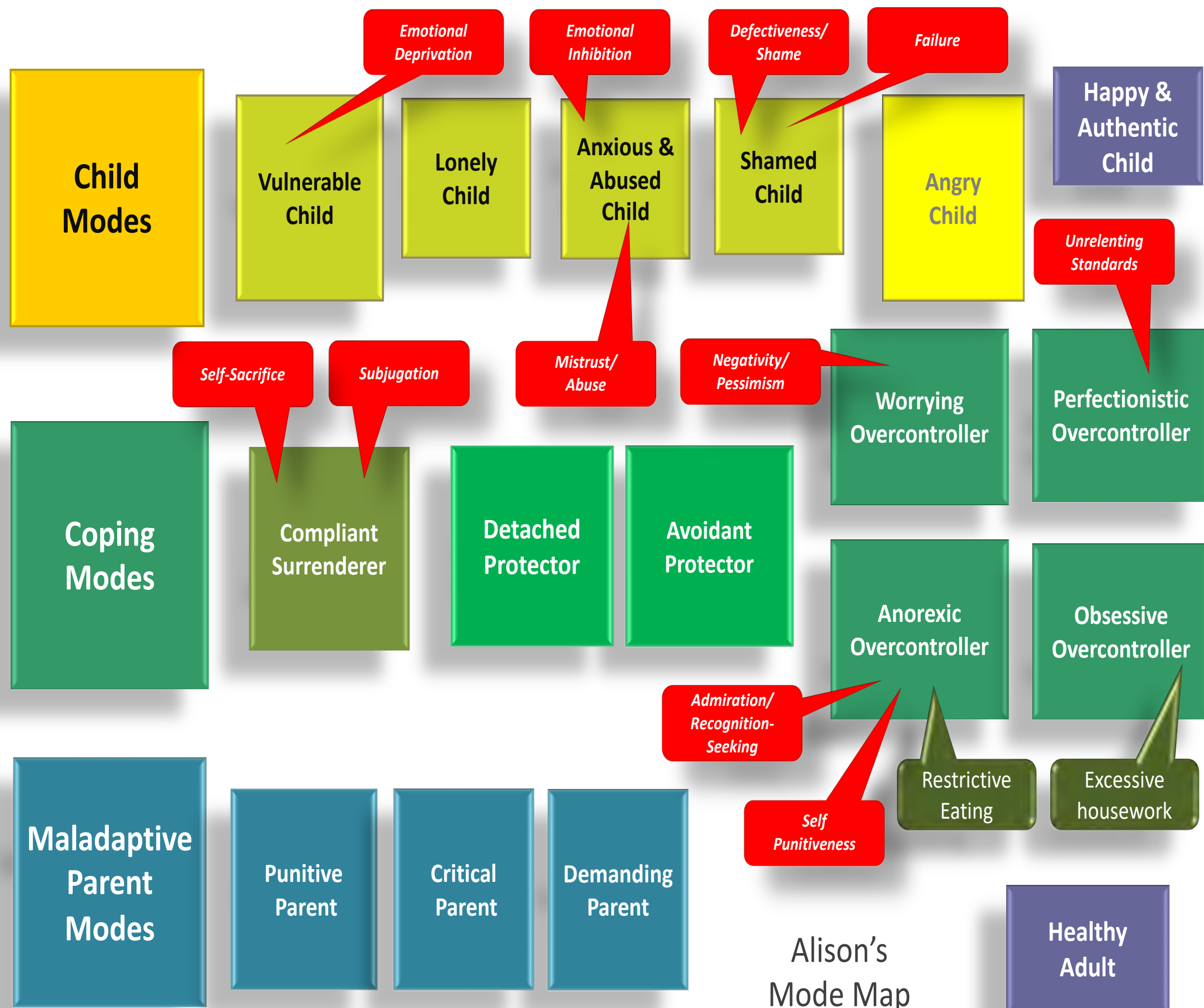
Obsessive-Compulsive Personality Disorder (301.4)

AXIS III: Osteoporosis (associated with extended amenorrhoea due to Anorexia Nervosa) (M81)

6.3. Mode Map

Once collaboratively constructed during the assessment phase of treatment by placing laminated mode labels on a Whiteboard®, I replicated the agreed-upon mode map in Powerpoint ® and provided Alison with her own laminated copy. When she forgot to bring it to sessions, I always had a copy to ensure that we had the mode map on the table during sessions to refer to. The mode map in Figure 17 below is the initial mode map that was developed during the assessment phase of treatment.

Figure 17: Alison's Mode Map



6.4. The Therapy Narrative

6.4.1. Therapy Session 1

Alison began the first session as she had ended the assessment a week earlier. The intensity of the PuPa mode was prominent – her automatic suppression of spontaneous emotion was legitimized by her deeply entrenched religious belief system. Apologetically cowering between shrugged shoulders, she uttered how "callous" she was for not mentioning her mother's death in her written assessment. This ferocious display of the PuPa, shaming the defenceless VuCh, reflected the tone of the entire preceding week in which the unrelenting nature of the PuPa left the VuCh repeatedly preoccupied with the notion of: "I really do deserve to be punished", all in reference to her forgetting to mention her mother's death. Alison's immediate and automatic reprieve for the child lay in the deeply entrenched Catholic belief that only confession would absolve her "wicked, unworthy, and despicable" qualities as a daughter. Despite some efforts earlier in the therapy, I had made no inroads into Alison vehemently clinging to an idealized notion of her mother – the very person who had indoctrinated her with the punitive messages of the family's religious belief system. Despite her split idealized notion of a "worthy mother," I assisted her to more accurately acknowledge someone whose nature she more accurately saw as "emotionally cold, vacant, and unaffectionate", and whose actions were "strictly authoritarian, and rigidly controlling." Here was evidence of an embryonic HeAd, which I aimed to foster by helping her see that her mother was the primary architect of her dysfunctional parent modes. She started to see that admonishing the errors of the "little child" was coming from a PuPa mode, which had its roots in her relationship with her own mother.

Meanwhile, I maintained focus and ventured closer to the fragile child, recounting a wealth of evidence that Alison had already shared with me of the serious neglect and abuse she had experienced throughout her childhood. As I empathically reflected some of these painful early experiences she shifted forward, her posture slumped, and her head dropped behind a curtain of neglected greying hair. The profound sadness that lay deep within the VuCh was now reflected in the sombre frown of her weathered and frail face staring at me knowingly. However, while I attempted to hold her in her sadness, Alison struggled to sustain the experience because of the intensity of pain and her wariness to expose it. Sitting up suddenly, the blunt expression on her face transformed into a cruel and accusatory one as she exclaimed emphatically: "If I punish myself, I feel better."

Later in the session she would be able to identify this as her PuPa, but for now the emotional anguish in the child was effectively dismissed. Knowing she had taught catechism class for many years, I wondered how often she had repeated her next comment before her class of young children. Finger aloft and with a faint smile on her face, she proclaimed with conviction: "Penance is there to bring healing." I withheld my impulse to refute this, but instead evoked dissonance by asking whether punishment had ever provided her with emotional relief or brought about healthy change. Her silence was telling. However, she continued to blame herself, saying she was personally responsible for her mother's poor parenting performance because she "had not let her needs be known".

Although I identified her RaOv at work here, my priority was to acknowledge the anguish in the child when I said: "No little child should be expected to show her mother how to do her job properly." I was not only addressing her HeAd, but also trying to empathically connect with her VuCh. Alison resisted. I could feel her pushing me away. I enquired whether she could see that this "punishing voice" served to "push away the sadness and frightened feelings in the little girl." She acknowledged this, adding: "I am scared of the anger that I might feel – very scared." She could see the link between her anger, her fear, and the neglected VuCh feeling "unwanted, unloved, and uncared for."

Alison diverted again from the child's pain by expressing the conviction that she had made herself personally responsible for ensuring her mother's happiness, especially following the death of her father – someone who had brought so much pain to the whole family. With her head solemnly bowed, she blamed herself for having failed both parents, and particularly for failing to secure a closer relationship with her mother. This was the guilt-inducing victim parent evoking in Alison a sense of "utter failure" as a daughter, but this, in turn, was rapidly counteracted by her voicing with conviction that "forgiveness" could be granted by attending church confession. "Penance is meant to wash away the problem," she said. Alison was convinced that this was the voice of her HeAd, but I challenged her. I pointed out that her DePa and PuPa were rapidly switching or working in combination and trying to masquerade as the HeAd.

There were two occasions in the session where, by speaking gently and compassionately, I was able to briefly connect with Alison's sad and angry "little child". However, such feelings were quickly intercepted. In the first instance, and with automatic precision, her DePr dismissed the sadness behind a severe facial expression as she uttered, "Oh no, not going to do that (express my sadness)". In the second, there was brief evidence of her AnCh confronting her parents, but this was similarly expelled by a silent reprimand from her DePa, leading to her VuCh responding, "Oh no, it's not okay for me to be cross about these things. That's not okay."

Alison's deeply embedded Catholic Code continued to be evident throughout the remainder of the session, and I reflected how it was the source of several destructive modes. Where I had previously read in the literature about the religious anorexia of Saint Catherine of Siena, I enquired whether Alison had knowledge of this historic figure. Without referring to the Saint's deathly starvation, she closed her eyes and displayed a beaming smile in deep admiration for the self-sacrifice and pious selflessness that made Catherine "so worthy of sainthood". She then extended this idealisation to her mother, expressing her admiration for her qualities of "sacrifice and self-restraint." In introducing Saint Catherine, I had hoped to evoke further dissonance, but instead, I was confronted even more sharply by how Alison's deeply entrenched religious beliefs supported a dangerous idealisation of individuals who seemed to me to have significant psychopathology. I realized that it was going to be an immense challenge to help Alison connect with her VuCh and to understand and disempower the toxic and dysfunctional nature of her Parent and Coping modes.

6.4.2. Therapy Session 2

In this session, while reflecting on material that emerged during the assessment, Alison clearly recognised the dysfunctional nature of her father's alcohol abuse after he returned home from being a prisoner-of-war in the final year of World War II. Although she justifiably felt that her mother wrongly tolerated the impact that his drinking had on family life, Alison displayed her CoSu coping mode when she eagerly expressed forgiveness for her father, despite being conscious of his significant absence and frequently embarrassing intoxicated state. She acknowledged my view that her father's excessive drinking demonstrated evidence of his DeSS coping - serving to repeatedly quell his numerous unresolved wartime traumas. She agreed with my comment that her eating disordered behaviour also functioned as a coping mode to numb the pain of her own traumatic childhood experiences. This discussion opened the way for her to participate in an experiential exercise for the first time. Using emotional focusing, I was able to help her access some deeply painful early childhood experiences and, through imagery rescripting, initiated her into the provision of corrective experiences.

With my encouragement, Alison sat back on the couch with her eyes closed and allowed images of her neglected early childhood to gently surface. She soon reported an image of a little six- or seven-year-old girl in her familiar blue dress. "Of course, my mother would never have allowed me to wear shorts. That wouldn't have been lady-like," she began. Although she continued to describe her little child in the third person, it did not distract her from providing an unfolding story that richly captured the essence of her early life experiences. "She's standing there all very insecure," she uttered before pausing to continue. "She feels frightened to be all alone, even though her mother is there. My child is nervous, timid, frightened, insecure, and desperately in need of some figure that she can look up to." Without my prompting, she shifted to speaking in the first person as though more emotionally connected, and described how her mother was wholly detached from her and intolerant of her distress and frustration: "I needed my mother to acknowledge the fact that our lifestyle was not what it should be. She smoothed it over all the time, pretending that it [dysfunctional circumstances] didn't exist. And it did exist, and I needed to be angry about it, but she wouldn't tolerate angry feelings."

Satisfied that Alison had sufficiently captured a vivid image of a neglected, lonely, and frightened child who was forbidden to express her distress and anguish, I enquired who could enter her room to comfort "the little girl who was alone on the floor, playing with her dolls." She expressed how at that time in her life she had "tremendous respect" for the nuns that taught her. She said: "If I had a nun at home and in my room with me, I would have felt safe and secure." However, when I suggested that we bring a nun into her bedroom, she felt it unrealistic and immediately suggested that her husband, Michael, would serve as a better choice. Keeping her eyes closed, Alison provided further detail of her distressed state, which suggested to me that she was not yet quite ready for the reparative script. "I'm feeling very insecure, frightened, and that there is nobody that I can confide in. I'm feeling

unloved and very vulnerable," she uttered with a soft and cautious voice, after which she let out a deep, knowing sigh. At this point she seemed more ready for the corrective experience.

Guiding Alison through the re-scripting process, I invited her to assist me in building a new visually rich and personalised image within which her VuCh would experience peace. As I described the bedroom door opening and Mike stepping through, she immediately contributed: "I run up to him and hug him," adding that she couldn't have done this with her mother because "she would not have tolerated it." She ran up to Mike and threw her arms around his "heart-warming" embrace, feeling "protected, comfortable, and secure." When I asked whether there was something she wanted to say to Mike, she said she wished to tell him that she loved him, but then said that she could not bring herself to say this. When I reminded her that she was "a little six-year-old girl" she felt more at ease to engage lovingly with him, saying: "Mike, I am so pleased to see you. I am feeling so frightened [long pause], timid, nervous, unsure of myself, and I am so frightened for when my father comes home and comes in [to my bedroom] in a drunk state." While still keeping her eyes shut, she voiced concern that Mike not be exposed to this image of her father's intoxicated state. Although she was temporarily distracted from the corrective image, this indicated to me that she was wholly and authentically immersed in the exercise. I brought her back to the positive imagery and relayed the warm, loving, and reassuring voice of Mike: "Alison, you are safe now. I am here to love and protect you, to guide you and listen to you and give you the love and affection that you deserve and never had in your life before." "Mmmm, that is very heart-warming," she responded with relief in her voice. However, she struggled to grasp this when her PuPa resurfaced, prompting her to say: "I don't feel worthy and I don't think I deserve this." Still assuming Mike's voice, I challenged this, reminding her of the care and the love that she deserved. Though she still deemed it "too good to be true," I held my stance, having Mike urge her to trust him and receive the love he wanted to give her. She was eventually able to tentatively receive his love, saying: "I will allow it even though I have difficulty letting myself go." It was clear that the VuCh was apprehensive about receiving unconditional love while being in an emotionally exposed state. As I persisted with a deeply nurturing and caring script, Alison trusted more and was able to say: "Well, I will just flop into his arms, I will be so relieved." I guided her through this image, which brought a gentle and lingering smile to her face. She voiced feeling safe and secure in his warm embrace. The hesitancy in the VuCh was still evident when she said: "I want to keep hold of it [the embracing image], but something still holds me back." I had Mike respond with an acknowledgement that this was unfamiliar and new to her, but that he wanted her to trust his love and feel safe to hold him. "I can do it," she said, after which she revealed feeling safer in her vulnerability when she was finally able to say: "I love you," and expressed that she was going to courageously accept Mike's love, seeing him "somewhat as a father-figure." I confirmed that he was, indeed, a "father-figure" to the vulnerable little child, and that he was providing her with "all the care, protection, support, guidance, and acknowledgement that she needed and deserved." With her eyes still shut tight, Alison was able to sit in silent meditation for a few minutes to embrace the new imagery.

Emerging from this 30-minute exercise, she expressed gratitude and said: "it felt good, relieving, and immensely pleasurable" to receive the loving warmth from Mike as a father-figure. After an extended silence she said: "I don't know why I feel like crying. I have nothing to cry about." As we explored this, she realized the urge to be tearful reflected "relief" for the new experiences that the little child had just received, but she also detected "sadness" for the enormity of loss and deprivation she had experienced throughout her lonely and bleak childhood. I empathized with her for such loss and ended the session by suggesting she closed her eyes again and stay with the relief afforded by this new and precious corrective imagery for a few minutes.

I felt that Alison had done admirably in her first experiential exercise. Not only did she demonstrate how accessible her painful past was, but how she was able to create a richly detailed canvas and, therein, capture a new environment where she received, although hesitantly at times, the unconditional loving support from Mike that she always deserved and desired. I deliberately provided the script of Mike's voice as I was concerned that her HeAd was still very under-developed and not yet capable of expressing the love and support that a corrective experience required. I was very touched when, in a very child-like manner, she enquired as the session closed: "Would you be fine if I cried by myself at home later on?" I was relieved that she was willing to sustain this deep emotional connection, albeit in the sanctity of her home environment, and it was telling that she confided in me and trusted me to endorse such emotional expression.

6.4.3. Therapy Session 3

Alison began the session by telling me about her visit to the dietician and admitted that she had deliberately excluded one of the two prescribed daily supplementary protein shakes in order to feel "more comfortable and in control". She could acknowledge this as a persistent message residing within the AnOv. It provided me with the opportunity to use experiential work for the purpose of re-establishing contact with the HeAd and cultivating an assertion in this guardian figure to restore the VuCh to safety. I chose to use a chair work scenario in which her HeAd confronted the AnOv. Although I had briefly done so during the assessment phase, I re-explained the purpose of chair work, after which Alison cautiously agreed to occupy a position on my couch designated for the HeAd. Kneeling beside her, I recapped for her the qualities of the HeAd, after which I requested that she confront the AnOv located on the couch opposite. I was astonished by the immediate conviction in her confrontation. "I want you to move out of the way and as far away from this space as possible, and allow me to get better," she cried in a clear and high-pitched voice, all the while pointing with a fixed stance at the threat seated opposite her. "Allow me freedom [pause] and stop interrupting what I am planning to do [for the child]. Just out of the blue you step in," she continued, emotionally overwhelmed by the experience. She said that she felt angry that the AnOv had managed to infiltrate the VuCh in such a manner. I encouraged her to sustain this anger, emphasizing that it was a healthy and legitimate feeling that her HeAd was experiencing. From the AnCh chair she forcefully said: "You have no right whatsoever to step into my life. You are not needed and not wanted, and you are a useless

part of my life. You must get away. I want to be rid of you." This was unfamiliar emotional territory, given the extent to which the AnCh had been suppressed throughout her life. Alison looked visibly overwhelmed and perturbed. I asked her how she was feeling, and she replied: "I didn't like being subjected to angry feelings." She described feeling physically shaken and was aware that she was trembling. The influence of her guilt inducing DePa was evident when she expressed her uneasiness with and lack of entitlement for expressing anger. However, she had enough of a healthy voice to recognize that her anger, in this instance, was legitimate and justifiable, as she said: "The AnOv has no right to be in my life and I've been immensely wronged by the AnOv," before finally bellowing out: "I have been grossly violated!"

In order to help Alison clearly differentiate between the anger emanating from the HeAd and that of the AnCh, I gently held her upper arm and ushered her to sit in the couch position designated for her child modes. Once seated there, I encouraged her to share with me how she felt as a young adult while she was engaged in a battle with the AnOv. Visibly exhausted, she described with a soft voice how she felt "unprotected, and insecure". Yet, she also felt frightened and compelled to hold onto the AnOv, explaining with a slightly knowing smile: "It gives me power. I feel in control of things. Everything just feels a little more in control and, yes, in control." While I had the option of pursuing this direction in order to gain a better understanding of this secondary benefit of the AnOv, I maintained my focus of validating the VuCh's pain associated with her many traumatic childhood experiences and, finally, condemned the deceptive nature of the AnOv. I felt a deep sense of warmth and kinship with the frail and frightened "little child" sitting alongside me. For half the session we had held a strongly collaborative and mutually trusting alliance while confronting the AnOv. I also felt distinctly protective of her and calmly reassured her of my full commitment towards helping her find a genuine sense of safety. With the VuCh feeling much calmer, I invited Alison to return to the HeAd chair and speak to "little Alison". She did so without hesitating. I knelt beside her and spoke first to the VuCh, represented by a stripy red cushion. Alison soon joined in, touching the cushion gently while she reassured the child: "I have the will power to do this…(and) I will banish the AnOv. I do not want you to depend on any of those things (the rules of the AnOv) to be noticed," she said. Reminding her that the child part of her had been under-nourished that week, Alison was able to reassure me that the complete meal plan would be resumed, knowing this to be a vital indication that the VuCh was being properly nurtured. When I reminded her of some of the commentary put forward earlier by the AnOv, she forcibly responded: "I have absolutely no respect for the AnOv. I cannot excuse any of that behaviour. It must get out! It's a sham. It is just not real." She found it "very liberating" to rebuke the AnOv in this manner. With the immediate threat of the AnOv having been neutralised, the HeAd was able to engage with the VuCh without interference. Still holding the red cushion on her lap, she spoke to the VuCh with deep sincerity and compassion: "I want you to feel comforted by the fact that I love you dearly. I want to protect you, give you love and affection, and help you to feel safe as you grow up. It is right that you grow up and mature. You don't have to stay as a child. You can become a teenager… and then an adult, and you don't have to feel stuck as a pathetic little girl. You need not be subordinate to all those

figureheads. You can be their equal; not a subordinate, submissive creature… I am going to help you to grow up and be able to appreciate the wonderful things of adult life." We explored how Alison's HeAd had clearly indicated how her overly controlled childhood had made it agonizingly difficult for her to confidently negotiate the transition into an autonomous adulthood. As she explained: "This little girl feels too restricted. Even though she is so young, she should be allowed to choose which toys she wishes to play with and not be told what to play with. That's ridiculous, and as a HeAd I won't allow it." She described feeling "compassion" for the child's difficult life and expressed her wish to provide this "little girl" with everything that defined a loving guardianship.

Despite Alison's courage in the previous session when we reflected on the chair work, she shook her head and anxiously declared: "I really don't like this therapy, Graham." When I invited her to elaborate, she said: "Well, I hate being in touch with my emotions so bluntly. I'm scared and I just like things to be calm and placid." Despite the intervention having drawn her very close to the limits of her window of tolerance, she demonstrated that she was able to sustain the process. This augured well for the use of chair work in the future. I expressed my appreciation for her honesty, and I acknowledged how difficult and unfamiliar this emotional path was that she had entered. As we discussed this further, she came to better understand how coping behaviour did not resolve, but merely blunted her into a temporary and illusory state of calm. Her comment: "It's a good feeling getting in touch with the little girl who's been pretty much dormant in my life." I confirmed this. I affirmed that we would need to enter this space to bring about lasting and genuine healing in the child. Alison provided further evidence of the healing impact of the chair work in the week that followed. She proudly explained that being conscious of her HeAd helped her to ensure that her VuCh was correctly nourished throughout the week. She also indicated that chair work had evoked more excruciating childhood memories of neglect, brutal control, and a deep shaming. This first use of chair work with Alison had evoked intense emotion in her that enabled me to engage with her in a new way. Our collaboration was now no longer just practical but involved my experiencing the care of a parent towards her. Alison also clearly engaged with her mothering instinct as she experienced deep compassion, loving care and an urge to protect the child from the harming influence of the AnOv. It was striking how the expression of anger by the HeAd provided a significant breakthrough to an emotion that had remained deeply suppressed all her life.

Further insight was gained in the session when Alison was able to make the connection between the restrictive impact that the eating disorder had had on her life, and how this was parallel to the restrictive quality of the DPMs and, indeed, her mother. Multiple sources of justifiable anger were being identified and the task lay ahead of ensuring that she would be able to express her newfound anger, not just for the eating disorder, but for all the sources of abuse that had been imposed on her.

6.4.4. Therapy Sessions 6 and 7

Alison's progress was highlighted in S6 when, bearing a confident, though child-like smile, she entered my office and introduced herself: "I am Mrs. Alison Smith. And I now weigh 52 kilograms." Sharing in the celebration, I applauded her milestone achievement and perseverance in finally crossing the lower limit into her goal weight range (GWR). She expressed how the chair work in the past few sessions had helped her to see the distinctly separate identity of her modes. This had helped her to confidently occupy the HeAd position and banish the DePa, after which she was able to engage with the VuCh. With the VuCh under newfound guardianship, Alison demonstrated a fresh freedom when she, for example, accompanied her husband for the first time in many years to a cocktail party and even ate a few snacks with pride and a sense of accomplishment.

By contrast, Alison entered S7 with a very different demeanour. As though confessing, she shamefully acknowledged: "The AnOv is back and I have lost 300g," indicating that she had consciously excluded some snacks from her meal plan. Although she reported that she was mostly taking very good care of herself and experiencing the stabilizing influence of her HeAd, "the AnOv still managed to get through." To better understand the mode sequence that led to the activation of her AnOv, we used the information obtained from the Cognitive logbook for Modes (cog sheet) that she had completed earlier in the week. The mode map is always available during sessions to facilitate reference to the mode activity. While dining with her husband at his bowling club, an acquaintance commented positively on her healthy appearance. Although she responded politely, his comment triggered feelings of anger and insult in the Child, who was "clouded with a black thought" that she was "fat and unattractive". As we systematically reviewed each step in her cog sheet, Alison was able to identify the PuPa mode as the antagonist that criticised the child's appearance, leaving her feeling "worthless and unimportant". As we scrutinized the mode map together in more detail, Alison was able to better appreciate the nature of each mode and the manner in which each was activated in an unfolding sequence. This discussion culminated in her better appreciating the purpose of the HeAd to bring stability and calm to the VuCh's world. "I can now see that our friend was giving me a compliment, and that it was my issues that made me see it differently. I know that I need to be conscious of those unreasonable thoughts and see the importance of eating properly on my plan," she said, seeing things more clearly from a healthy perspective.

Our discussion about the mode map helped Alison better appreciate the function of coping behaviour in temporarily dulling the anguish inflicted upon the child by the dysfunctional parent modes. For example, she began to see how her fastidious daily housework was a manifestation of her ObOv, an overcompensatory coping mode that compelled her to engage in obsessive tidying to temporarily distract the Child from the pressures imposed by her DePa and feel more in control. We, again, identified the influence of her stern Catholic Code which, together with her mother, formed the foundation of both her PuPa and DePa. The mode map further

brought into focus the function of the HeAd in protecting the child and providing love. Both of which Alison deserved, but had never received.

After identifying a few more of her mode sequences, I suggested as a homework task that she draft a flashcard to deal with the threatening influence of her AnOv to restrict her food intake. What follows is her excellent homework effort, which was only slightly altered by our collaborative review in the next session:

When I am tempted to exclude something on my Meal Plan:

Right now, I am reluctant to eat. This idea is probably following some uncomfortable thoughts or feelings. In all likelihood I have triggered one of my schemas; perhaps my failure, my emotional deprivation or my defectiveness schema which I developed as a result of my very bad upbringing. These schemas resulted in me being very unfairly and wrongly critical of my body and appearance, which leads to me thinking that I should not eat everything on my meal plan. Even though I might be convincing myself that I am big, the reality is that I am actually very slim and have only just reached the lowest level of my normal weight range. I have been assured that following my full meal plan will keep my weight stable and at a low, normal level. Therefore, even though I feel like not eating this food, I need to share my discomfort with Mike or Graham or Elliene RIGHT NOW. They have the healthy and accurate view that my own Healthy Adult needs to have, so that my own little Child can trust what is good for me. Only by eating properly on my full meal plan can I carry on living a fuller and more authentic life. Following the meal plan is an act of kindness and love to the little Child inside me; Little Alison.

She kept this card with her at all times and regularly referred to it.

This work with her mode map not only helped me to clarify the mode sequences that underlay Alison's conflicts, but also raised her awareness of them. This awareness was a significant feature in the task of building the HeAd, a mode that could enable her, in due course, to establish mature self-regulation. I was also beginning to name the important role of the HeAd in offering an empathic and compassionate stance towards the VuCh and AnCh.

6.4.5. Therapy Sessions 8 to 11

Over the next few weeks, Alison gained greater access to her sad VuCh and AnCh. They appeared interchangeably to evade the PuPa and DePa. Although she was able to provide authentic compassion for the child from the HeAd chair, her refusal to occupy the child's chair was indicative of the emotional limits at this stage. Respecting her limitations, I continued to support the cultivation of a stronger and more confident HeAd, who became increasingly effective in banishing both the coping modes and the dysfunctional parent modes. Growing more familiar and comfortable in chair work, Alison naturally began speaking more consistently in the first person and present tense from the appropriately designated chairs. Indicative of the HeAd's protective quality of the child modes, she increasingly directed legitimate and authentic anger at the PuPa and DePa, which invariably

culminated in her throwing cushions, that represented threats to the child, out of the consulting room into an empty waiting area. Although Alison's weight remained within her goal weight range (GWR), the occasional fluctuation in her food intake indicated the persistent nature of the AnOv, surfacing whenever opportunity arose to the triggered Child.

Alison arrived at S11 and timidly described: "feeling like a naughty school child coming to see the teacher today." Anticipating that she was going to be scolded for having marginally restricted her intake, I made use of the opportunity to focus on a prominent mode sequence. Although she was still reluctant to occupy the chair reserved for the guilt induced VuCh, she was confident enough to sit in the HeAd chair and scold the DePa responsible for making the child feeling guilty. Thereafter, the HeAd firmly confronted the AnOv with comments such as: "I will not allow you to manipulate this little girl…I will protect her (and)…I will be a barrier against you. You cannot interfere with this dear little child any longer," and finally raised her voice to say: "I have no time for you!" Despite the continued reluctance to express emotion from the VuCh, chair work provided an excellent forum from which the HeAd built confidence to vociferously banish the PuPa and AnOv and display tenderness towards the VuCh who, represented by a cushion, sat on the couch beside her. A further pertinent opportunity arose to provide imagery rescripting in a scenario similar to the one in S2. This culminated in her husband accompanying her into an exquisitely detailed and richly pleasurable sensual garden that served as her "safe place" to enter whenever she felt threatened. Up until this stage Alison had forbidden herself to access any notion of her sexuality.

Despite the invaluable purpose that experiential work was serving to draw Alison deeper into the unfamiliar emotional world of the "little Child", it was also important for me to provide basic nutritional education which demonstrated the practical importance of her complying with the prescribed meal plan. I explained how her body would achieve weight stability within a set point weight range, provided she consistently followed the meal plan. Role playing was another means by which Alison gained practical experience in social engagement in a positive and confident manner. Her friends and acquaintances at this time were commenting positively on her noticeably improved physical health and appearance.

6.4.6. Therapy Session 12

Alison consulted with her dietician, Elliene, on a weekly basis and routinely did so a few days prior to her sessions with me. Before seeing the dietician, she described to me how she had attended church to receive Holy Communion, prayed, and hoped that she had gained weight that week in order to meet what she assumed to be her dietician's expectations. While this did reflect something of the CoSu coping mode, it did also demonstrate the bold determination of the HeAd to continue along her steady pathway to recovery. When the scale registered a 500g increase, Alison was both "relieved and happy" to have achieved the expected weekly weight gain, especially since she had fully complied with her meal plan. In dramatic contrast to this, she was palpably angry as she

entered her therapy session just two days later about the same situation. This illustrates how Alison frequently switched modes with the AnOv often being present and a driving influence. It would also become evident, as the session proceeded, that the chair work of the previous sessions, particularly the work with the HeAd, was giving her a new and liberating attitude towards expressing her anger.

With a hurried and agitated voice, Alison explained to me how in just a few hours following her dietetic consultation she was swamped with commentary from the PuPa. "I'm disgusted with the way I feel. I'm a fat and a grotty, old woman," she said, and told me how she had immediately resorted to AnOv behaviour by cutting back marginally on her daily snacks. Thereafter, the AnCh emerged, for once not being muted by the suppressing quality of the CoSu. Alison read aloud an entry she made in her weekly Session Bridging Form: "I am reluctant to tell my therapist that I feel betrayed by my support group and regret my disgusting increase in weight." She told me that Elliene would be dumbfounded hearing her now, given the "genuine relief" she displayed when it was confirmed that she had gained weight that week. As she began apologizing, I countered her attempts to suppress her anger and continued pursuing the AnCh by affirming the honesty with which she had already documented her feelings. She identified a time when she was 10 years old, attributing her anger to having been denied autonomy and never being acknowledged or respected as an individual with her own voice.

She next revealed an interesting contamination of the HeAd. Contamination describes the risk of the Child mode misconstruing a situation when highly triggered and not being able to step out of that heightened emotional state to view the context from an objectively clear and accurate perspective through "mentalisation" or "defusion" (concepts outlined in more detail in the introduction to Chapter 8). In this instance, rather than Alison seeing the treatment team as supporting the HeAd in her goal of restoring her to a healthy weight, she now experienced us as undermining her. Of course, what was being undermined was not the HeAd, but the AnOv, a mode which she still could not reliably separate from the HeAd. For now, though, her experiencing the needs of her 10-year-old self being ignored and neglected was projected on to me and my colleague: "I am absolutely furious with you for having the audacity for doing just what you think is right for me, and not even listening to what I am saying. Our goal has not been the same. Your goal for me and my own goal for myself are two different things," she said in an agitated tone. Speaking more softly, she continued with a sadder voice: "I feel betrayed by you, Elliene and even Mike." But her experience was paradoxical, because the outcry of the AnCh was about wanting and asking for an end to her subjugation. With an authenticity that astonished me, she finally spoke from the genuine AnCh, saying: "It's unbearable. I want to let it out and get rid of it; that intense feeling of being overpowered by other people." This created an opportunity for the HeAd to support the child, where she spoke both forcefully and with compassion: "I want to push in the way and give this little child freedom. She wants to be heard and listened to and given a place. She's not non-existent. She's somebody!" With her heart "bursting with anguish" and gasping for breath, Alison was caught in a dilemma between expressing her anguish and blocking her sense of having been

betrayed by both her dietician and me. I was invested in her emotional expression and thus persuaded her to occupy the AnCh chair. Using emotional bridging, I deliberately drew her away from her conflict towards me and Elliene and enquiring with whom her "little 10-year-old child" was angry with, many years earlier in her life. Alluding to her parents, the DePa began echoing her religious beliefs of the Catholic Code in an immediate attempt to suppress this anger. However, this was dealt with quickly. Alison was soon able to acknowledge that both parents had failed her miserably. Spontaneously speaking to me in the present tense, she expressed herself with deep authenticity and conviction: "My parents never hear me. They just see me as an object, not as a person." I created a space for her parents on the couch opposite her, each represented by a cushion, and urged the AnCh to engage directly with them. With minimal facilitation from me, she asserted herself with ease. The extract of her successful engagement with the AnCh will be presented later in Section 9.6.

Once the anger had subsided, I helped Alison relieve the built-up tension in her body. She was able to close her eyes and sit back comfortably while I guided her into deep and regular breathing. Reflecting on her brave encounter, I gently validated her anger and acknowledged the pain involved in carrying so much suppressed anger for so many decades. After saying: "Gee, it's such a burden on my shoulders to carry it around with me and not let it out," she, for one brief moment, hesitated to question the justification for holding her parents accountable for their actions. However, she was soon ready to stand up and throw the cushion that represented the anger at her parents across the room as she exclaimed: "All the anger is thrown at them and it's gone from me. I haven't got it anymore." Once re-seated in the child's chair, Alison said: "It's a relief to finally be rid of all this garbage!" Calming her down, I affirmed the bravery of her actions, to which she responded: "It's a good feeling to be so relieved. It's absolutely marvellous. It's a weight that has been taken away from me." I was relieved to hear her recognizing that, as even all these decades later, it was important to do this. She addressed her parents once more: "It's not too late to have done it now, even though I am old. I've had it with me all this time and it's good to be rid of it now. It's been a long time; me waiting to tell you this, but it's still as genuine now as it was then. My anger is the same as it was when I was a little girl, and I have got the right, now, to get rid of it, even though it is so much later." I reiterated what she said in order to demonstrate my alliance with her healthy attitude. She added that she also realised that she had her husband's loving support and finally said: "I don't actually need to try to find the love from my parents." She had, finally, realised that they were not capable of providing her with love – not due to her shortcomings, but due to theirs.

I was astonished at Alison's newfound insight when she expressed regret for having accused me and her dietician of betrayal, realising that her anger, more justifiably, lay with her parents. "I directed it at you, but it was something inside me that was to do with my parents," she explained. As she described her mother as "an iceberg", she suggested evidence of her DePr by confessing to having been similar for many years. However, she was now aware of how frequently she was both initiating and receiving warm demonstrative affection. This

reflected her progress in inviting authentic expression into her child mode and emanating the same from her HeAd mode. Ready to occupy the HeAd's chair, she expressed warm and gentle compassion directly to the little child beside her, who had now become symbolically represented by a small pewter angel figurine that she kept in her pocket at all times to constantly remind her of her guardianship role. "I want you to know that there is no more reason to feel frightened and insecure," she began. "You have been feeling very angry with your mother and father, and you have had every right to feel like that. You are a good person and you have been made to feel like a nuisance… unwanted, and insecure. You are an innocent little child that deserved to be loved. I love you dearly, and you needn't feel ashamed. In fact, you have every reason to feel proud of who you are. You are now safe and you have nothing to fear from your mother or your father." In a gentle, whispering voice, she concluded by reassuring the child that she can play as she wished, without the controlling interference from her parents. With Alison's permission, I spoke to the VuCh, providing reassurance that I was there to support the HeAd in taking loving care of her, and helping her experience the life she was so sadly denied. While I listed each individual in her support system, I reassured the VuCh that we would "allow her to play, have fun and enjoy good food". She felt assured that her "little child" was both relieved, at ease and trusting her caretakers.

The session culminated in Alison reminiscing about a social outing with Mike earlier that week in which she was oblivious of her AnOv voice and able to "actually enjoy the food". She was amazed that she could feel this way after decades of having been trapped in her ED. In the same way that she began to feel liberated from her ED, she also realised that she was beginning to feel emancipated from the restrictive control of her mother, who forbade all emotional expression, whether tears or laughter. She described how she had been comfortably tearful by herself at home the previous two days, reflecting on her fears and brewing anger. I left Alison with the reinforced image of a little girl walking hand-in-hand with a loving parent, reinforcing the trusting bond that needed to continually be built between the Child and the HeAd.

Though she occasionally slipped into CoSu and apologized for the anger, the session was a defining moment for the AnCh, who had become sufficiently safe and trusting to not only express herself but do so with courageous authenticity. For the first time she was able to hold anger for her parents' faults, while concurrently feeling "compassion for their own misfortune". The breakthrough provided an opportunity for a richer and more dynamic forum upon which to examine and engage with more intricate sequences of modes. Chair work was proving an excellent tool with which to help Alison safely introduce her child modes and thus facilitate the important limited reparenting process that lay ahead, most notably, to permit the child to express herself outwardly without fear of condemnation from her dysfunctional parent modes, of which her mother was the primary architect.

6.4.7. Therapy Sessions 13 to 17

As sessions proceeded, Alison's eating patterns remained stable, accounting for her weight remaining consistently within the designated GWR. While there was some marginal restriction, I did not focus on this, but prioritized addressing the fear, sorrow and anger that lay in her child modes. While Alison's HeAd grew in confidence to effectively banish the PuPa and DePa both from my office and in her everyday life, it made way for the HeAd to turn attention to the child, providing her with love, compassion and protection. Alison succeeded in her efforts to broaden her social life, but what was most significant was the bravery with which she allowed family and friends to venture closer to her and engage in an intimate and authentically vulnerable way that she had not previously permitted. There were instances in which Alison demonstrated the deepening trust and intimate connection with me in our therapeutic relationship, voicing her deep gratitude for my care. This was most noticeably expressed in a hug she initiated when sessions resumed after a two-week break.

6.4.8. Therapy Session 18

Alison's AnCh had already achieved some meaningful progress towards expressing outrage at her parents, but her CoSu continued to hamper her outward expression of this anger, given the distorted beliefs imposed by her mother and her religious beliefs. This session illustrated the continued challenges facing the HeAd to help the child feel safe to express herself authentically, not just in her anger, but in all emotional expression. Alison continued to eat sensibly, maintained a stable and healthy weight, and remained committed to trusting her dietician's continued guidance. However, the AnOv remained a peripheral threat, serving to leave the child feeling "a sense of control", albeit in a distorted and paradoxical manner.

Alison completed her homework task of writing a therapeutic letter to her mother, in which I asked her to reflect on her experiences under her mother's care. What follows is the short letter she wrote:

Dear Mom,

As I write this letter, I find myself hoping so much I'll be able to clearly express the depth of my love and respect for you. Regretfully, our relationship as a mother and daughter, when a child and adult, was an unhealthy one.

Training me to suppress my emotions was harmful. You always discouraged me from crying and warned me of the danger of indulging in too much laughter. You also taught me not to display anger even if it was righteous.

Your penitential way of life I admire, but it has caused me to feel unworthy of the joys and pleasures of life. I wish you had been able to allow yourself to experience more happiness in your own life. Mortifying yourself so much prevented you from sharing joy with others.

I am very sad you and I, including my brothers, did not feel closer to you. You were the unreachable mother mounted on a pedestal. It is my sincere wish that you do not feel hurt, and that you receive all the blessings you so richly deserve.

Your ever-loving daughter,

Alison

Alison described how reading the letter in the privacy of her home brought her to tears, which reflected both sadness and anger. She associated the sadness with the loss of love she needed, while the anger reflected the realisation of her parents' failure to provide her with her basic childhood needs. This suggested that the homework task achieved the aim in eliciting an authentic reflection of the extent of emotional pain residing within the child. She said that she was feeling anxious and, hence, reluctant to deal with the letter in the session as she was still feeling "unbearably furious" about her mother's actions. While the letter indicated the direct and vicariously learnt influence of her mother's powerfully entrenched religious beliefs, Alison was compelled to attend confession once she had completed writing it to have it confirmed that her anger was justified and "righteous". Feeling relieved to have the priest reassure her of the legitimacy of her anger, Alison was able to reason that her mother had "done her best". The manner in which Alison formed an idealised view of her mother reflects an Abused Child dissociated together with the abusing parent. She dealt with this by normalising her childhood and adolescent experiences through overcompensatory coping. This idealising of her mother created the notion that she was part of a normal and loving family which, of course, was contrary to the overwhelming evidence of the neglect and abuse that existed. However, it is also plausible that she was exhibiting a healthy compassion for her mother when she uttered in a soft, hesitant tone: "for the Grace of God, I have forgiven them [both parents]". However, Alison still felt ambivalent about her anger. On the one hand, the HeAd acknowledged that it was justifiable, while on the other the introjection of her mother's belief was now manifesting in a DPM that held adamantly to the notion that all angry expression was selfish and sinful. Alison said she was: "selfish… instead of being understanding and showing that my parents did their best, and that I've expected more than what they had to offer." While two months earlier (S12) she had been able to hold both anger and compassion for her parents concurrently, she was still very reluctant to fully own her anger. I asked her if she did not feel that she had the right to expect more than what her parents provided. As she was about to disregard this notion, she suddenly became tight-fisted and taught in her facial expression, declaring with certainty that her father's alcoholic behaviour and the detrimental impact that it had on the whole family, was "unacceptable". This demonstrated a resilient and determined HeAd asserting her authority. Re-evaluating her view from this healthy stance, Alison was able to condemn "a mother who puts on such high standards, making it impossible to reach them, and making you feel a failure". Despite some further hesitation, Alison was eventually able to appreciate that her forgiveness of her parents served to ensure that she would be able to continue uninterrupted along her recovery path. It

required acknowledgement for what “little Alison” still required that was sadly deprived by her parents, while simultaneously providing a safe space for the same little child to be justifiably angry for the pain she was subjected to.

For the remainder of the session I used chair work for the purpose of consolidating and deepening the emotional quality of what had been discussed earlier in the session. She spoke with warmth and deep conviction from the HeAd chair, encouraging and reassuring the AnCh of the legitimacy of her anger for her parents. She reiterated the importance of the guardianship role she played, emphasising how she would prevent the coping modes from compromising “little Alison’s” safety. I was less concerned about her spending time confronting the DePa and PuPa directly and prioritized her cultivating a deeper and more trusting relationship between her child mode and HeAd.

Reflecting on the chair work, Alison spoke with clarity and tenderness of her role as the HeAd: “I have everything in my favour to not abandon this little child, but to protect her. I don’t for one moment want to have her feel uncared for, or unwanted, or unloved. I feel a certain sense of responsibility towards her. She deserves an adult who is responsible and understanding, and who recognizes how she needs to be nurtured and never feel that she is unloved. Never.” She demonstrated immense insight when she then expressed her re-evaluation of the role of her most dominant coping mode: “Graham, the AnOv gives me a false sense of taking responsibility. It’s got to go. At the moment it is gone.”

Although Alison’s acknowledgement of the impact of her parents’ behaviour was steadily increasing, this session reminded me of the slow and patient pathway that we would need to traverse together before the full extent of the emotional impact of their influence would be fully experienced, especially the anger towards and disappointment in her mother. It was, nevertheless, not only encouraging to see the AnCh speak out as she did, but equally promising to see the HeAd gaining insight and clarity in the vital role she was playing to maintain guardianship over the child.

6.4.9. Therapy Sessions 21 and 22

These sessions defined a watershed as we explored Alison’s realisation that a driving motivation behind her emaciated and child-like anorexic body was the role it played in suppressing guilty feelings associated with sexuality. This insight provided an opportunity for her to negotiate the impasse between either continuing to use her AnOv to suppress her sexuality or to welcome the emergence of her own sexuality for the first time. Although Alison and her husband did have some sexually intimate contact early in their marriage, the influence of her strictly Catholic upbringing and the implicit guilt-inducing messages about sex and sexuality relayed by her cold and undemonstrative mother had resulted in the eventual absence of all sexual contact between them once she had fallen pregnant.

Alison explained how she had been growing more comfortable and accustomed to the increasing number of affirming comments from friends and acquaintances regarding her improved and healthier appearance. When her husband, however, made the comment that it was "nice to have something [her physical body] to hold onto", she was "thrown into chaos". She began obsessively scrutinizing her body in the mirror, where her PuPa voiced that her body was both "disgusting and appalling". She recalled her mother's many guilt-inducing religious references, especially to her developing pubescent body. By contrast, there were two factors that motivated Alison to sustain her recovery path and not heed the AnOv. First, she felt compelled to combat her normal coping of remaining withdrawn and, instead, ensure that she met her husband's sexual needs that had been neglected through much of the marriage. "I must do this for Mike. It's not fair that I have already deprived him for so, so many years. It's just not right," she reasoned. The other motive was a healthy one in which she was able to reflect on the many positive changes in her life since she approached a normal weight. "So, my physical health is so much better," she said, adding that, "…my way of relating to Mike and, oh, to all our friends is so much better." When I encouraged her to describe the physical contact between her and her husband, her eyes welled up with warmth as she described a lingering embrace for the first time in years: "You know Graham, it was such a beautiful sharing, such a beautiful and sharing experience.". I sat with her in silence as we knowingly shared an appreciation for this deep and loving experience between them.

Inevitably, the PuPa voice intruded. The remainder of the session was used countering this through chair work. It blatantly dismissed the VuCh: "You are not entitled to all this pleasure. You are just unworthy… and unlovable," while it finally pressed the VuCh with a question: "You have not been there for your husband all these years and you think that you are now entitled to any pleasure yourself?" Although the HeAd was able to offer the VuCh a compassionate response by reminding her that she did not deserve to be punished for her emotionally blunt existence, she remained preoccupied with guilty feelings associated with having deprived her husband of an intimate sexual relationship throughout their marriage.

Unsurprisingly, Alison returned the following week to report that she had restricted her eating, and lost a full kilogram, in the process almost falling below her GWR range. She described feeling like "a naughty little schoolgirl" as she "confessed" to the prominence of her AnOv. Although reluctant to participate in chair work, I managed to persuade her to occupy the VuCh chair, where she felt frightened and timid for being deemed "disobedient and naughty… for letting the side [treatment team] down". As much as she tried to distract from this dialogue by focussing the discussion on food and weight, I persisted in engaging with the vulnerability in the child. The influence of the DePa was felt when Alison voiced her urge to subjugate her own needs for the sake of meeting those of others and, thus, avoid disapproval. She also expressed the feeling of being: "never good enough for anyone", while her abandonment EMS was reflected in her comment: "I don't want Elliene (the dietician) or you, for that matter, being cross with me and being upset, and telling me to go away and not come back to you. I

really don't want to do that. It's not what I want." Overwhelmed by a feeling of inadequacy and a fear of rejection, she was too identified with her VuCh and so too unsettled to feel able to occupy the HeAd chair for the purpose of confronting the AnOv's intrusion on the child's vulnerability. As such, I assumed the protective parent role and scolded the AnOv for being "a brute" and being "deceptive" and for exploiting the child while she was feeling overwhelmed at the hands of the DePa. Forcibly reprimanding the AnOv, I finally said: "I WILL stand between you (the AnOv) and her (pointing to Alison in the VuCh chair) because she needs and deserves my genuine love and protection." All the while, I placed my hand on Alison's shoulder in order for the little child to physically sense my sturdy support and protective presence. When, this time, I invited Alison to participate, she stood up, grabbed the cushion representing the AnOv on the opposite couch and threw it onto the floor in the corner of my office where, in solidarity, we stamped on it repeatedly. Returning to her seat, she was able to express great relief, but not without the AnOv still attempting on a few occasions, albeit unsuccessfully, to regain the ascendancy.

While Alison's primary motivation for following the meal plan emanated from her CoSu avoiding condemnation of the VuCh, I still commended her intention to comply with the plan rather than allowing the AnOv to dominate. Realising that her HeAd had retreated, I suggested to her that her husband join us for the remaining 10 minutes of the session. She agreed to this and allowed Mike to play a supportive role in ensuring that she ate properly and exhibited HeAd behaviour. Furthermore, during the week Alison responded for the first time to my many invitations to call me during the week for telephonic support. Although she was apologetic at first, I reassured her that her phone call was another healthy behaviour in reaching out for the support of others. She was able to report that she and her husband were taking excellent care of the "little child".

These two sessions demonstrated how Alison began to broach a crucial theme in her therapy. With her beginning to appreciate that her ED was not merely an instrument associated with weight control, she began to understand how it had suppressed her sexuality and deprived her marriage of the intimacy that it deserved. As such, the AnOv had hindered her from engaging in a healthy way with her sexuality and the prospect of a meaningful sexually intimate relationship with her husband. Although the prominent resurgence of the dysfunctional parent modes echoing her mother's severe condemnation and expectations inevitably resulted in the VuCh re-deploying various coping behaviours, her HeAd demonstrated a willingness to continue venturing deeper into a new and meaningful territory in order to provide both her and her marriage a richer life experience.

6.4.10. Therapy Sessions 23 to 35

Alison's emerging sexuality remained a consistent and central theme throughout these sessions, while chair work continued to demonstrate itself as an invaluable experiential technique in revealing the sometimes subtle interplay between modes. Used in each session, it brought the sometimes extremely fragile VuCh to a heightened emotional level, especially when the feelings around her emerging sexuality were disrupted by the PuPa and DePa,

and drew the Child mode back into a state of intense shame and anxiety. While the HeAd and the dysfunctional parent modes fought out a battle for ascendancy, Alison gained a clearer understanding of the role her coping modes played to evade uncomfortably amplified emotions. A primary goal in these sessions was for me to assist Alison in negotiating a safer pathway in which to invite her unfolding sexual identity and to cultivate meaningful intimate relationships within her nuclear family.

Alison recalled experiences during her childhood that demonstrated her mother's harsh and shaming attitude towards sex and sexuality that reflected the strict Catholic belief system in which she was raised. Vicariously learning from her mother's suppressed sexuality and being repeatedly shamed about anything sex-related resulted in an especially agonising adolescence during which Alison was sexually maturing. While the term "little Alison" had been designated to define the VuCh until then, she felt uncomfortable with this term being used to identify her adolescent years. She felt it more pertinent, at my suggestion, that we refer to the VuCh by the term "teen" or "teenager". Initially I was often required to model the HeAd in chair work, where I repeatedly defended and protected the "teen" from the brutal attacks of the PuPa and DePa. However, Alison soon developed confidence to echo my sentiments and banish parent modes or, specifically, the "cruel" voice of her mother. The AnOv was rarely present in the chair work during these dialogues.

The guilt inducing DePa became extremely pronounced in chastising Alison for prolonging her failure to be sexually available to a husband who had waited patiently for decades. Mike, however, had explicitly indicated to Alison that he was delighted with the pace with which his wife was stepping closer to him in both a sexually and emotionally intimate way. I reminded Alison of the importance of developing a steady and authentic bond with her husband, rather than feeling compelled to hurriedly eradicate decades of forgone intimacy. Once in the HeAd chair, she was able to reflect on some of the already wonderfully intimate moments she had shared with Mike and was more willing to accept that she continue to progress down this path of intimacy with caution so as to not become overwhelmed again. As she described it: "You know Graham, we really are growing closer in a warm and relaxing way. It is so rewarding."

Each time Alison engaged with her husband in a physically intimate way, she invariably felt the presence of her condemning mother and described feeling "contaminated and unclean". As she explained: "You know, it feels like my mother is there in the bedroom, watching over me and it is not nice!" Each time she experienced this she recalled automatically feeling compelled to restrict her eating, although she managed to mostly resist the impulse to do so. As we explored this further, we identified that the AnOv was associated with two processes. First, it served to suppress all sexual feelings. However, we also discovered that it served as a punishment whenever she had erotic thoughts or when she considered how she was depriving her husband of the sexual relationship. The AnOv was, thus, serving as the 'executioner' to the verdict imposed by the DePa and PuPa. However, Alison was able to often successfully counter this from either the HeAd or even the child's chair by reprimanding both the

AnOv and the PuPa. For instance, her child said: “You are not allowed to interfere with Mike and me any longer. You must both go now. I have a mind of my own, and I am an individual. I will not allow this anymore.”

I was extremely encouraged to witness the awakening of an intimacy in Alison’s life that had remained dormant for decades. The chair work in S25 continued to effectively capture the subtle shift of emotions in the adolescent girl. Where she had initially identified with a 14-year-old whose emerging sexuality evoked fear, guilt and deep shame, by the time I had guided her through the next year in her life by way of an imagery progression, she had become genuinely more inquisitive and embracing of her emerging femininity. “I can see that I am physically changing into a young woman [pause] and this is good,” she said with an assured voice. Soon thereafter, she cautiously paused on the edge of tearfulness, uttering that she did not want to cry, reasoning it as “a sign of weakness…and a loss of control”. Behind the tears, however, lay anger at her parents, especially for the deprivation of love and the humiliation imposed by her mother. Still in the VuCh, she heard her mother’s voice saying: “sex is dirty and bad…and bad things happen”. While I acknowledged the appalling nature of this shaming, Alison responded from the same chair, but this time with bold confidence: “You have no right to put the fear of sexual attraction into me [long pause]. Sex is something good and sacred and a gift from God.” Immediately thereafter, however, she reverted to a frightened child, wary to connect with this new sexuality. Overwhelmed by this exchange, she pleaded with me, as she had done before: “Graham, I don’t like this therapy. I want to stop this therapy.” Although this was not an indication that she wanted to terminate therapy, it was a reflex to stop the session to gain immediate relief from the emotion that it was triggering. The chair work was essentially drawing her close to the emotional limits of her window of tolerance. Confident that I needed to persist to guide her closer to the anguish in the child, I turned to her and reassuringly said: “You are neither dirty nor bad and you are certainly not irreparably damaged. You are just an innocent and perfect young person.” After spending some more time providing the VuCh with further reassurance, she was ready to transfer to the HeAd chair as the “loving guardian”. I reminded her of our collaborative task as caretakers of “little Alison”, after which she turned to the child’s chair, taking the pillow in hand, and saying: “Graham and I won’t let you feel unclean and contaminated. You are a pure and beautiful…and an innocent young woman and we will take care of you.”

While the growing intimacy in Alison’s marriage was met with loving and compassionate messages from her HeAd, a contrasting PuPa took every opportunity to shame the child. In S29, Alison described the notion of having been “born and bred with it”, saying: “My sexually inviting body is dirty and is to be hidden away. It is right that I have a non-sexual identity. That’s what I am. I can’t tolerate these [sexual] feelings because they are sick.” Immediately thereafter she switched to a healthy voice, realizing the source of her PuPa when she said: “You know Graham, if it wasn’t for my mother, I wouldn’t feel like this.” Although Alison was clearly realizing that her mother lay at the source of this PuPa voice, she was determined to hold on to the notion that she had remained entirely in her HeAd the whole week. To challenge this, I took the calculated risk of placing her in the PuPa chair. She was startled at

this suggestion and assumed that I was promoting punitive behaviour. However, she appreciated my explanation that I wanted to test the legitimacy of the PuPa voice by exposing and amplifying it. Quicker than I had anticipated, she forcefully lashed out at the child, saying: "You are not to dare to think of yourself as sexually attractive because it contaminates you and it is dirty and should be avoided at all costs… and you become a disgrace! You have to stop it! You are dirty and disgusting and you should actually be ashamed of yourself for daring to think that you can attract a man physically. It is absolutely abominable to contemplate such ideas! You contaminate yourself sexually if you involve yourself sexually with a man. It makes you disgusting." Overwhelmed with emotion and sitting quietly in contemplation, Alison intuitively knew that she needed to occupy the Child's chair and with a very quiet but determined child-like voice uttered: "No, I am not going to feel like this. It is absolutely wrong to take all these (sexual) things away from me because they are my rights. You are not going to make me feel guilty… I had these thoughts embedded in me when I was small." We sat knowingly in silence for an extended time before I enquired whether she still felt the inclination to speak from the PuPa. Her response was emphatic: "It is infuriating to think that I should have to feel this way… and it does not belong to a sinful person. My attitudes towards my husband are totally pure and unblemished." She said that she wanted to challenge her long-held notion that it was "shamefully sinful to do this [be sexual] and that's why it is so pure and good to be in an anorexic state". Shifting convincingly into the HeAd at her own accord, Alison stated that she "wants to reassure that Child that she need not feel ashamed". While remaining seated in the HeAd chair, she responded as the VuCh who, clearly pressurized, said with the distinctively soft child-like voice that she felt "like a very naïve, immature little child", unsure of how to proceed with her husband as a loving wife. "I need to make sure that I am appealing to my husband. I have not got time for this," she continued, very quickly aware that she was placing undue pressure on the child. Instead of the child feel increasingly pressurized, she was lucid enough to re-engage with the HeAd in recognizing a "sickness" in her hesitancy to grow sexually, growing in the clarity of the dangerously suppressing role her AnOv was playing in inhibiting her sexual development.

As we reflected on the chair work, Alison was conscious of a complex dialogue that had her VuCh facing the condemnation of her mother's voice, synonymous with the PuPa and a DePa voice that simultaneously pressurized her to forgo her apprehension and hurriedly meet her husband's sexual needs. In contrast, there was also an emerging HeAd that recognized this and said: "The tragedy of not allowing a little child to develop naturally is abominable." Alison had the insight to realise that, as thankful as she was to be "coming out of anorexia", she still had to explore her emerging sexuality, just as it was the case when she was much younger. She was beginning to appreciate that her coping behaviour had never brought about resolution to her earlier traumatic life experiences but, merely, delayed the healing required in the Child.

Despite Alison having already demonstrated a sturdy HeAd on a regular basis, she was apprehensive to occupy the HeAd chair on this occasion, deeming herself "not sufficiently there". I felt that she was underestimating the

strength of her HeAd and persisted in encouraging her to occupy the HeAd chair and engage with her VuCh. She obliged and did so with warmth and compassion, steadfast in her reassurance to the VuCh that she need only progress at her own pace: "You have nothing wrong with you, and you even have a loving husband who does not find fault with you. Your physical relationship with your husband is wholesome and good, sacred and pure." Turning to the PuPa, the HeAd was able to instruct her to "leave her alone to allow her to enjoy naturally what was given to her by God. She has a loving husband. And you must leave this young woman to grow and be [an] equal to her husband. You have no right to contaminate this marriage with your derogatory remarks." Addressing her mother's voice directly, she insightfully said: "You have no right to impose what was your own damage onto this woman because she does not deserve it. You are the one that is taboo, not me!" She banished her mother after echoing my words: "I am not going to allow you to cripple this woman anymore." Stepping over to the cushion representing her mother, I reminded her that her mother was unlikely to ever change and that she should just be banished. She threw the cushion that represented both her PuPa and her mother's critical voice to the floor, after which she kicked it, instructed her to: "Go off into that corner and stay there." She began scolding the other cushion representing her DePa in a similar manner, after which I suggested that they be bound up to immobilize them. Using a computer cable, we bound them, an action that Alison found very empowering. "They are not going to interfere with the woman in me, and they are not going to interfere with me (the HeAd) either, because they are not going to return," she ended.

After I had commended Alison for doing a sterling job in immobilizing the PuPa and DePa, she felt confident that she more clearly understood the essential needs of the child and her ability to protect and guide her. Returning to the HeAd chair, she embraced the cushion beside her that represented her VuCh and uttered: "You are a perfect little child, and you are innocent, and what you do is good in God's eyes." She promised the child guidance, protection, and care, reassuring that "those guys tied up there are never going to be allowed to get to you". My guidance helped her realize that her VuCh deserved the comfort of an intimate relationship with her husband, cultivated at a pace that was not overwhelming, even though she hesitated on a few occasions to consider the demanding threats to be more sexually active. She was eventually able to acknowledge: "Mike and I have enjoyed the little steps (of sexual intimacy) immensely." She told me that earlier in the week Mike had bought her a bunch of flowers to show that he loved her. He had responded to her confiding in him that she was emotionally working through the pain of her "little 14-year-old child". Appreciating her husband's patience, I described a metaphor of a small seed germinating and growing into a small sapling, and how the plant cannot be hurried beyond its natural pace. She valued this, saying that she was going to hold onto this image.

Not only was the PuPa viciously cruel about the emergence of Alison's sexuality, but S30 demonstrated how this attack extended directly to her body image. Although she consistently complied with the meal plan and remained stable within her GWR, an increasingly amplified critical voice resulted in the VuCh responding: "I do not want to

present this bloated (and) hideous body with a distended stomach, big breasts, and huge thighs to my husband." While this criticism made particular reference to sexual parts of her body, she was reluctant to initiate any sexual intimacy with this "grotesque" body for fear that her husband would be unresponsive. Alison shared of an incident in which she subtly initiated sexual contact by baring her breasts to him and felt dejected and ashamed when he did not respond in the way that she had expected he would. When they were able to talk about this later, Alison learned that he had been hesitant to initiate physical contact for fear of imposing undue pressure on her. As we explored further, it became clearer how naïve and sexually misinformed Alison was. When she told Mike that she would soon feel ready to have sexual intercourse, he explained that he had been impotent for many years. It became apparent that Alison was completely naïve as to other means by which their intimate relationship could still be mutually satisfying, despite his erectile dysfunction. She was genuinely surprised to learn that masturbation was not solely a male's domain. I felt that both Alison and Mike would benefit from some expert psychoeducation, which prompted me to correspond with a sexologist colleague of mine who recommended her book "Ageing and Sexuality" (Wasserman, 2009). Although the book only arrived on the day of her next appointment, she arrived that day to excitedly report to me that she had experienced her first ever sexual orgasm a few days earlier. She recounted being "lifted out of the world... in an ecstasy of emotion". Even though this experience precipitated a wonderful deepening in their emotional intimacy, it was not without a resurgence of the PuPa still condemning her for having deprived the marriage sexually for decades.

I was conscious in each session, as I was throughout the unfolding therapeutic journey, of my own shifting experiences of joy and disappointment. For each increment in which a slightly more confident HeAd won the trust of the wary little child, the harsh interruption of her PuPa and DePa drew the child back into a stranglehold. While in S34 the "teenage" VuCh still felt shamed and fearful, our reflection on her current state reminded us that some remarkable progress had been made. Whereas in the past the AnOv had completely suppressed any notion of sexuality, Alison was now deeply engrossed in her new book on sexuality. She proudly and confidently told me that she was "teaching him [her husband] a thing or two". Like two "carefree teenagers", they found themselves occasionally laughing uncontrollably as they adventured through their newfound sexual intimacy. Where she was previously only retiring to bed once her husband was fast asleep, she was no longer avoiding physical intimacy, but now eagerly enjoying an early night to experience her husband's warm embrace. The toxic sense of her mother being in the bedroom was being replaced by an "inner guardian" (a term we often used for the HeAd) confidently endorsing a newfound intimacy. Furthermore, Alison's social life was growing, where she was tentatively more accepting of the love and affirmation of friends and acquaintances. Even her preoccupation with the topic of food and weight was being marginalized for more authentic and pertinent issues. Her weight remained stable and comfortably within the GWR while the temptation to restrict became rarer and easier to divert. Without commenting, I noticed that she spontaneously, and for the first time in a session, ate a shortbread biscuit with the cup of herbal tea that she routinely drank each week during sessions.

Alison became increasingly familiar and confident in her vocabulary around the mode model. She still experienced occasional waves of criticism from the PuPa with regards to her physical appearance which prompted the VuCh to reflexively turn to the AnOv for temporary relief. However, the HeAd was becoming more adept at intercepting these deceitful and cunning messages from the AnOv. In S35 Alison suggested that she consult less frequently with her dietician. Although she was insistent that she had been in HeAd all week, it was evident that her DePa was pressurising the VuCh: "Graham, I need to learn to get on with my life on my own and not be accounting to Elliene (her dietician) to eat properly." Although this steady autonomy around food was conceptually HeAd, it was clear that she was feeling hurried to reach that point. Chair work spontaneously began with Alison shifting to the PuPa and criticising the VuCh: "You look frightfully fat and ugly and sexually unappealing, and you need to be hidden away. You are an unsightly grotesque creature that wonders around, and you are not even in control of what you are doing." Conscious that she did not want to acknowledge this destructive parent mode, I encouraged that we persevere with this unfolding drama. She continued: "We are going to get someone to keep you in check and we are going to get the AnOv involved." In a peculiar move, when I asked Alison what she was going to do with this "unsightly child" before her, she banished her by tossing the cushion out of my office, saying: "You get in the way of our sexual pleasures because you appear so, so, so unsightly!" She slumped back into the couch, gasping for breath, trying to justify herself: "I want to be the desirable woman, not an overweight, flabby, fat one. She is gone." She confirmed that she was relieved to have banished that undesirable child but was now concerned that she not "be rid of the woman who can flourish and be sexually appealing". I respected her request to reposition herself into the HeAd chair, from where she, with forcible determination, said: "I need to be alright with her body being in its present state." However, the PuPa immediately resumed with a flurry of critical comments about the woman's "unsightly body that should not be allowed into the bedroom". I strongly encouraged her to occupy the PuPa chair for the purpose of exposing the contamination, challenging her on her criticism of the VuCh. She replied: "I see it in the mirror, it's plain and simple. Mike doesn't understand that this healthy sized body, which he claims to be attractive, is so appalling." However, when I inquired whether she believed that Mike was being honest, she conceded that he was. This realization helped her to see that the only source of criticism was emanating from her PuPa and that it was this that automatically activated the AnOv notion that she should lose weight. When I alerted her to the fact that her PuPa had cast the VuCh from my office, she was immediately shocked and distraught at the insinuation that a part of her had literally thrown the child out. The chair work had confronted how an intolerant and abusive part of her, that she, on this occasion, called "the creature," had expelled the child who was slowly evolving into a woman. "I'll be damned if I am going to allow that critical parent to have another say," she said with real determination. Before returning to the HeAd chair, Alison retrieved the cushion that she had previously thrown out of my office. Sitting with it on her lap, she engaged with a consistent and authentic warmth and love for the little child, although I needed to direct her to speaking in the present tense to ensure immediate reparation. Apologizing to the child, she reassured her that she was going to encourage her

to resume the pleasure that she and her husband had a few days earlier. She described how she had begun to detach from the physical intimacy earlier in the week, convinced that she was unworthy of such pleasure. When I realized that she was expressing herself from the VuCh, I seated her there to focus on the reparenting process. I deflected her from focusing on her body image and obsessing about food in order to gain access to the emotions residing in the child. She described how she and her husband had never before experienced such "joy and pleasure" in their sexual intimacy, of which there had been none since Alison conceived her son 27 years before. Yet, the influence of the PuPa was still present as she tried to convince me that she was undeserving of such pleasure in light of the disappointment she had caused her loved ones over many years due to her ED. She identified this PuPa, also recognising its source when she said: "I think I have been abused by both my parents emotionally. My mother overprotecting me… and never allowing me to say what I wanted to say. I just had to keep quiet. My father was just not there and just a terrible burden that I had to hide. As a child I had to be like an adult and keep him from not embarrassing all of us. I had to be on my guard at all times." Reflecting on my summary, Alison acknowledged that she had been "alone and a lonely child in a very frightening world".

Whilst the VuCh listened to my reflection that she was entitled to all the loving care and protection that she was denied throughout her childhood, her immediate response was: "If I just go with this good feeling, there's no stopping it. Then I get out of control again." She expressed a similar fear earlier in the session that the newfound joy and pleasure of her sexually intimate relationship might "spiral out of control". As we explored this together, Alison identified that the anxiety is derived from her mother's attitude and her own deeply entrenched religious beliefs. When I expressed my own "fondness and protectiveness" for her, she was overwhelmed to know that I and others felt this way about her. Although grateful in her response, she could not help reflecting that she felt anxious and undeserving of such care. However, when I reframed the anxiety as a normal response to the unfamiliar and novel nature of these new life experiences, it was like a sluice gate opening for an immensely excited and authentic young child. As she explained: "I'm very tempted, but I get a bit frightened at times. It's new and unknown. I don't know where I am going with this sexual pleasure. I am even writing notes in my book (the book "Aging and Sexuality"), that is my Bible." Where previously the HeAd scolded the PuPa, her VuCh was now confidently admonishing the PuPa not to interfere in her relationship with her husband: "I'm telling you, you are not going to raise your voice in my company or Mike's. When I am alone or when Mike is with me, you are not going to be able to say one word and you are not going to prevent me from looking forward to pleasure." After repeatedly smacking the cushion that represented the PuPa, she threw it out of my office, uttering afterwards that it felt relieving to be able to "feel a bit crazy sometimes getting all this stuck emotion out".

As strenuous as the chair work was proving for Alison, it continued to demonstrate itself to be a very constructive means by which to draw out and articulate the specific character and expression of each of her modes. While a struggle was being fought between the PuPa and the HeAd to determine the direction in which the "teenager's"

emerging sexuality was going to turn, the chair work in the last few sessions revealed a tenacious drive in the VuCh to step further away from the smothering effect of the AnOv and emerge in a celebration of newfound physical and emotional intimacy with her husband that had never been previously envisioned. Furthermore, the honest and amplifying quality of chair work provided Alison with the insight that her mother was the primary architect of her PuPa. She recognised the discernible and similar quality between her mother's voice and her PuPa in the couch opposite her. As the VuCh cultivated trust in both her HeAd and me, she demonstrated confidence in the VuCh herself, banishing the threats to her authentic development. Although pushed close to her emotional window of tolerance on occasions, the visual quality of chair work provided me with a gauge to know when to push her deeper and when to hold her back and preserve her from detaching from the rapidly unfolding therapeutic process. This pacing provided me with the options to guide her through a confrontation in a collaborative manner, or personally carry the healthy position and model the way I wished to see her HeAd develop. On the occasion that Alison spontaneously initiated chair work, I took this to be an indication that she was growing more comfortable and familiar with this central and vital component of our schema therapy work and more comfortable and authentic in our therapy relationship.

6.4.11. Therapy Session 41

In this session, a discreet crisis demonstrated the ferocity with which the PuPa was activated to scold the VuCh. Both Alison and I became increasingly aware of the extent to which the PuPa echoed the sentiment and precise voice of her mother. The main feature of the session involved the use of chair work to break the impasse residing within the VuCh, who swayed between the compulsion to face severe consequence from the PuPa due to her supposed character defaults and shortcomings, and the challenge to embrace the unconditional and forgiving love of an inner guardianship that defined the HeAd. The crisis served as an excellent platform upon which to help Alison evaluate the consequences of each option as she looked more clearly at the positions of the PuPa and the HeAd in their battle for dominance.

While Alison continued over the weeks to make gradual progress in her self-care and appreciated the way in which her marriage was realising ever-deeper levels of intimacy, she hit a crisis. While cooking burger patties for her and Mike one evening, she left the kitchen for a short moment, during which time the oil ignited and caused flames to leap from the pan. After attempting, unsuccessfully, to douse the fire with water, she called Mike, who rushed to the kitchen to suffocate the flames. Although no physical damage was caused, Alison's PuPa leapt in, rebuking her as "a negligent, unreliable, and irresponsible adult". So bilious was she from the tension and anxiety of that incident that she vomited the next day. Alison needed to discuss this with the dietician because she was concerned that she would be accused of being bulimic. She sustained the critical voice, deeming herself "an absolutely incompetent fool". When I enquired which voice this was, she knew by my tone that I was alluding to something dysfunctional. Although she was able to identify the presence of her PuPa, she was adamant to hold to

the notion that such comments belonged to her HeAd because she was justifiably "out of line and irresponsible [for the incident]… and forgiving myself would have been a cop-out". This demonstrated the ease with which a dysfunctional attitude was easily misconstrued as healthy, especially where she had been exposed for decades to her mother's religious preoccupation with atonement. Although Mike insisted what had happened was an accident, her PuPa vehemently persisted with the notion that her actions were "unacceptable and unforgivable". She recognized the familiarity of her mother's voice echoed in her PuPa and described how she bathed for an extended time after the incident. While there was the connotation of religious ritualistic cleansing of sin in this act, she also described engaging in obsessive housecleaning, a familiar coping behaviour that, depending on the phenomenology of the experience, served as an Obsessive Compulsive Overcontroller or a DeSS means of coping.

Chair work demonstrated a succession of rapid flipping between the PuPa relentlessly chastising the Child and the HeAd trying to assist the VuCh to perceive the situation from "a new [healthy] perspective". Although I invited Alison to occupy the VuCh chair, she was more invested in the PuPa position, scolding the child for being "an absolute idiot" for failing in her responsibilities. "You should have known far better. You are hopeless, incompetent and an absolute foolish child," she continued. Then, emotionally overwhelmed and identifying with the enormity of the child's feelings, she uttered: "I feel sick." Concerned that she might vomit as she had on the weekend, I made a wastepaper bin available. She was able now to tell me how the VuCh, shamed by the incident on the weekend, was feeling "timid and frightened, unsure, and hurt". As I repeated back to her all these feelings in the child, I asked Alison if it was justified for the child to be left feeling this way. Although I had hoped that she would access compassion for the VuCh, the PuPa persisted with further venom: "Well, she downright deserves to be punished." This was then followed by another flip to a healthier consideration of the HeAd. "It is not helping her," she said suddenly. This prompted a softer and compassionate voice in which she insisted: "No, no, no, she can't be punished." But then she flipped into the helpless VuCh and swiftly dismissed the HeAd's compassion by declaring: "There is no HeAd around." As she was reluctant to occupy the HeAd chair, I offered her the VuCh chair instead. She resisted this, but in a manner that acknowledged the child's distress: "No, I can't sit there because if I am the little child, she is going to cry, and I am not going to do that." I took this to be the guilt inducing DePa still insisting that any visible display of emotional pain was unacceptable, something Alison distinctly remembers her mother repeating throughout her childhood. However, there was also the possibility that Alison was reluctant to be emotionally overwhelmed with the tears never abating. Repeating what she had said to me some weeks earlier, she insisted that this was "the wrong therapy" for her. This was, again, an indication that she was at the limit of her emotional window of tolerance. However, I was able to persuade her to settle into the VuCh chair. Like a very young child, and with terror in her face, she spoke softly: "I'm frightened, I'm terrified of what kind of punishment I am going to get for my shocking behaviour. Someone in charge of me is going to punish me because I am such a failure." No longer confined to the consequences of her weekend crisis, she broadened the terrain in generalising that she had failed everyone, including her own son. "He can't even trust his own mum," she voiced,

staring blankly ahead of her. Then, rapidly, she flipped yet again as she hastily composed herself and shifted back into the HeAd: “When I am calm, which isn’t often, I want to protect that child.” The PuPa countered, again, that the HeAd was “too irresponsible and unreliable”, and the child was left feeling that she should not be “let off the hook as this would be too easy a cop-out”. Although I anticipated an ongoing surge from the PuPa, she unexpectedly demonstrated resilience as she flipped back to feeling compassion for the “frightened child”. Despite some resurgence from the PuPa to damn the child’s “gross mistake [the fire incident]”, Alison was responsive to my support. I normalized her accident as something that could happen to anyone, which included describing a similar accident I had had myself some years previously. So unentitled and undeserving had she felt to being forgiven that she had evaded Mike’s warm support after the accident. Only because he persisted in comforting her did “a trembling little child” eventually accept “comfort in his arms”. I challenged the unique set of harsh rules that she imposed upon herself and inquired how she would view it if Eric had caused the same accident. With certainty in her voice, she reflected appropriate compassion, and responded: “I would never scold him. I would tell him it is a dreadful mistake that they had every right to make.” Then she flipped again “… but listen, I am not worthy of forgiveness. I’m anorexic and I’m garbage.” She could identify this as her prejudicial PuPa reminiscent of her mother’s voice. From her HeAd she knew this to be the identity that urgently required banishing and I seized the opportunity to draw this mode into focus when she, again, flipped into the HeAd with the claim: “I would also be compassionate to that little child that got such a fright.” She insisted that I wait for her to retrieve the pewter angel from her pocket that symbolized her VuCh, which she placed upon her lap. Although I briefly needed to guide her to engage directly with the VuCh in the first person, she looked down upon the child lovingly, and spoke: “You are an innocent little child who made a dreadful mistake and I want you to know that you are not a failure and that you made a mistake.” As she continued, I suggested that she reflect what the child must have been feeling on that terrifying night. In a soft voice she uttered: “Little Alison, you shook like a leaf on Saturday.” She briefly migrated into the VuCh role, reflecting: “I was in such a panic state that I was not responsible. I couldn’t even do a simple thing like take the pan off the fire.” The PuPa failed to make any inroads as the HeAd exonerated the child of all blame for the events of that evening: “This little child is so innocent, pure and good…You just made a mistake.” The limitations in her HeAd were exposed when I asked if she could forgive this child. She hesitated before pointing her finger at the child and said: “If you can promise me to never do it again.” When I succeeded in interrupting this harsh tone and intimidating body language to model a warmer and more comforting parental style, Alison aligned herself with me to reassure the VuCh that she had made a mistake common to most people. She even had sympathy for the child’s reflexive compulsion to obsessively tidy the house following the weekend incident. “You needn’t be ashamed of yourself, because everybody makes mistakes…and you are no different,” she said with loving warmth. I succeeded in helping her to see that mistakes were not only normal, but also provided the opportunity for valuable lessons. I reminded her of the incident when two strangers knocked on the front door posing as the neighbour’s gardeners, but then stole her purse. Although Alison’s

immediate impulse was to scold such "incompetence", she was quick to re-evaluate and appreciated a heathier perspective on that incident. Forming a stronger bond with the VuCh, she adamantly insisted: "This little child doesn't need a PuPa…and that if the ugly PuPa dares to come close to you, I am going to push it away." She reflected feeling "blessed" to have a husband who neither scolded nor judged her for the accident, and who constantly and unconditionally supported her. In closing, she was able to confidently say of the VuCh that "Mike has forgiven her and I [the HeAd] have forgiven her."

While the rapid flipping between PuPa and HeAd persisted throughout the chair work, this therapeutic technique managed to successfully prize these opposing forces apart and allowed me to guide the child closer to the warm and loving guardianship of the HeAd. I experienced some anxiety during the session, wondering whether I would manage to bind the HeAd/VuCh relationship before the session concluded. As thankful as I was that this task was achieved, I was reminded of the extensive pathway the VuCh still needed to negotiate before she would harness sufficient trust in the HeAd and not be easily influenced by the PuPa, who echoed both her mother's voice and the brutally penitential stance of her Catholic beliefs. The session succeeded in addressing the notion of "forgiveness", something that Alison had always unequivocally provided for others, including her parents, but which was proving excruciatingly difficult to grant herself due to the unique and harsh set of self-imposed rules with which she burdened herself.

6.4.12. Therapy Sessions 42 to 46

While Alison continued to make progress, she still experienced ambivalence about eating and struggled to accept the notion of maintaining a weight within her recommended GWR. There were the competing voices of conflicting modes and sometimes significant contamination of the HeAd. For example, in S42 she expressed her reluctance to continue consuming protein shakes on a regular basis, despite her dietician having repeatedly explained that she would need to do so due to her high metabolism, and the fact that Alison would justifiably struggle to consume significantly higher quantities of food if she did not take the protein shake supplement on a regular basis. Alison explained that she perceived the protein supplement as "medication" and that consuming them long-term would imply that she would never be able to relinquish the anorexic "sick role". Behind this concern, which came from a legitimate healthy voice wishing to permanently relinquish her eating disordered status, I detected the allure of the AnOv promising that she would remain "in control", provided Alison remained vigilant to her calorie intake. She, again, expressed her wish to consult less frequently with her dietician. While there was a plausible HeAd view that she had been consulting with Elliene long enough to warrant her making independent decisions about food, the real incentive to taper contact with the dietician emanated from the AnOv. Alison had frequently acknowledged Elliene's clear message that absolute compliance to the prescribed meal plan was required in order to ensure weight maintenance inside the GWR. However, she was insistent: "The meal plan should be adjusted [down] because I am of a reasonable and healthy weight." This was contrary to longstanding evidence that her

weight had remained very stable within the GWR on the full meal, and that each time she unilaterally decided to reduce her intake, it inevitably resulted in weight loss. When I asked her to reflect on the "physical stability in the little Child", she immediately reverted to an honest and healthy acknowledgement, responding to me with a concerned voice: "I am feeling very irresponsible. I haven't got the little Child on my mind at all. I'm, not ready to help her at all." She confirmed my enquiry that the HeAd felt disempowered, but still insisted that she was "absolutely in control", and wanted to "take charge" of her life and reduce her intake. Whilst a demanding voice insisted that "I can't be dependent forever on others to rescue me from the troubles I am in. I must be responsible and be out of all this mess", she quickly conceded that she was not ready to leave Elliene and knew that she still required her regular advice and guidance in order to not be tempted by the AnOv's agenda.

While activation of the AnOv served as a vigilant means to rigidly control weight, it also created the apparent notion of control in more subtle ways. Although Alison felt that her husband was fully entitled to the joy of their newly discovered sexual intimacy, a punitive voice deemed her "not commendable… and unentitled to be admired". She attempted to persuade me that she was "a worthless entity", and that she was not entitled to enjoy the newfound intimate pleasures, which she feared could escalate out of control towards a "slovenly, overindulgent existence". In fact, she rationalized that the only reason she engaged in sexual intimacy with Mike was because he deserved such pleasures. Such intimacy powerfully awakened the religiously influenced PuPa: "I should be on a penitential road that is strengthening in character and that makes me a worthwhile person." I invited Alison to bring this process into chair work, where she shifted with remarkable ease into the HeAd position to defiantly banish the PuPa: "I command you to shut up. You do not have the right to terrorize this pure and good little child… I am not going to allow you to put thoughts into her head which are cruel and malicious, and abhorrent." As boldly as she continued, there remained signs of contamination. For instance, while still sitting in the HeAd chair, the influence of a punitive voice could be heard in the child: "Even if I deserve it [abuse], Mike does not", while an introject of her mother was expressed in the comment: "You got to work for it, and not just get it", indicating that the VuCh was required to earn love, rather than being unconditionally entitled to it. Although I interrupted Alison when these intrusive parent voices appeared, I ensured that she was not too distracted from protecting the child with loving warmth from the HeAd chair. The session culminated in a confirmation from the HeAd that she was going to ensure that the dietician's meal plan was strictly adhered to.

As had been previously observed, in S43 the PuPa revealed itself to serve the purpose of ensuring that Alison was duly punished for her shortcomings. Where she had just finished reading "My Mother, My Self" (Friday, 1997), she was able to better appreciate the source of her emotional injuries lying in her mother's inability to love and protect her. However, when her son, Eric, told her earlier that week that he had just entered therapy, instead of trusting his explicit explanation that he was seeking professional guidance to re-evaluate his career path, Alison was convinced that he was shielding her from the real reason, that being "… the anger and rage that he had

bottled up" towards her for her failure as a parent. She acknowledged that her PuPa was relentlessly insisting that the VuCh be punished for hurting Eric psychologically and emotionally during the many years that she was anorexic. Alison insisted: "I followed in my mother's footsteps. While my mother over-controlled me, I was overly protective of Eric, never giving him a chance to be himself. I did everything for him, which must have been detrimental to him." When we more closely compared her own and her mother's parenting styles, she made a healthy acknowledgement that, although she overcompensated for her mother's neglect, she knew that she had always loved him "to the core of my heart". She readily saw that her years as an anorexic sufferer impacted negatively on all her relationships, but I cautioned her contemplation to ironically restrict her eating as a "penance" for failing in her duties as a mother. Luckily, her HeAd successfully stonewalled such temptation.

In S45 we worked, again, with the AnOv contamination of the HeAd and Alison's difficulty in differentiating these modes. She persistently tried to convince me that she would not lose weight if she were to exclude the supplementary protein shakes from her meal plan. Although she claimed she was speaking from her HeAd, chair work exposed this as a motive of the AnOv; not only to prevent possible weight gain, but to hopefully lose weight. I, again, reminded Alison of the nutritional information I had previously provided, explaining the rationale behind Elliene's need for Alison to remain compliant to the full meal plan, including regular supplementary nutritional shakes. At times when she did comply with her meal plan, it was often out of an obligation to meet her professional team's expectations. While this was a clear indication of the CoSu coping mode, there was also a healthy element in realising the importance of eating appropriately. But the Child was often left feeling vulnerable and exposed: "I think that I am afraid of taking on responsibility, and I think that as I get healthier, so I get more frightened of living up to certain standards that I am not capable of living up to. As a healthy person there are so many expectations of me that I can't reach and that I'll fall short of…I prefer the idea of being a little, weak child that needs to be mothered and protected, rather than living up to expectations." This demonstrated the significant fear residing in the VuCh that she was not capable of assuming responsibility for herself, as well as the demanding impact of her mother insisting that she aspire to levels that Alison felt were unattainable. Overwhelmed by the notion of adult responsibilities, it appeared to be a motive of the AnOv for her to "remain small and immature and not venture into adult activity", for which the consequence was that she remains immature. She made a comment that was reminiscent of her mother's cautionary voice: "Too much of a good thing is a bad thing," which required Alison to "be a good, pure little child" and not be contaminated by adult pleasures. Not only was her mother's voice cautioning her against sexual pleasure, but it also denounced the way in which Alison was "enjoying [everyday] life and doing all these adventurous things" on a daily basis. Meanwhile, the HeAd was adamant that it was non-negotiable that she "was not going to give up any sexual pleasures", and that she would not tolerate "a parent" chastising her sexually intimate relationship with her husband. Although not permanent, Alison was beginning to exchange the DePa voice with that of the HeAd that provided a more

valuable flexible control to ensure moderation and a balance between her daily responsibilities and the pleasurable activities that the child should be able to enjoy without feeling guilty.

Alison was very tempted to cancel S46 because she had anticipated that I would chastise her for the kilogram that she had lost due to some restrictive eating. Although she was stubbornly insisting that she was in HeAd mode, it was clear that her motive to exclude supplementary protein shakes reflected contamination from the AnOv. I was less invested in directly tackling the AnOv coping behaviour and maintained a focus on identifying the underlying feelings in the VuCh. Alison acknowledged the presence of the AvPr when she considered cancelling the session, then betrayed the contamination of the HeAd by the AnOv when she reluctantly admitted: "I do not have much regard for the little child at all. I have no space for the little child. I have just got to prove that I am a HeAd in absolute control." I turned to the space on the couch that was the place of the VuCh and acknowledged a frightened and abandoned little child sitting there. With detail, I recalled some of the dreadful experiences of neglect and abuse that she had had to endure at the hands of her parents. A deep sorrow spread across Alison's face as she witnessed my empathy for her VuCh. This made it easier for her to join me in engaging with her VuCh, as she said: "This little child is in a very poor state. She feels so uncared for, and so unloved, and so unprotected, and so she has got absolutely no one to turn to." As much as Alison acknowledged my protection of her "little child", she still dismissed my suggestion that she resume following the prescribed meal plan, trying to convince me that a small reduction would still serve the child adequately. While this illustrated the extent to which the HeAd was still significantly contaminated by the AnOv, she expressed concerns that Elliene was "only interested in weight gain". This was contrary to the evidence in which her dietician's prescribed meal plan had successfully maintained Alison's weight with minimal fluctuation inside her GWR for an extended period of time.

I, too, had repeatedly provided dietary education to reassure Alison that her prescribed meal plan was necessary in order for her to remain within a normal weight range. But now she argued that she needed to eat less in order to prevent continued weight gain. I realized that persisting with this argument would prove worthless. As I had done earlier in the session, I avoided confronting the AnOv and shifted focus to identifying the distress in the VuCh. While I wondered aloud what the VuCh might be feeling, Alison revealed that her child was feeling "absolutely abandoned, frightened, unloved, uncared for and deserted". She began speaking directly from the VuCh saying that she felt "absolutely alone", but then revealed evidence of AnOv contamination of the HeAd when she explained that her husband had insisted that she attend her therapy session, which made her feel that "he wasn't even on my side". I confronted Alison with the threat being imposed on the VuCh and reminded her of the necessary HeAd qualities needed to ensure the child felt protected and supported. AnOv contamination was evident as she continued to try and convince me that her plans to reduce the meal plan reflected adequate care for the child. As I challenged this, she took a deep breath, looked at me with anguish in her face to say: "Oh no, this is too complicated. I fail her [VuCh] time and time again. I'm the irresponsible, neglectful mother." I

recognized this to be her PuPa and commented that it sounded "a bit like her mother". Startled, she immediately switched back into HeAd, voicing that she was adamant that she does not repeat her mother's failings. Whilst she acknowledged that she had neglected to nurture the VuCh in what appeared to be a compassionate manner, there was another rapid switch into the AnOv: "But I was enjoying being in control. Yes, I enjoyed it, and I am going to continue to enjoy taking control of my life and my eating habits." The AnOv was back in charge. Alison became agitated and tearful when I pointed out her conflict between legitimately nurturing the "terrified" child and standing firm on the reduced meal plan in order to "feel in control". Alison continued speaking, giving voice now to a scolded child: "I feel like an absolute failure, and I've failed everything. I've failed my weight, I've failed the little child, I've failed Mike, and I've failed everything because I do not want to do the little child thing. It makes me too anxious." She felt deflated, perceiving me to be seeing her as "a hopeless failure as a HeAd". I calmly reassured her that I did not wish to judge her, but that it was my task to alert her to the fact that her HeAd was contaminated and, hence, incapable of effectively caring for the "little child". Relieved that I had no intention of scolding her and that my role was to encourage her HeAd to grow stronger and establish a trusting relationship with her frightened VuCh, Alison identified "a demanding and punitive parent being in the way" of her HeAd's ability to take proper care of the VuCh. She could hear her mother's distinct voice saying: "Don't indulge in these good things. You don't deserve them. Don't do this, and don't do that. If you indulge like this you are going to find yourself in trouble." Although there was further evidence of contamination in the HeAd as she again aspired to maintain rigid control, the session culminated in her appreciating my explanation of the importance of a sturdy, yet gentle control that the HeAd could provide to assure safety for the VuCh. Once she was genuinely realigned with the HeAd, Alison was able to speak reassuringly to the VuCh: "I am going to attempt, with all my strength, to protect and care for you, and to follow Elliene's advice because she knows exactly what I should do. And I know it too." With my guidance, she was able to reassure the VuCh that she would attend to all her needs, while drawing on the support of the loving and caring individuals in her life. Alison called me a few days later to report that she was managing to take impeccable care of the "little child" and that she had consistently adhered to her dietician's meal plan.

These sessions were a reminder of the extremely destructive and deeply entrenched influence of Alison's dysfunctional parent modes and the ease with which coping modes, most notably the AnOv, were activated to supposedly ease the abuse and pressure being imposed on the triggered VuCh. Chair work continued to demonstrate itself to be a highly effective means by which to clearly separate out the different modes and help both of us to see clearly the intricate interplay between such modes. With the AnOv being powerfully and regularly activated, Alison began to appreciate the depth of complexity in this prominent coping mode. It revealed itself as a mode that still successfully contaminated the HeAd to leave the Child with an illusion of control, whether superficially in food quantities and body weight, or as a means to maintain vigilance and not fall victim to a "slovenly" or complacent everyday existence. The AnOv further demonstrated itself to serve as a remedy when

the VuCh felt daunted by the prospect of adult responsibilities, or when she felt overwhelmed by the guilt and anxiety associated with assuming an adult sexual identity and lifestyle. Although Alison appeared to be more readily identifying her coping modes and was beginning to more assertively banish both her PuPa and DePa, there still remained a significant challenge in helping her effectively recognize when the HeAd was contaminated by her regular reversion to coping behaviours. She was beginning to conceptualize the notion that only once she could confidently sustain the HeAd position would she be able to experience a consistently safe and trusting relationship between a loving guardian and her "little Child".

6.4.13. Therapy Sessions 47 and 48

In these sessions Alison acknowledged how the persistently abusive treatment by her parents had resulted in her VuCh frequently feeling fearful, unworthy and defective. The AnCh was also triggered as specific and painful childhood memories surfaced. Her birthday in the preceding week was a significant trigger. As we explored it, she unearthed memories of the extent to which she felt herself to be both burdensome and unwanted by her mother. Opportunities were created for the VuCh to express herself and feel validated and to facilitate important healing processes as themes of her denied emotional expression, parentified role in her family, the shaming of her adolescent sexual development and the ferocity of her PuPa came into focus.

Alison opened S47 expressing a clearer understanding for the way in which her HeAd was contaminated by the AnOv the previous week. She felt compelled to apologize for what she described as "regrettable behaviour" and explained in a quiet, child-like voice, how she had had to "muster up so much courage" the previous week to tell me about her reduced intake while anticipating that I might judge and reject her for her non-compliance. I commended her healthy response of complying with the meal plan since the previous session which had led to her regaining the kilogram she had lost a week earlier. Not for the first time, Alison described how she held a conversation between her HeAd and her VuCh while alone at home which, this time, brought her to tears as she more fully realised the predicament she had created for the VuCh. She recalled aspects of the healing conversation: "I [HeAd] told her [VuCh] that she can trust me, that I will care for her, that I will nourish her, that I will be there for her emotional needs and if she felt like crying, she could cry. We both cried. I had to nurse the little child because she was upset." Although Alison was relatively comfortable being tearful in the privacy of her home, it did not feel permissible in my company. "Oh no, I am not going to allow myself to cry now. That, I don't allow," she said, wiping away the start of tears as she yielded to the influence of her mother's suppressing voice that prohibited all emotional expression. With the voice of an anxious child, she said: "I must keep my emotions under control, especially here, where I have immense difficulty preventing myself from crying. I don't want to do it, and I'm not going to do it." Alison told me how her mother's harsh condemning voice "tells me that I am a weak character and that I am not worth much if I just cry and take self-pity. Self-pity is not to be indulged in. These tears are deplorable." Although Alison accepted and even admired her husband's capacity for deep emotional

expression, including being tearful, she still felt compelled to unquestionably obey her mother's strict instructions. However, she then told me that she became "tearful from the child" following a telephone conversation we had the day after her previous session in which I reassured her that I would not condemn or reject her if she still struggled to conform to the expected meal plan. In contrast to her mother's judgmental and punishing manner, my unconditional support brought tearful relief to the child, enabling her to more easily resume her full meal plan and engage in loving compassion with her VuCh: "This dear little child is not to be punished and deprived; and I do not want this little child to be frightened of punishment anymore."

Alison's tears dried up as she began rationalizing: "I should have had the backbone to stand up for myself and faced my mother when I was seven years old." I reminded her that neither she nor any other seven-year-old should ever be expected to assert themselves in the face of such a mother, and that this was the very reason she developed coping behaviours in order to survive an environment from which she could not escape. Conflict was never resolved. She remembered, for instance, her mother's "silent treatment", where days would pass without a word being spoken between them, and she recalled how guilty and anxious she felt during such silences; always ready to subjugate her own needs in an attempt to break the silent tension between them. Alison said that she never rebelled as a teenager. She had only recently recognized that she "buried" her own feelings, made numerous sacrifices, and subjugated her own needs because she felt responsible for minimizing conflict in the family to keep it stable. This followed from believing she must take her mother's place in the family: "Thirty years ago I thought that I had to be my mother. When she passed away, some of her clothing she wore I thought I should wear. I didn't get round to it, but it is what I thought I should do… to help keep my family connected… I had to control the family and not let them go out of line. I had to be the guiding light and be there for them to come to me for support." As she saw this, she felt angry with her mother both for giving her inappropriate adult responsibilities while still a child and for shaming her emerging sexuality. With conviction she said of her mother: "She made me feel ashamed of growing up and developing! She made me feel quite unsightly. I had to hide myself!" This angry response from the AnCh recognized her mother's abusive nature: "Oh no, that's not acceptable. That's wicked!" As the session continued, she realized that she had already begun dismantling the introjection of her mother's distorted prejudice, stating that she was beginning to feel more convinced by and accepting of her husband's recent remarks that he found her body desirable.

Alison began S48 expressing gratitude for the phone call she received from me on her birthday a few days earlier. However, she described profound discomfort with the attention she received from others on that day. She cringed with each birthday wish and act of generosity she received, describing herself feeling like "a little child that feels unworthy and undeserving". Although she was brought visibly close to tears, overwhelmed and unfamiliar with the abundance of kindness she was experiencing and thankful to her well-wishers, her VuCh wanted to tell people: "Don't say this; I don't deserve this telephone call. I don't deserve anything." Her voice trembled as she

recalled an arrangement of flowers being delivered to her home: "It's a terrible burden. I can't joyfully accept a bunch of flowers. I want to cry about it." With excruciating pain in her voice, she acknowledged this to be "a very painful little girl that doesn't deserve the kindness shown to her. She isn't worthy of it. I have to have something to offer to feel worthy to accept this kindness. I have to warrant it, but there is nothing in my character that warrants it." She noticed that even her hand-written cards of gratitude for her gifts expressed this sense of "unworthiness". Alison could hear her mother's demanding voice: "I could not put a foot out of line. I had to be the perfect little girl. And in adult company, I just had to shut up and just be there [inconspicuously]." Having voiced this, Alison spontaneously shifted into HeAd, saying, "That is wrong, that is wrong. It is stifling. It kills you!" She realised that she had never felt safe in her childhood "living in a perpetual state of fear from morning to evening" which was exacerbated by anticipation of her father arriving home in an intoxicated state.

As Alison recalled her father's embarrassing behaviour and her mother's unpredictably impulsive and scolding manner, her facial expression creased in anguish and her eyes shut tight with agony. Although I expressed my deep sympathy for the suffering that the little child experienced at the hands of her parents, I was unable to silence the PuPa. She connected with a memory of when she was about 8 years old and feeling displaced, never having "a place in the house" and being utterly alone without a personal voice. Alison could see now how, as a child, she had created a protective haven for herself in which she experienced "a state of invisibility in order to keep out all the cruelty" surrounding her. Alison soon came to recognise that this coping behaviour was subsequently replaced by another coping mode – the AnOv – which served a similar purpose of protecting her from the fears of rejection and the unbearable pain she experienced throughout her life.

At this point I initiated chair work. As she expressed her mother's message to her VuCh saying that she was "an absolute burden, a nuisance… and unwanted", it was clear to her how this was echoed by the PuPa, who bellowed from across the room at the little eight-year-old child: "You do not deserve…love, care, and attention." Of course, this was in stark contrast to the idealised view that Alison had given me early in her therapy that her parents were delighted with their baby daughter. From the HeAd chair, Alison was initially reluctant to engage with what the VuCh alongside her was feeling. However, she was eventually able to engage with a Child that must have felt "anxious, embarrassed, unloved…and excluded". Standing alongside Alison, I offered the VuCh the comforting support she needed. This had the effect of enabling Alison to accompany me in engaging directly with the VuCh in a surprisingly authentic manner. I deliberately made emphasis in my reference to the importance of the child requiring "healthy nourishment" as I wanted her to be reminded that her meal plan was a very important component of care for the child.

These sessions reiterated for Alison the recognition that the PuPa was largely the voice of her mother. Her birthday brought to the fore memories of the extent to which her mother had not only failed to provide any loving warmth or attention to her daughter's life, but also reminded her of the severity of neglect and shame the Child

felt at being unwanted, unwelcome, and unentitled to a personal identity. It had become clear how Alison had coped with this cold, unloving and punitive maternal figure through an overcompensatory "Protector Child" coping mode early in her life, and how later the AnOv served to further insulate her from the shame and fearful existence she experienced as she entered puberty. I felt optimistic observing Alison venturing closer to the truth of her childhood experiences. Not only was she recalling more painful childhood memories and openly expressing a broad spectrum of uncomfortable emotions related to them, but she was also, from her HeAd, developing empathy and compassion for the predicament and experience of this VuCh that had remained suppressed for decades.

6.4.14. Therapy Session 49

In this session I helped Alison see how she could put her new awareness of her modes to work in dealing with an everyday situation at home assertively (from the HeAd) rather than getting caught up in dysfunctional coping behaviour that masked the VuCh's anxiety. I initiated role play to help her explore and refine new and healthy ways of identifying her needs and getting them met both in the present situation as well as similar situations in the future.

Alison opened the session deliberating whether this particular issue was worthy of discussion, but I encouraged her to do so. Her son, Eric, had given her an electronic reading tablet for her birthday. She expressed healthy gratitude towards Eric for his generous gift, even describing it as "a masterpiece of a gift" due to her love for reading. However, such gratitude was overshadowed by the intense anxiety associated with her fear of not being able to operate unfamiliar modern technology. "I do not know how to work these modern contraptions," she said, explaining: "I'm too old for this. These are the kind of things that only you young people can work. Oh goodness, I'm way too old for this kind of thing. It's beyond me, I'm so intimidated and so nervous when I hold this Kindle® in my hand. It's in control of me. I don't even know how to move the pages," she said in a high-pitched and tremoring voice. "Graham, I'm old-fashioned and I can't help that… and I have no desire to operate this modern, sophisticated technology," she rationalized, trying to convince me that it would be best to avoid this challenge. This was despite her husband having successfully shown her a week earlier how to operate a cell phone in order for them to have better access to each other in case of an emergency. However, she felt this to be a far more overwhelming challenge. I normalized the anxiety that many of her generation typically felt for such unfamiliar technology but saw this as an excellent opportunity to address anxiety that was unrelated to anything eating disordered.

Alison's son was planning to visit her later that afternoon for the purpose of demonstrating how the Kindle® worked, so I suggested that we use role play to explore healthy ways to deal with the situation. She described herself as "anxious and frightened of this monstrosity", and wanted to convince her son to take the device away and spare her the humiliation of exposing her incompetence. I was able to reframe and normalize her anxiety as a

normal response to the unfamiliarity of the situation. I modelled a healthier approach that Alison could take, expressing gratitude for the excellent choice of gift, and being open and honest in acknowledging the anxiety associated with facing something novel. I demonstrated how she could communicate to her son how she needed him to be patient and explain the workings of the device slowly using simple language. Thereafter, I invited Alison to speak to me, where I assumed the role of Eric. She said: "Eric, I am most grateful and thankful for your generous gift, but I have to tell you that I was feeling so terribly anxious and frightened by this contraption device when I first opened it. I just placed the box in the cupboard, and I was concerned to just give it back to you. But now please listen to me. I am most grateful. You know that. But I have been very anxious about how to work this device. I would very much love to keep it, but I ask of you very kindly if you would be very patient with your mother here. I am anxious that you will need to be very gentle and slow in the way you explain each little step to me. I know that you have always been marvellously patient with me, but I will need to let you know the soonest I do not feel that I understand what you are explaining to me. Would you be alright with that?" When we reflected on her experience of the role-play, Alison was able to say: "I am going to do this Kindle® at my own pace. I am going to do it slowly, and I am going to do it very well." Recognising that this was an important development for the VuCh, she said: "The little child is going to get pleasure from it." I was immensely proud of Alison's capability, and reminded her that she experienced similar anxiety a year earlier when she embarked on her weight restoration, only to discover that the catastrophes she feared did not manifest. She left in a buoyant mood with a new outlook towards her son's gift. At the start of her next session, Alison excitedly described her new morning routine of rising an hour earlier than usual so as to sneak in some reading time on her new device before breakfast.

The session demonstrated the crippling impact that Alison's anticipatory anxiety played and how it denied her pursuing truly authentic needs throughout her life. Exploring the process associated with receiving the birthday gift from Eric provided her with an excellent opportunity to continue cultivating robust strength in her HeAd for the purpose of meeting the child's needs. Developing this guardianship continued to be a central process in Alison's therapy; something that was necessary in order for the child to feel more liberated and capable of expressing herself with confidence. While the activation of coping behaviour would have clouded Alison's ability to be authentic, the role-play exercise succeeded in instilling the confidence necessary to address the specific challenge in a healthy and assertive manner when her son visited her later that afternoon. However, this basic CBT intervention would have been less likely to succeed had Alison not already engaged in mode work to cultivate a sturdier HeAd, and engage with and begun healing the VuCh. It would, thus, seem useful for Alison to continue to confront other fearful circumstances across a wider range of concerns, including her ED and the deeper levels of intimacy in both her marriage and her other close relationships.

6.4.15. Therapy Session 51

Alison continued to eat consistently well and expressed it being unnecessary to talk about food or weight. Given that she did not bring any specific issues to the session, I suggested that we explore her anger for her parents more closely, given that she was still very invested in avoiding all conflict situations. Although she knew it to be a necessary topic to address, she remained reluctant to broach it due to the emotional inhibition rooted in the many threatening messages she received from her mother that were now residing as an introject in the DePa. My challenge was to encourage Alison's emotional expression, thus permitting her to feel safe to express her anger and be tearful when she was flooded by the pain and suffering caused by her parents' abuse and neglect. Where chair work had already proven a useful avenue by which to deepen Alison's tolerance for healthy and legitimate expression of difficult emotions, I continued to use this technique to help her gain access to numerous early childhood memories and experience the emotion associated with her many EMSs.

Alison was able to identify it as an "unhealthy" voice forbidding her from expressing anger towards her parents. With an unsteady, but healthy voice, she was able to say: "I should be in touch with that anger which I feel so much. When I leave these sessions, I am beside myself when I sit down at my desk [at home] and I so much regret not crying, because I am so angry." Then she flipped in an attempt to vindicate her parents' actions by saying: "I have to take that little child home and absolutely reassure it that I'm looking after her and that she has got parents that care about her. They did the best they could under their circumstances." She continued rationalising, determined that her mother "did a fine job with what was available to her, didn't shirk her responsibilities and took on her responsibilities very, very aptly for what she thought was the best for her children". I immediately challenged this idealised and split view of her mother, reminding her that I was not interested in judging her mother, but concerned with the impact her actions had on "little Alison". When she realised that I was not going to align myself with her outlook, she quickly reverted to an honest, realistic and more appropriate view, saying: "My mother was hopeless in letting me grow up. She just kept me as a child and she made me feel that growing up was something unsightly, bodily." When she realised how her mother dissuaded her physical development, Alison clearly recognized how her self-imposed restrictive eating from her mid-twenties served as an attempt to mask her womanly body and, hence, alleviate the emotional pain associated with her mother's frequently shaming stance. Alison further realised that the effect of her restrictive eating echoed her mother's religious ideals when she said: "She led me to believe the only right way of life is a penitential way of life, and that suited me being in anorexia. And that suited punishing myself. Although my mother wanted me to overcome the illness, I actually thought I was pleasing her in my diminishing state." While she realised that she had wrongly pursued her mother's approval through self-sacrifice and the subjugation of her own needs, Alison was now clearly beginning to appreciate a new and healthy perspective that contrasted dramatically with the oppressive lifestyle she had led for

most of her life: “No one is going to interfere with this intimacy in my marriage that I am so enjoying. In the eyes of God, it is what it is meant to be.”

While most of the discussion centred on Alison’s abusive mother, it was important not to omit the impact of her father’s influence. As a child, she remembered “being on edge every day, waiting and not knowing how he would come home each night” from excessive drinking. She described the terror of anticipating his often unpredictable and unruly behaviour. This deepening appreciation for the way in which she was emotionally abused by her parents throughout her childhood paved the way for some powerful chair work. I invited her into the HeAd chair to reflect on the child’s predicament rather than place her in the child’s chair from where it would have likely been far more difficult to elicit the thoughts and feelings residing in the child. I asked Alison to face the space between us on the couch reserved for the child and encouraged her to repeat my words: “It’s not fair what you were put through in your childhood.” As she cautiously attempted to voice these words, her face filled with sorrow: “I’m on the verge of crying and I am not going to do it. I’m just not going to cry these angry feelings. I am not going to be weak and I am going to be in control.” Just as the VuCh was being triggered by memories of her painful past, so the demanding voice of her mother intruded to suppress her emotional expression. This elicited coping behaviour in order to re-establish a sense of control, which was best illustrated when she said: “I am not going to cry. I don’t even want to hear my voice, and I don’t want this therapy.” She explained that she was attending a funeral immediately after the session and that she wanted to appear composed when she left my office. When she added that tears were only appropriate for the grieving, I shared my thoughts that we were, in fact, grieving for a child who had lost an entire childhood and adolescence. Although Alison knowingly nodded in agreement, she then, very interestingly, said: “I’d rather talk about food and weight.” She was shocked to realize how reflexively she had suddenly awakened her AnOv. I did not enter this line of thought but invited her to occupy the DePa chair to insist that the child continue suppressing her tears; not to advocate this parent mode, but to amplify it for the purpose of exploring its character within her mode constellation. She declined my invitation, saying: “Oh no, I am not going to do that because it is absolutely cruel to tell that little child not to cry. I will not be cruel.” It appeared that the palpable quality of the modes brought out through chair work had sufficiently exposed the harsh quality of the DePa, forcing Alison to re-evaluate its existence. Continuing to engage with the child from the HeAd chair, she tried to encourage her that it was safe to be tearful. She was warm and compassionate in her engagement with the child, managing to reassure her that she had always been innocent and was deserving of loving parents. I reinforced what Alison conveyed by reassuring the child myself that she deserved abundant loving care in the wake of such a neglected and deeply traumatised childhood.

Still cautious to express her anger, Alison reverted to defending her parents and insisted they not be blamed for their parenting styles. When I reminded her, again, that our priority was to validate the child’s experiences, it provided the necessary relief and convinced her to confront her parents on their shortcomings. Still seated in the

HeAd chair, she began describing various early childhood experiences that explained the origin of her numerous EMSs. While recounting these in a voice of tight anguish, she expressed being deprived of an identity (social isolation/alienation) and that the "little child felt unloved (emotional deprivation), unwanted and unneeded (abandonment.)". She elaborated, stating how the child was feeling: "She's unheard of, she's a non-identity, she feels like garbage, a nuisance, and in the way (defectiveness). That's what that little child was for my mother and my father. It's very important to feel that you are somebody." And while she was pressurised to be "perfect" (unrelenting standards), she was discouraged from pursuing her chosen career in teaching and left to feel inadequate and incapable of achieving autonomy (incompetence/dependence). Alison described the fear associated with the unpredictability of her father's behaviour due to his frequently intoxicated state, which resulted in her suppressing all emotional expression (emotional inhibition) for fear of his unpredictable responses. As she explained to the child: "Just imagine all that rage being shut up in you. That's dreadful. It's very unhealthy to have all that rage in you, and if you show it, any sign of anger, you are sent to your room to stay there until it is time to come out." She described a vivid memory of being frequently shut alone in her room and suppressing her preferences while her mother instructed which toys she should play with (subjugation of needs). This first instance in which Alison described "rage" for her parents was significant, especially while she was still often struggling to just acknowledge the child's anger. Overwhelmed by emotion at this point, she became quiet and expressed a wish to disengage from the child by no longer talking to her. However, I persisted in maintaining contact with the deprived child as we reflected on the many circumstances of grave misfortune the little child experienced throughout her life. While I documented in the therapy notes the numerous EMSs that developed as a result of her childhood experiences with both parents, I maintained my engagement with Alison at an emotional level, reflecting the feelings that she was carrying throughout her dreadfully abused and neglected childhood.

I succeeded in convincing Alison to remain in the HeAd chair, from where she was able to restore a sturdy connection with the VuCh. Softly spoken, she said: "I want you to know that no matter what your mother or your father said or did, it was not a reflection on you. You were not at fault. You were an innocent little child growing up and trying to do the right thing, but you were being bullied and pressurised by a mother and a father." Alison briefly shifted her attention towards her parents to reprimand them: "You couldn't hug that little child," before re-focusing on the child to say: "You couldn't go to your mother and hug her. It was not allowed. That is what it was; not allowed. It was a bad thing." Not only was Alison revealing the extent to which the VuCh was emotionally deprived, but her voice became more animated as she recalled further evidence of her parents' failure: "They showed you that you were weak and that you were not in control. You shouldn't need all these hugs. Your mother just didn't believe in it." I enquired with Alison what she felt for the little child sitting beside her. With her voice quivering, she was able to reflect: "Oh, I feel it. It is so painful. It's unbearable. It's just so unfair to do that to an innocent little child that meant no harm to anybody and didn't mean to be in the way of anybody." So deep was Alison's empathic engagement with her VuCh that she, once again, broached the edge of her narrow window

of tolerance to say: "Graham, I'm not doing this. I am not doing this therapy. It makes me feel very fragile and near to tears, and I am not going to cry." She identified the tears coming from the "little child", but then rationalized that the tears should have been shed when she was still a young child, and that it was now too late. Despite her best efforts to suppress her tears, Alison began crying softly for the "little child". While I made every effort to help her sustain her emotionally fragile state, she acknowledged: "This is still a child that does not feel worthy of any good things that come her way." She expressed that the little child "wholeheartedly" deserved love, while at the same time realising that she had, for too long, held back from receiving her husband's unconditional love. While Alison realised the extent to which she had suppressed and avoided the loving exchange in her marriage and bridged this to the deprivation imposed on "little Alison" more than six decades earlier, she began to appreciate the enormity of her loss of love and intimacy throughout her lifetime. Overwhelmed by this, she briefly cried more freely for the first time in many sessions. Not even the threatening voice of the DePa or her fear of a loss of control could abate the authentic emotional release from this fragile child. We sat quietly for a short moment before Alison broke the silence in a soft voice: "That little child should just be crying for days on end because she is so hurt [pause] and angry."

Still sitting in the HeAd chair, Alison composed herself and then acknowledged: "That anger is still so real." But she then added: "I have not been able to rid myself of it." I did not clarify with her whether this latter comment pertained to her urge to suppress her anger, or whether she was merely referring to the unresolved status of her anger. I still encouraged her to engage more deeply with the anger, reminding her of some of the terrible abuse inflicted upon her by her parents. Without my instruction, she turned to the child's chair and engaged in a deeply authentic soliloquy: "You are absolutely correct in feeling angry. I understand your anger and your sadness, and fear, and terror, and everything that made you such a nervous and timid child. I understand why you were such a lonely child because you had to just look after yourself. You didn't have any protection from either of your parents. You were horribly neglected." When I prompted her to say that the child "deserved so much love", she hesitated to say to me that she did not like the word "deserved". However, as I persisted in conveying the deservedness of love to the Child myself, she immediately realigned her healthy side with me, saying to her: "It's grossly unfair that you should have been made to be suffering all those horrible, unkind, unloving feelings. Day after day you had to suffer them, and you weren't allowed to speak about them. That was very, very cruel. I am going to now provide you with whatever you need. I'm going to give you all the love and all the attention, and all the nurturing you need. Your parents didn't know what you needed, but I know what you need. I am going to help you to feel safe. I love you unconditionally."

Chair work continued to provide Alison with an opportunity to engage, albeit cautiously, in a more open and honest way with the child's emotional experiences. Although I had hoped that she would engage more readily from the VuCh and AnCh, it was necessary to proceed cautiously, given the narrow window of tolerance for the

outward expression of such emotion. Even though she continued providing a genuinely unconditional love and protection for the child from the HeAd, this did not cease the child's apprehension to express tears and anger. This session reiterated the significant work that lay ahead in both easing the stranglehold that the DePa held in prohibiting the child's outward expression of anguish, and instilling trust in the child to feel safe and sufficiently contained to express herself, whether tearfully or in expressing her anger and rage.

While Alison's weight continued to remain comfortably stable within the GWR, the session provided insight into the original motive of the AnOv to protect the child from her mother shaming her developing body, and to signify her adherence to the pious culture instilled by her mother. This provided vital evidence to the fact that Alison's ED did not simply reflect superficially physical concerns but operated as a deeply complex process that served to protect the child from directly experiencing insatiable anguish associated with an over-identification with her mother's own prejudice.

6.4.16. Therapy Session 54

In this session, chair work served as a platform for Alison's most significant expression of anger yet. Rather than challenging her PuPa and DePa, she directly confronted her parents as numerous childhood memories of neglect and negligence flooded to the surface. The challenge for me was to help her sustain contact with the intense emotions in the child, and not flip out into coping behaviour that quelled such emotion.

In the preceding two sessions the HeAd demonstrated an increased capacity to tolerate the pain and anguish residing in the child, while also providing a deep and genuine love for her. On one occasion, while holding her VuCh (represented by a cushion) in her arms, Alison groaned in loving tenderness for the fragile little child who she now felt fully deserving of her unconditional love and attention. While she made some references to the dissatisfaction with her new body shape and occasionally bargained against the necessity to comply with the full meal plan, those issues became peripheral as the legitimate source of her anger surfaced. Her unwillingness to be tearful (reflecting deeply entrenched avoidant coping behaviour) continued to distract her from exhibiting the emerging anger. These sessions signified the challenge that lay ahead in marginalising such behaviour so as to provide safety for Alison to express the intense anger residing in the AnCh.

Alison opened this session describing a defiance with which she deviated slightly from her meal plan, even noting that her dietician had commented in their session earlier that week that she appeared to engage like "an angry child". What was most notable was her clear insight into the true motive behind her AnOv behaviour. She admitted that her growing anger was not food and weight-related, but that the previous sessions (S51 to S53) had brought her into more direct contact with the anger she felt towards her parents. She acknowledged there being "a very, very, angry child in me" that both she and the dietician realised a few days earlier was not angry about the food, but about "things that happened in the past". In a high-pitched and unsteady voice, she said: "I have to

absolutely reprimand them; I'm speechless; I don't know how to explain the anger I feel towards them." She was reluctant to confront her father, rationalising that "he was non-existent and not worth talking about". I maintained the focus on him because Alison had not yet expressed much anger towards her father. I recalled some of the many ways that his abusive and embarrassing drunken behaviour left "little Alison" tense each evening, anxiously anticipating the state in which he would return home late at night. I placed Alison's father on the couch opposite her and invited her to confront him. Close to tears, she uttered: "You are a selfish father, a selfish husband, and you are an unpredictable hindrance in every one of our lives." Despite her becoming distracted by her emerging tears, I encouraged her to continue: "You were shocking! Every day of my life I was scared to see what condition you were going to be in that night, and I had to keep my friends away from you. I couldn't enjoy playing because I was too conscious of saving my friends from any embarrassment coming from you. You were an appalling embarrassment, and you were a shocking father. You must get the Hell out of here! You have no right to be near me. Even after your death you still plague me because I have such dreadful memories of you. I have no respect and no regard for you whatsoever." There was now a sudden flip into PuPa that evoked her VuCh as she said: "I'm not a worthy daughter." Not to be distracted by this, I continued to confront her father myself, which had the effect of restoring Alison's connection with her AnCh. "You are a piece of rubbish. I am going to get rid you once and for all; banish you, absolutely get you out of my life," she said to her father with renewed vigour. Still tearful, Alison reflected on the moments when her intoxicated father urged her to sit on his lap to provide affection. Even as a young child she intuitively knew it was "phoney", alcohol-induced behaviour and not genuine parental love. During such times she recalled that he "smelt awful" and that "it was like getting contaminated by him". In response to my suggestion that she "get rid of him" she walked across to the other couch to grab a cushion that represented him, punching it repeatedly and shouted: "You are absolutely a load of rubbish! I will not tolerate your behaviour!" While saying: "You have no place in this home," she threw the cushion out of the room.

Overwhelmed and visibly exhausted, Alison slumped back in her couch to reflect on what had just transpired. There was a guilt-inducing voice about expressing her anger, so she attempted to diminish her good work by rationalising that it was "ridiculous" speaking in this way of a "deceased man". However, I calmly reminded her that the potent work that she had just done was irrefutable evidence of a longstanding wound that had been opened. I commended her on her courage and honesty in expressing the pain of a little child whose feelings had been supressed for decades. The chair work helped Alison stay in the present and reflect the raw honesty residing in the child, while her tearfulness was only a temporary disruption as she sustained her focus in ultimately banishing her father. As our discussion continued, sadness emerged from behind the anger. "He never, never gave me happiness," she said, adding with disgust that, "his whole being was distasteful." She revealed evidence of early avoidance coping behaviour in which she hid from her father: "I used to be especially quiet in my bedroom

so that he would not know that I was there." I empathised with her predicament and explained how no little child should ever have to live with such anguish.

Having banished her father, Alison's focus turned to her mother. Although there was some legitimacy in her comment that her mother deserved compassion for her own hard life, my priority was for her to appreciate the abuse and neglect that she experienced throughout her childhood. She realised the responsibility she held for the child and shouted at her mother from the HeAd chair: "You failed this child!" She boldly accused her mother of being unapproachable and never encouraging her to have her own, independent voice, while displays of anguish were scolded and forbidden in the public eye. Alison never experienced any praise or encouragement from her mother and always sensed that she was a disappointment to her mother for never living up to her strict and demanding standards. She felt perpetually shamed in the face of such severe emotional deprivation. With the voice of a despairing child, she faced her mother in the opposite couch to say: "You were cold and unreachable, and I craved you hugging me, but you didn't do it because you thought that was weak character. I never felt that I could hug you either." Despite continued rationalization that her mother's shortcomings were "unintentional", Alison was able to restore a healthy voice and say to her: "You callously dumped all your injury and failings and all that rubbish on this innocent, little child. It was selfish of you. You made our home feel like a prison and you made us [including her brothers] follow rules and restrictions that were unrealistic. And you enjoyed the praise that you got for having such well-behaved children, but they weren't really like children; they were puppets on a string. They weren't little children enjoying life." Whilst punching a second cushion, Alison reprimanded her mother one final time before throwing it out of the room, just as she had done with her father. She was visibly overwhelmed and exhausted by the experience as she slumped back into her couch. I calmly summarised what she had courageously achieved and reassured her that she had expressed a very legitimate and healthy anger both from the protective parent and from the child.

In the remaining chair work of the session, I facilitated the HeAd in acknowledging the child's lifelong abuse and neglect. The HeAd empathized with "little Alison" for the pretence that the child and her brothers were expected to maintain as they "were dragged through a lie" in order to maintain the veneer of a normal and functional family life. "It is appalling that you had to pretend that you were living this lie to all of your friends, and not even be allowed to talk to them about what was happening," she said.

This clear expression of anger towards her parents was a big step for Alison. These feelings, suppressed for decades behind coping behaviour, were embedded in vivid childhood memories she was not able to access. Chair work continued to provide a context within which she was able to safely express condemnation directly from her AnCh in a manner more potent than previously. So far, Alison's memories of her father had not been prominent in the treatment. Now the traumatic impact of his alcohol abuse on Alison was becoming apparent and she was

acknowledging the significance of these experiences in her childhood and the damage this inflicted on her development.

6.4.17. Therapy Session 56

With Alison's consent, I invited her husband to join this session because I could see by his demeanour in the waiting room that he was deeply grieving his sister's death earlier that week. In a previous conjoint session I had experienced Mike's warm and trusting nature, where he comfortably shed tears of joy as we spoke about the new and loving intimacy that he and his wife were experiencing in the face of her steady recovery. This time, Alison empathically consoled her slightly tearful and grieving husband. Soon, however, he left to attend to some phone calls and Alison's comments at this point disclosed ongoing conflicts between her HeAd, PuPa, AnOv and VuCh. I used chair work to differentiate the qualities in each mode and how they contributed to her ongoing problems.

When Mike left, Alison unexpectedly expressed being "such an encumbrance in his life" due to the 700g she had lost that week. Besides feeling ashamed, it was appropriate for Alison to be concerned as to how this might distract her husband from his grieving process. "I absolutely have to be a HeAd for Mike," she insisted, but then revealed contamination in her HeAd as evidence of the AnOv emerged: "Now, Graham, you cannot label me as an AnOv as I absolutely have to be a HeAd for Mike and I have to maintain my weight. But I am not going to gain. I am not going to regain my weight!" Standing firm, she began rationalising: "I am going to maintain it [her weight] as a HeAd." While she clearly refused to acknowledge the presence of her AnOv, she continued rationalising that her reduced intake was a justifiable consequence of the considerable time she had been required to solely attend to her grieving husband. I articulated my observation that it was ironic that her husband's distress at her weight loss was being accounted for as a result of her support during his grieving process. She ignored this comment and blindly continued bargaining with me to endorse her reduced intake as "healthy". To expose the contamination, I used a paradoxical intervention. I asked Alison to sit in the HeAd chair and instructed her to echo my words to the child: "Look, just for the moment I am not going to give you your full meal plan." After silently contemplating this, she faced me to say: "No, no, no, I can't do that," realising that this would leave the child, by her own admission, feeling "abandoned, very lonely, and on her own." She acknowledged the contamination and realised the ease with which her AnOv could cloud the HeAd position.

Despite declaring that her HeAd "will never abandon the child like that again", Alison was prepared to "leave this little child out in the cold". She flagrantly admitted that it was permissible for her to keep her inadequate intake secret from her husband, the dietician, and me in order to sustain feeling "more in control". Without judgement, I insisted that she leave the HeAd chair. When I blocked further attempts to try and portray her restrictive eating as "healthy enough", she rapidly flipped into the PuPa and began condemning herself saying: "a despicable character… and unworthy of the good husband." Alison then resumed rationalising that it was acceptable that "the child be just left a bit in the background… who was a little bit in the way". When I responded by asserting that

I, alone, would "look after the little child", she flipped back into the PuPa, more vociferous than ever to say: "There is a certain amount of punishment that I have to put on myself for being an unworthy wife, and the child cannot be my priority." Still unaware that I had physically ushered her out of the HeAd chair and into the one reserved for the dysfunctional parent modes, she pointed across the room and spat: "This child needs to be punished at times! Be punished! Be punished! You are not worthy of any love." Dismissive of the child, she continued: "You are undeserving of love, you are in the way and you are an absolute hindrance. You need to disappear, you take up space, you are just a nobody, and you are not wanted." Although she was physically exhausted by her outburst, I suggested that she throw the cushion representing the VuCh out of the room. I had, again, used paradoxical intervention, which had the effect of flipping her quickly back into the HeAd mode, repeatedly exclaimed: "No, no, no, no, no!" and apologetically asked for another opportunity to make amends with the child. I was relieved that Alison initiated this positive shift without my prompting and welcomed her return to the HeAd chair. I empathised with the "frightened and abandoned little child", reassuring her that she was loved and cared for. Alison was equally empathic and apologetic, reminding the child of her love by saying: "You have a special place in her heart where no one will be able to get to you and harm you." With deep authenticity, she continued to reassure the child that it would be safe to both feel and express herself outwardly, including being tearful. Still in the HeAd, Alison said: "This little child was starved of affection and all that love." Beginning to cry, she reflected on the unfair plight of the child. Although she, expectedly, became self-conscious of the tears, I was able to sustain her focus on the VuCh, where she continued speaking to me with deep compassion: "I feel so sad, so sad for her. It was unfair what she was put through. She was starved of affection and safety and a feeling of being wanted. You know, she felt a nuisance, but that is not right." Without prompting, she then turned to the VuCh to make reparation: "And I am not going to let you feel like that anymore… and I am going to nourish you." For the remainder of the session, Alison and I discussed some practical ways in which to maintain stability in her daily life. She suggested that she make more frequent use of her flashcards, while I reminded her that her meal served as a clear guideline for the purpose of maintaining consistently good nourishment.

This session illustrated the still deeply entrenched and easily activated state of Alison's PuPa and the automaticity with which the AnOv masqueraded as the HeAd. The PuPa and AnOv are activated in an attempt to ease the distress being experienced by the VuCh. During the chair work, Alison was better able to identify the various modes, and became more adept at recognizing when she rapidly flipped between modes. Most importantly, she was able to identify when her HeAd was contaminated by the AnOv. The extent of the destructive nature of the PuPa's lambasting of the VuCh was completely exposed, with a paradoxical intervention encouraging Alison to confront her continued endorsement of the PuPa. Once she had neutralised this destructive parent mode, she was able to empathize with the VuCh from the HeAd's vantage point to thoroughly appreciate the pain experienced by the child for decades. My active participation in the chair work facilitated the building of a collaborative therapeutic alliance. It served as a creatively effective and emotionally contained space within which

I was able to actively assist Alison in developing her HeAd for the purpose of banishing the PuPa and to nurture the VuCh. This forum also served as an emotionally safe space within which to provide limited reparenting, something which Alison could model in order to instil trust in the VuCh as we continued to work through the healing process.

6.4.18. Therapy Session 59

This session demonstrated the importance of making the distinction between different sources of anger. Alison entered the session being very angry with the team. Where a similar situation had occurred a year earlier (S12), her anger then pertained to the team requiring her to strictly adhere to the prescribed meal plan, despite her fears of weight gain. Although the anger was not contextually justified, affect bridging did trace the anger back to a legitimate source associated with her overly controlling mother who denied her autonomy and self-determination throughout her childhood. While, at first glance, the anger that Alison brought into this session appeared to be similar to that of the session a year earlier, this was different. She explained: "Well, I just want you to all back off from stopping me having to eat ALL this food. It's scary and it makes me uncomfortable. Nothing must stop me from being able to eat less, I guess. Stay away from that part of me that wants to eat less." This was not anger residing in the AnCh, but anger emanating from a coping mode, the purpose of which was to preserve the agenda of the AnOv. This was an important observation, given that it would have been a mistake to provide this latter anger the empathy and compassion one would otherwise provide the AnCh. Instead, it needed to be identified as self-defeating, and extinguished in order to promote access to the authentic Child seated behind it. For the first time, Alison was being alerted to an undesirable form of anger; a form of anger that was not welcome. The extract that pertains to the identifying of this coping mode anger is outlined in Chapter 9.

Once the angry coping behaviour had been successfully identified and understood, I recalled the anger she directed towards the team in the session a year earlier. This had the effect of renewing a "rebellious" child; indicative of how unresolved the anger she had towards her overcontrolling mother still was. She was honest in admitting that she still harboured anger for the team's insistence on her following the prescription of the meal plan, saying that she was "sick of being a puppet on a string and being told what to do all the time", and admitting that she "still often has that voice that says 'I don't always want to be told what to do'. Where do I get a say?" As was the strategy a year earlier, I encouraged the rebel to express herself. While the initial anger towards the treatment team was unjustified, the notion of "needing to break away and stop being pushed around and bullied anymore" was an important point of departure. When I seated her mother in the couch opposite her, she instantly realised that this was the pertinent source of her anger, which precipitated a worthy scolding. "Well, It's DESPICABLE!" she screamed, before continuing to reprimand her mother: "I'm furious because you don't let me make a single decision for myself, even the most elementary ones that can do no harm to me. Even the clothes that I WEAR; these were not the clothes that I CHOOSE! These were the clothes that you choose for me. And I think that I should be allowed to choose my own clothes. I'm capable of that, am I not? And you know, even the

friends that I have come over to play – YOU choose who can come. Not me. I'm not allowed to make that decision. I'm sick and tired of listening to you, and I won't listen to you anymore, and that's the END OF IT!" Alison had very effectively transferred her anger to its pertinent source and was demonstrating increasing confidence in sustaining her anger. Becoming increasingly familiar with the impact of her mother's control over her, she continued: "You need to get a life of your own and stop pushing us [including her brothers] around! Stop bullying us!" After listening to me reiterate all that she had said, Alison sat forward and in an even more stern voice reprimanded her mother: "Mom, take charge of your own life! And don't you dare put what you think is best and right for me onto me! Allow me to decide for myself. I can make my own decisions." Alison felt good saying this. As we continued, Alison confirmed existing evidence that her mother lay at the root of her DePa as she continued to confront her: "I don't have to be a perfect example of a well-behaved, good little child. I must even be allowed to be naughty because that is natural for a child." Becoming increasingly overwhelmed in her anger, she raised her voice to say: "You can't restrict me in everything that I do," before pausing to shout: "I'm rebellious! That's what I am! I'm rebellious and that's why I am so, so angry with you!" Her anger subsided and she became quieter and tearful. She was now in touch with the anguish of the VuCh to such an extent that she wanted to abruptly end the session; an expected AvPr response. I voiced my concern that her mother "hadn't got it yet", which immediately restored her explosive outburst: "No, no, no, if you get in my way again, I am going to throw you out of the house, and I will do the right things for everybody!" I asked what "little Alison" needed at that exact moment. Her response indicated that her priority remained to extract herself from her mother's control: "I need you to get it in your head that I am not an extension of you. I am somebody absolutely separate from you. I am not you; I am my own person!" When I, again, asked her whether she thought that her mother appreciated what she was saying, she cautiously answered: "I don't think you can get through to a person like that." It was valuable that Alison recognised that her mother was irreparably damaged and that her own healing would lie in the changes she orchestrated within herself. Alison continued to confront her mother more vociferously and confidently than before: "Get out of my space! Get far away! You are no good. You're useless, and you are a burden in my life!" Again, she wanted to stop at that point due to her imminent tears of "anger and sadness". But without much intervening on my side, she continued: "She was cruel, so cruel! You know, she denied me all that love and affection. I was starved! I never experienced a loving hug from her. I was starved of all that love and affection that was my due." After a short pause, and in a softer voice, she reflected: "You were never approachable." With brutal honesty and courage she, again, raised her voice to her mother: "You ruined my childhood! You didn't let me grow up like a normal, healthy little girl. And when I reached my teenage years you made me feel that I was a disappointment." Alison continued to berate the way in which her mother discouraged her career plans. She had the insight to realise that her mother lacked confidence, within herself, to pursue her own career path and personal dreams, and then selfishly imposed the same constraints on her daughter. Her anger turned to sadness as she reflected how she "did not have a childhood" and, again, she held her mother

accountable for making her feel "dirty and guilty in the eyes of God" throughout her adolescence and shaming her transition into womanhood. With more clarity than ever, she acknowledged the harmful influence of the strict religious principles her mother cruelly imposed on her. "She made me feel guilty that I was growing up and that I should hide myself away," she explained, describing how ashamed she felt about herself, especially her body. Her mother had condemned all outward expression of emotion as attention-seeking, whether it was tears or laughter, and she had insisted that "one should always be a blank page". Her feelings of social inadequacy had been perpetuated by the emotional detachment and other avoidant coping behaviours she had adopted in order meet these demands. Now, as she saw this more clearly, she continued to be infuriated with her mother for inducing so much guilt in her over the years and labelled her "a deplorable mother" who completely failed her. In a final effort, Alison pointed to the opposite couch to say in a high-pitched voice: "This has got to stop! You have got to get out of my life!"

Alison had thoroughly and mindfully embraced the chair work experience, capturing a very potent experience with her mother sitting before her. She told me during an interlude in the chair work that were her mother still physically alive: "I would make her sit in front of me, and I would tell her all the mistakes she made, and how dare she do that." When I asked her who else might have been sitting in the chair occupied by her mother, she instantly responded: "Myself; my critical and demanding parent [modes]. But I am not a demanding parent, but to this little child [pointing to where she was sitting] I am." Aware of the time constraints on the session, I asked Alison to occupy the HeAd chair and engage with the child beside her. Once seated, I asked her to hug the cushion next to her that represented the child, after which she engaged lovingly with her: "You know, you need never just sit and wish or pray that your mother will come and hug you." Imminent tears, again, temporarily interrupted her engagement with the child, but I urged her to continue, given the needs of the child: "You need a loving mother, and I will be that loving mother. I love you, and I will look after you, I want you to be happy, and I am going to let you be yourself." She continued to reassure the child of her availability and encourage that which would best ensure a trusting relationship between them. I asked if she would still be willing to tell the child that the dietician's meal plan required downward adjustment. Being authentically in the HeAd stance, she appreciated that the contamination that she was carrying would only befit the AnOv. She thus refused to convey this to the child and voiced her commitment to following her dietician's plan. "I can't let go of Elliene for anything," she said in closing.

It was valuable that Alison had identified and understood the role the angry coping mode played in preserving the AnOv, and that this was an undesirable form of anger. Thereafter, she showed courage in revealing her rebellious streak towards her professional team, and insight into its true source – her anger towards her mother. During chair work she expressed this in an amplified manner that reflected genuine progress in her ability to set aside the influence of her coping modes and DePa to quell such expression, as she increasingly accepted its legitimacy. While the challenge remained to resolve the shame associated with tearfulness that hindered the further

expression of anger and sadness, much time would be required to help her feel safer to express her anguish as she accessed ever deeper and more unbearable pain. However, confidence could be taken in the evidence of Alison's stronger HeAd and the trust she was instilling in the child that relied on her sturdy guardianship.

6.4.19. Therapy Session 60

Although Alison left her previous session supposedly committed to following her meal plan, the AnCh did not yet feel comfortably supported by the HeAd, thus resulting in continued AnOv behaviour. In this session, further efforts were made to acknowledge the unresolved anguish residing in the AnCh by challenging the ongoing rebellious behaviour that manifested in an undermining of the meal plan prescribed by her dietician. Efforts were made to decontaminate the HeAd of AnOv influence by appealing to the emotional needs of a child that was being defiant in the face of her vulnerable exposure to an adult world she was cautious to face.

Alison's visit to her dietician earlier in the week confirmed that her slight undermining of the meal plan resulted in marginal weight loss. Elliene cautioned her that continued, such behaviour would necessitate a psychiatric admission as her weight would continue dropping if she did not resume following the prescribed plan. Although there was no real clinical indication that hospitalisation was indicated, I did not offer this reassurance and deliberately stayed with the sense of "threat" that activated the AnOv as the child felt increasingly "frightened and intimidated". After she told me that she would never endorse hospitalisation, she described "despising" her body. "I avoid the mirror. I don't want to see the despicable shape I am in, and I am not going to gain weight," she insisted. Here was the AnOv in full force, but Alison rationalised that she was in HeAd as she was assuming firm control over the child and would not lose weight but maintain it. Then she mentioned that it might suit her to lose weight, exposing the AnOv even more clearly. Alison adamantly asserted that "assuming control [of her meal plan]" was a HeAd position, and that "the little child must just follow on". To evoke dissonance, I asked her to describe the main role of a loving parent. She responded by saying: "It is someone who cares for the little creature that she has in her charge, and she loves her and gives her everything that she needs, wants, and deserves." I was, thus, able to contrast between this loving description and a supposed HeAd whose inflexible preoccupation with control left a child both emotionally and literally undernourished. When I asked Alison to occupy the HeAd chair and I reflected on some of the severe neglect "little Alison" had suffered throughout her childhood, she dismissively announced: "No, no, no, I'm not going to get involved with the little child." She continued to hold firmly to the notion that she was in HeAd and rationalized that she was not on diet, but "eating healthy meals". I eventually succeeded in convincing her to engage with the VuCh by asking her to describe the experiences of this little child sitting beside her: "She is a 10-year-old; frightened, intimidated. This little child is very rebellious. That's what she is. She is frightened of rejection. I got rejection from Elliene. This child was rejected, not cared for and not listened to, and she was misunderstood." I commented that this seemed to reflect the many ways in which she experienced life under her mother's control. This realisation temporarily revealed the protective quality

of Alison's genuine HeAd as she described the "cruelty and treachery" that the little 10-year-old experienced "from the PuPa; the punitive mother". But then Alison reverted to the current context, explaining that "Elliene is not in my good books for mentioning hospital". She understood her dietician's comment to be a purposeful provocation to "frighten and shock" her into complying with her prescribed meal plan. Feeling agitated, she flipped back to the AnOv which she insisted on calling the "controlled HeAd" and, rejecting the VuCh, said: "The little child is just going to be maybe sleeping, dormant! And we are not going to worry about feeding her and nourishing her and nurturing her." I voiced my concern that the "starvation" of this child echoed the deprivation that "little Alison" experienced at home when she was a young child. Although flustered by this comment, she continued to insist that she was a "HeAd in control", but I stood firm and called her on her contradictions.

I insisted Alison consider that the AnOv was masquerading as a HeAd and dismissing the needs of the VuCh and I reminded her of what she had described in the previous session as her mother's suffocating control. Alison's voice softened as she acknowledged that "this little child wants to be recognized and have an identity of her own with no strings attached to her mother". Though I had hoped in this way to reconnect her to the VuCh from her Head, she quickly flipped back to AnOv, insisting that "the little child needs different nutrition in order to not gain weight". Again, Alison vehemently denied it when I stated that her adjustment of the dietician's meal plan was AnOv behaviour. I then reviewed evidence from past situations where she had consistently lost weight whenever she excluded anything from her prescribed meal plan. This rational discussion also had no positive effect. Next, I asked her if there was any justification to "withdraw the necessary food from this little child" and, in more carefully considering her response, asked herself "Who will benefit more? By listening to the HeAd or listening to the [Anorexic] Overcontroller?" This statement revealed the hidden experience that she avoided by repeatedly flipping back to the AnOv mode. Alison explained: "As a little child I felt very rebellious, but I never got the chance to be that." Now she realised how Elliene's comment about hospitalisation had triggered a rebellious voice that had remained dormant for decades. I clarified that the dietician's comment had triggered the ReCh, but her defiance had been channelled into AnOv behaviour.

To investigate this further, I asked Alison to occupy the ReCh chair and choose whomever she wished to place on the couch opposite and to express her protest. She chose Elliene, explaining that she had "a one-track mind". "All you see is the need for me, the 66-year-old woman, to eat and become heavier than she already is," she said. Elliene seemed oblivious to her need to be comfortable in her body and was, thus, ignoring her feelings. Although Alison's anger was dangerously feeding her anorexic beliefs, I encouraged the pathway of the ReCh to elicit expression of this longstanding suppressed anger. For now, I was prioritising this important development, rather than immediately challenging her distorted views. Later on, when I very carefully voiced Elliene's perspective, she acknowledged that she had, in fact, lost weight each time she even slightly undercut the prescribed plan. She conceded that her dietician's comment about hospital admission reflected justified concern if she continued to

restrict her intake. It came to light that Elliene's mention of hospitalisation had evoked dreadful memories of the extended state hospital admissions decades earlier during which she suppressed her anger and fear to blindly comply with the hospital staff's expectations. Throughout the admission she had never expressed her reluctance to restore weight, but merely continued, as she had always done with her mother, to subjugate her own feelings to avoid conflict.

In a final attempt to help Alison appreciate the contamination of the HeAd by the AnOv, I requested that she return to the HeAd chair and repeat my words of unconditional loving care for the VuCh seated beside her. She comfortably repeated all that reflected a loving, protective and encouraging guardianship, but when I described providing the child with a nourishing meal plan provided by the dietician, she was silent, knowing that this would not be a sincere comment. As much as she was healthy in her honesty, Alison remained steadfast in the AnOv for the remainder of the session, rationalising "my situation is not that serious and I have it under control", and trying to persuade me: "I have an agenda. I'm going to feed this frightened little child a suitable amount of snacks." Then she named a third factor; she was not willing to commit fully to the meal plan, as this would equate to her being in CoSu and she would feel like a subjugated child. At the end of the session, Alison had still not restored a clear HeAd position, although she was able to say: "I haven't been altogether honest, and I know that I have to get away from the AnOv… but the HeAd desperately wants to be in control." I did not challenge her parting comment when she assured me that she would return the following week having maintained her weight.

I felt disappointed and concerned in this rare instance in which Alison left a session without healthy resolution. However, I accepted that there was a powerful process unfolding before us. Evidence of obstacles to the establishment of a HeAd position emerged in the session. Alison was convinced, and repeatedly attempted to persuade me, that her restrictive eating was a legitimate reflection of her "controlled HeAd", oblivious to the fact that her HeAd was severely contaminated by the AnOv. When the dietician cautioned Alison that her continued restrictive eating would necessitate hospitalisation, she was reminded of her previous and extended state hospital admissions decades earlier. This triggered the ReCh who was adamant that her need for self-expression and autonomy were not subjugated. Although the child's authentically angry expression was a healthy development, the rebellious behaviour manifested in AnOv coping behaviour. She was further hindered from strengthening the HeAd through rationalisations that her health circumstances were either sufficiently under control or not severe enough to require change. It was clear that a significant challenge lay ahead to not only interrupt the rapid flipping between modes, but more specifically to decontaminate the HeAd and cultivate within it an authentic and genuine assertion that would provide the child with the necessary and deserving guardianship.

6.4.20. Therapy Session 61

Alison's difficulty in clearly differentiating the HeAd mode from the AnOv continued in this session. Although she had not lost further weight, she was experiencing heightened body distortion and dissatisfaction, especially pertaining to her sexual identity. In this session chair work was used to explore the conflict between Alison's newly discovered sexual intimacy and the shame and guilt residing within the VuCh, who felt undeserving of love.

Alison stated that she was "very pleased" that she had intentionally maintained her weight at 53kg and was not perturbed that she had defied her dietician's wish for her to restore the kilogram that she had recently lost. Despite controlling her weight, Alison experienced heightened body-image problems. "I have a distended, bloated, and undesirable stomach that is out of proportion," she said, considering that she should possibly lose further weight. Were she to consult with a gynaecologist she suspected that he would find her "three months pregnant". Before I could explore the symbolism behind this comment, she abruptly added: "My HeAd says that I am too distended, and the HeAd knows what she wants in having a healthy-looking body." The HeAd was clearly contaminated by the AnOv as she revisited the feasibility of losing further weight until her stomach was "at least flatter". Other than feeling "fat and ugly", Alison provided no tangible evidence to show that her current body shape and size were compromising her current lifestyle. She revealed that the motive for her continued restrictive eating served the purpose of "resolving an unacceptably big body" in order to avoid feeling "out of control". I deliberately evaded discussion about Alison's preoccupation with food and body shape, and this led to exposing a more pertinent and significant source of anxiety residing within the child.

Alison was perturbed by her husband's description of her body as "normal", explaining that "he's got the wrong conception [sic] of what normality is". In a soft and distressed voice, she explained how her husband "just sees my flesh and body as healthy". She told him to refrain from saying "that I feel [physically] so good [to him], because, oh my God, that's how fat I am." This condemnation from the PuPa that dissuaded her from engaging in physical intimacy was contrasted by the desperate need in the VuCh for physical intimacy. "It feels very good. I love it… The warmth of the expression that Mike conveys to me, I want to hold onto. I want to grasp him closer to me," she said enthusiastically: "But there is something there that is no good. It says that you are fat and ugly," she revealed of the voice that left her feeling physically defective. But when I pressed for her to describe the experience of being in an embrace with her husband, she resumed describing the pleasure residing in the child: "I don't even know where I am. I don't even know if I am in a bed. My mind is just overwhelmed by his glorious, loving relationship with me. I want to grasp it more and more. It's like a miracle. I'm glad he can't feel bones. I don't want him to," she said, gasping for breath. But then the blissful expression on her face suddenly broke as she expressed a wish to cease discussion on this matter. Instead of following this rapid flipping of modes, I steered the focus back to the experiences of intimacy within the marriage by recalling to her the positive experiences she had shared with me a moment earlier. Alison, again, resumed describing the delight in her intimacy: "I'm lifted out

of myself into another situation. Our love for each other is a most beautiful thing. It's so liberating that nothing else counts, nothing else matters. I just want things to stay like this forever." But when I invited her to close her eyes in order to form an image of this intimacy, she declined. I was, however, still able to maintain her focus on her intimate relationship, during which she disclosed that she sometimes initiated the physical intimacy between them. She continued her description: "It's all-absorbing. I lose concept of all my surroundings and everything else. It's a miraculous feeling." And yet again, Alison's celebration was harshly disrupted: "But I have to put myself into a logical position, and what Mike is actually saying to me is that I have become very fat." It was evident that each time Alison acknowledged the liberating feelings of the new-found intimacy residing in the VuCh, the PuPa countered it with criticism and a shaming of her physical form.

When Alison said: "I feel cared for just like a little child by my husband", it suggested that she was now experiencing the loving tenderness that was absent throughout her upbringing. However, this was countered by a punitive voice which left the VuCh saying: "I do not deserve to be loved." She hesitated to acknowledge her PuPa being responsible for leaving her feeling this way, but she avoided exploring this further. She was more intent on being in HeAd, but with the proviso that she was not required to gain weight. She occupied the HeAd chair and expressed loving support for the child but culminated her monologue by saying to the child: "Most of the time you are safe with me." In light of the susceptibility the VuCh still faced at the hands of the AnOv, I urged the HeAd to engage with the child. She did this with strong intent and authenticity, emphasizing the guardianship qualities that she would provide for the child. She was adamant that the child confides in her and not feel isolated in the way she was throughout her childhood. Alison concluded: "You are my little girl." At this point, I asked her to repeat my words: "But we need to do something about that stomach!" She sat in silence as my paradoxical intervention exposed the contradiction in the HeAd. Alison was clear that this statement did not fit the HeAd position, especially in the face of her loving monologue to the child. "No, no, no, that does not fit," she said, adding: "We are not going to put that burden on this little child." When I asked her to identify the voice that criticised the stomach earlier in the session, she was evasive, but I pressed for a response. "That's the DePa and the PuPa, but we banished them the hell out of this place," she insisted, not wanting to acknowledge their obvious presence. While the inner critic most certainly had its origin in the DPM, I suggested to her that this particular criticism of the body was emanating from the AnOv coping mode; a mode that had recruited its critical nature from the DPM. As we continued, she finally did acknowledge that this commentary was "fault-finding", after which she admitted that she had misinterpreted Mike's affirming comments about her body and their physical intimacy due to AnOv and DPM influence. Alison did, however, still reflect further evidence of the PuPa when she said that she could not repay her husband for the unforgivable anguish her ED had caused, and that she was thus unworthy of his love. When I clarified that this was the love that "the little child" required, she had renewed compassion. With a clear and determined voice she said: "If you are talking about the child [receiving love], then she deserves everything", reiterating that "the love is unconditional" for that child. She stated clearly that the child unquestionably deserved

love from her HeAd and she identified that the PuPa threatened this. From the HeAd chair she reprimanded the PuPa and banished her with a vociferous expression of anger that culminated in tears of rage. She knew that her difficulty in sustaining the tears reflected another intolerant aspect of her mother's voice, but she did not allow this to derail the reparation. I was still concerned that the HeAd was contaminated by the AnOv and so asked Alison to identify who was best equipped to determine her required nutritional intake. She was honest in her response: "Well, I hate to admit it that Elliene is the best guide… and I want to follow Elliene's advice if it is going to help the little child, because the little child is my main priority." This confirmed to me that Alison now clearly understood that the child required consistent nourishment from a HeAd that responsibly ensured that there was no deviation from the dietician's prescribed plan.

The pleasure that Alison was now experiencing in her sexual intimacy with her husband seemed to be fulfilling her need for a deep and authentic intimate connection, something she had been deprived of for decades. As blissful as she experienced this newfound intimacy, the VuCh still experienced heightened anxiety which manifested in the form of heightened body image dissatisfaction. The struggle was evident in the frequent and exhausting flipping of modes; the VuCh revelling in the newfound sexual intimacy of her marriage, the interrupting influence of the PuPa shaming her body and the pressures being imposed by the AnOv for her to lose weight and be physically smaller. The guilt-inducing nature of the PuPa prohibited Alison from engaging in physical pleasure due to the anguish her ED caused her husband for decades. Chair work succeeded in identifying the VuCh who deserved love and protection, and the HeAd received clarity about her responsibility to provide the child with such care whilst also marginalizing any threat facing the VuCh from the PuPa and AnOv.

6.4.21. Therapy Session 62

In this session I challenged Alison's obstinate intention to continue her restrictive eating by gaining access to the child's anguish residing behind the AnOv behaviour. I confronted ambivalence between her need to persist with the perceived benefits derived from continued AnOv behaviour and the new life she was leading beyond the deeply entrenched ED, namely, her more healthy and meaningful relationships as well as the more substantial access to feelings residing within the VuCh and AnCh. As the AnCh emerged more prominently, I guided Alison's HeAd to become increasingly aware of the substantial abuse and neglect she had experienced throughout her childhood. As experiential techniques exposed the extent of the pain in her VuCh, Alison further re-evaluated the purpose that her AnOv was still fulfilling in her life.

Alison entered the session reluctantly, even questioning the entire therapy process and stating: "I regret every kilo I have put on and so I feel that my support group is against me." She expressed that her longstanding dissatisfaction with her body shape would never change and refused to continue to follow her meal plan only for the purpose of meeting the expectations of her family and helping professionals. She also expressed heightened distrust in the dietetic plan, having gained 400g in the week, despite having restricted her intake. I interrupted her

discussing details of her weight in recent weeks and asked her what she really wanted, to which she responded: "I really want to be an anorexic walking skeleton; getting attention for that." Annoyed with herself for holding this attitude, she acknowledged that she was speaking from her AnOv. But this did not break her unyielding intention to continue excluding snacks from her plan and rationalizing that her behaviour was justified as she only intended to lose one kilogram.

Alison ceased her discussion about food and weight and shifted her attention to the distress associated with disappointing her support team. "You see, I have got to be the CoSu, and I am not into that," she said, demonstrating ambivalence with respect to meeting the perceived expectations of her support system and wanting to be self-determined, even if from the AnOv perspective. Distressed by the strong obligation to meet my expectations of self-care, she said: "I've got to meet your expectations, and I hate that… But you've given me all the tremendous amount of support and help." When it became clearer to her that my support was specifically for "the little child's" well-being, she initially appeared to be adopting the HeAd position, expressing concern that the child was being betrayed. However, the AnOv was evident in her refusal to nourish the child in the prescribed manner, despite saying that she intended to nurture the child. Besides this unyielding AnOv rule, she remained in HeAd, disappointed in her preoccupation with the food and weight theme and expressing a wish to recapture "the wonderful feeling" associated with the "enriched relationships" that she was enjoying with others. She was aware that while these relationships were flourishing, the VuCh was free from the lure of the AnOv. Alison became increasingly distressed as she realised her dilemma; wanting to continue cultivating deeper levels of intimacy in these meaningful interpersonal relationships and yet anxious about relinquishing the perceived benefit of maintaining rigid control over food and weight. Alison acknowledged that she was not in a sufficiently stable state to assume proper responsibility for the child while the contaminating influence of the AnOv in the HeAd was evident: "Listen, I need a little space to be at an average normal weight for a little while, and then I will feed the little child." Yet, she was acutely aware that the little child felt "very, very lonely and abandoned, and definitely screaming for support and help." More secure in the HeAd position and realizing that the AnOv was responsible for the urge to restrict the child's food intake, she decided she would nourish the child in a manner that reflected healthy guardianship.

Alison realised that the nutritional neglect that she was imposing on the VuCh echoed the emotional neglect and abuse her parents imposed on her throughout her childhood and adolescence. This insight reignited her anger towards her parents, yet she hesitated to express her anger while she still heard her mother's voice forbidding her to express it. When she attended confession earlier that week, Alison's priest refuted this notion, as he had done previously, by encouraging her to confront her anger at her parents in therapy. Despite this, Alison remained reluctant, rationalising that it would be wrong to be angry towards the deceased. While contaminated earlier in the session by the AnOv, the HeAd was now influenced by the DePa, where she promised to "take care of the little

child", provided the child's anger towards her parents was marginalized. As we reflected on some of Alison's childhood experiences, she described an incident in which she walked accidently into her parents' bedroom to find her intoxicated father urinating on the floor. "It was a dreadful experience," she said, remembering how she felt obliged to say nothing about it to anyone, even though her mother also witnessed the incident. Alison recalled that, when her friends visited, she was constantly vigilant to protect them from being exposed to her father's frequently "messing on the bathroom floor… because it was just so embarrassing". Speaking from the HeAd, Alison was angry that "this little child" was exposed to such a dysfunctional environment, realising that her mother should have confronted her husband's drinking problem and protected her children from his drunken behaviour. With no escape, Alison knew that she had to tolerate such home circumstances. While her mother controlled her "with an iron rod", Alison was denied her own opinion and went into PrCh coping by "semi-disappearing". Having first made this connection some months earlier (S48), she again equated her "invisible protection" at home to the role her anorexic condition played later on in her life by hiding her from the world. She well described it when she said, "the less of me there was to see, the better." From the perspective of the AnOv, she recognized that, although she could not identify any current danger in her life, her ED absolved her of what seemed like the unbearable pressure to be a loving wife and mother. However, from the HeAd Alison also recognized that she was, in fact, already engaging in increasingly deep and meaningful relationships with her family and that this was largely as a result of having marginalized her ED. Yet, she still insisted she "hold tight to the reigns of not following the meal plan" despite the contradiction that such restriction precluded her from this more meaningful lifestyle. I challenged the source of this in chair work.

I asked Alison to occupy the VuCh chair, where she experienced feeling extremely neglected and abandoned by her mother who was more concerned with maintaining an ideal veneer of the family than confronting the dysfunctional nature of the home environment. "Behaving like that was not okay, because I was not allowed to be myself," she said with distress in her voice. She shifted into HeAd, becoming tearful as she spoke: "That should never have been allowed. That was depriving the little child of the help that she needed." As she became aware of her elevating level of anger, she became preoccupied by her need to suppress it, fearing that her anger would escalate into an uncontrolled rage. When I asked whether she was going to tell the child to be silent, she declined and shifted into AnCh, infuriated with the way her mother treated her. "I need to feel heard and recognized. You never once asked me whether I like this or like that. That is the way it has now got to be." With my encouragement, Alison eventually shouted to her mother: "You failed me!" She elaborated on this, saying that she never did to Eric what her mother did to her and her brothers. She was particularly infuriated with the manner in which her mother tolerated her father's frequent drunken behaviour that everyone in the family was subjected to. "He wasn't even a father," she said, clenching her jaw. She described how he was either drunk or absent and continued: "Mom, you made it okay for him to carry on with all his vices while we were in the background having to let it all pass by and pretend it was all not happening. That was living a lie. My life was pretence. That's what it

was!" Alison realised that she had felt unsafe throughout her childhood. Rather than encouraging her, her mother quelled her dreams. She became uncontrollably tearful as she began to appreciate the extent to which her mother had limited her. In that moment she stood, intending to occupy the AnOv chair, which illustrated the automaticity with which her coping behaviour was activated in order to spare the child from feeling distress. I blocked this and persuaded her to remain in the AnCh chair from where she said to her mother: "In every possible way you failed me! You are just a big pretence! You are distant; a fake! I hate what you did to me and my brothers." As she had repeatedly done before, Alison threw the cushion representing her mother out of the room. She resisted flipping into the parent modes from where she would have been scolded for expressing anger at her mother and judged for doing so to a deceased parent. In remaining secure in the HeAd, she expressed anger at a mother who abused "little Alison". She also realised that it was her mother's influence that made her feel unworthy of Mike's love, which then drove her to seek refuge in AnOv. She explained how "at times, I allow the AnOv to stop me from feeling what I deserve".

More so than in any session previously, Alison continued expressing anger towards her parents. Asked to describe a particular childhood memory, she described one in which her intoxicated father had soiled and urinated on the bathroom floor while her mother was hosting a dinner party for family friends. Instead of her mother attending to the situation herself, she instructed Alison, who was 5 or 6 years old, to tidy the mess while her father already lay asleep in his bedroom. In order to prevent guests from knowing what had happened, Alison's mother even banished her to her bedroom after she had cleaned the bathroom. She tearfully described the incident to me, totally mystified as to why her mother did not acknowledge her efforts, express gratitude, or give her a reassuring hug. She now felt infuriated seeing the adult responsibilities her mother had imposed on her when she was a young child. With her eyes closed, I guided Alison through a corrective experience in which she chose Mike to enter the house, interrupt her from cleaning the bathroom, and tell her mother to assume responsibility for the incident without involving Alison. "Mike would not tolerate that situation," she told me. She described him asking her to go to her room as a safe, protected place. She played happily with her toys while Mike instructed Alison's mother to deal with the consequences of her husband's drunken behaviour. Alison was comfortable that Mike instructed her mother that she never expose Alison to such a situation again, after which he joined her in her room to physically comfort and reassure her that she was now safe. Alison was happy with my suggestion that Mike invite her to their current house where she felt safe. She was deeply involved in the exercise and described the scenario in detail. Afterwards, sitting in silence, a warm and glowing smile filled her face that suggested that the exercise had offered an effective rescripting of the trauma she was carrying.

While Alison had entered the session firmly entrenched in the AnOv stance and perceiving numerous benefits associated with remaining in this coping mode, she was able to shift to the HeAd position with relative ease to empathise with the VuCh. She identified the child's need for intimacy and nurturance and acknowledged the pain

associated with parental abuse. This ignited a more vociferous expression of anger than had been previously experienced from both the HeAd and the AnCh, despite the DePa attempting to dampen the angry expression. Shifting between the AnCh and a VuCh in the experiential exercise that closed the session demonstrated Alison's increasing appreciation for the extent of neglect and abuse that was imposed on her by both of her parents during her childhood. Her rescripting image, reflected in her previous imagery rescripting work, suggested that her husband was now safely fulfilling the crucial role as a loving and trusted protector that her parents failed to do decades earlier.

6.4.22. Therapy Session 63

In this session Alison flipped from the HeAd into the PuPa mode in a sudden and unexpected way. Although she stated at the outset of the session that she was maintaining good care of herself, the sudden emergence of and ease with which the PuPa endorsed that "little Alison" be punished revealed the significant shame and disgust still residing in the VuCh. The challenge to restore the ascendency in the HeAd lay in identifying and marginalizing the PuPa so that the HeAd could reassure the child of the love and care she deserved.

I had not seen Alison for three weeks due to my annual leave, yet during this time she had taken remarkably good care of herself and followed the meal plan fully. "I'm just doing it," she said, proud of the fact that she was "taking excellent care of the little girl" from her HeAd and not from the CoSu. Reflecting on the previous session three weeks earlier, Alison was now appreciating how the contamination in the HeAd had made her conditional in her care for the VuCh. She described her renewed confidence and well-being, and a desire to be well. "I am enjoying the many wonderful pleasures that have been coming my way," she said, confident that she was now going to "stay on the right track". She described how the little child was feeling loved and appreciated and enjoying the intimate care that she was receiving from Mike. By being "more adventurous and outgoing" she experienced her marriage as more "intense, honest and open", which lent to an emotionally deeper, more intimate, and safer experience than she had ever felt before.

Alison suddenly flipped saying: "It's right to punish myself if I have to, but I have no right to punish Mike. And that is what I have been doing, but I am not doing that anymore. What I have allowed myself to do to myself is one thing, but it is sinful to do it to another person. No, I can't punish Mike along with me." I interrupted her in order to position "little Alison", represented by a cushion, next to her. Then I briefly reflected some of the abusive and neglectful experiences that "little Alison" had previously shared of her childhood. When I enquired from where this child's punishment was derived, she immediately identified her mother and the PuPa. Once she saw that it was her "own little child" under threat from the PuPa, her attitude changed: "There is no way that we can find that commendable," she said, reflecting her return to the HeAd. But then she flipped into the RaOv to emphasise that not allowing the child to be punished was only due to the "will of God". I was determined that the care of the child be not only endorsed on religious grounds, and so reflected my own view that "little Alison" deserved to be

protected and nurtured. She identified that her HeAd held the same stance. "My mother's voice must shut up," she said emphatically. However, this was short-lived as the PuPa countered with an attitude that "little Alison" was unworthy and undeserving and that "the best thing to do is to punish that little child". "That is what is in my head, and it is the truth," she continued. To create dissonance, I requested that Alison occupy the PuPa chair and deliver this script to the child. Of course, she refused to do so. As had happened in previous sessions, once seated in the PuPa, Alison was sharply aware of the abusive nature of this mode and instantly flipped back into the HeAd who was not prepared to allow harm to come to the innocent child beside her. She scolded the PuPa: "You have abused this child enough… and I won't give you a minute longer to interfere with the child." Alison recognized that everything that her parents had imposed on her was subsequently perpetuated by the PuPa's attacks on the VuCh. When we reflected on the incident detailed in the imagery rescripting exercise during the previous session, she still held both parents fully accountable for the ways in which they failed her. "I will never allow that little child to be terrorised like that again. I want to get her away from all that sordid, obscene, brutal upbringing, and put that behind her," she said, determined that she was now going to assume full responsibility for nurturing the child. "I have the dearest little girl under my loving care," she continued.

Alison excitedly asked me towards the end of the session if I would be comfortable with her buying my 4-year-old daughter a Christmas gift, emphasising that it would be from Father Christmas. She revealed that she wanted to protect my daughter from knowing that it was from her, saying: "I can't contaminate her with my anorexia. That's why I need to be unknown because anorexia is unacceptable." She explained: "Whenever I do a kind gesture towards someone, I have this slight reservation whether I am contaminating them with anything distasteful in me." Alison identified her mother lying at the root of this self-disgust and said that her mother found fault in everything about her. With little time remaining in the session to explore this further, I reflected the excellent progress that Alison had made in marginalizing the shame residing in the VuCh. In an interesting choice of words, Alison described how her ED had been "eating me up" and that her level of anxiety had paralysed her ability to move forward adventurously in life. In closing, she agreed with me that she had made significant progress towards nurturing the "little child" and commented how her marriage was "blossoming".

Despite Alison's remarkably good self-care during the 3-week hiatus while I was away on leave, the VuCh still remained highly susceptible to parent mode abuse. Chair work helped Alison to become very conscious of the duel being fought between the HeAd and the PuPa. Through this, it was evident that a child was more readily emerging who was becoming increasingly familiar with and trusting of the loving care of the HeAd, but there still remained a deeply entrenched ShCh who remained easily susceptible to the scolding and intimidating voice of her mother and the introjected parent modes. The task remained to continue cultivating the emerging authentic child and to facilitate the continued balance of power in which the VuCh was more safely secure in the hands of the HeAd and more consistently protected from the influence of the dysfunctional parent modes.

6.4.23. Therapy Sessions 86 to 89

Alison requested that I facilitate a series of joint sessions in which her son, Eric, could have the opportunity to confront her on the negative impact her ED had on her ability as a mother. The sessions evoked much memory of her mother's critical and demanding attitude, which was strongly echoed in the dysfunctional parent mode introjects. This provided much opportunity to focus on strengthening Alison's HeAd to ensure that the VuCh received the necessary protection and nurturance.

Alison began therapy session 86 setting down some "ground rules". The first of these was that she would not tolerate herself being tearful during the session. She insisted that, should she be on the verge of tears, Eric and I should reprimand her and tell her that it was not necessary. She stated that she returns home after sessions in which she had been tearful, thinking: "I'm weak, useless, and selfishly seeking sympathy," and intolerant of the notion of "indulging" such tears in sessions. She realised the source of this attitude when she said: "My mother would think it appalling that I leave the session crying." This was echoed in the PuPa, who would chastise the tears and leave the VuCh saying: "I'm disgusting!" She tried rationalising that her son and husband's "worthy, selfless, and warm" characters entitled them to be tearful, while she was devoid of such redeeming qualities. She also rationalized that her responsibilities towards supporting her grieving husband required her to be "strong" and withhold her tears. Alison severely rebuked the child in her by saying "You've got nothing to cry about", but once I sat her in the HeAd chair, the uniquely self-imposed rules dissolved as she refused to repeat the comment. She made the healthy correction: "It's cruel to stifle the tears. Maybe we need to treat this child the way she deserves." With the deep compassion of the HeAd she turned to the child to say: "I want you to know whatever you are feeling, you can actually shed tears." In that moment, Alison became overwhelmed and tearful, but was able to still reflect how the "little child" was "deprived, hidden away, and not seen". Thoughts of the PuPa re-emerged to reiterate the unique rule in which love for the VuCh had to be earned while, in contrast, Alison's love for her son and others was "unconditional and so easy to provide". As I began challenging the notion of conditional love imposed on "little Alison" who had "never received a hug [from her mother]", the HeAd expressed a wish: "If I could transfer the love I have for Eric to that little child [VuCh], then that would be heaven on earth." While she saw the legitimacy behind my comment that "little Alison" deserved the same love that should be afforded all children, she expressed a fear that this might lead to an "over-indulgence" in the child. I shared my thought that this sounded similar to a previously expressed fear in which relinquishing the AnOv would leave the child prone to "gluttony". This revealed the lack of confidence in the HeAd to maintain moderate and flexible control over the child.

Although Eric hardly voiced anything during the session, what he said contrasted significantly with the PuPa. He reassured his mother that he held no resentment for the way in which her ED had compromised her ability to

parent him and also expressed a delight in the way in which their relationship was now flourishing in the face of the newfound emotional intimacy they were sharing as a result of her recovery.

Alison arrived at the following session in a buoyant mood. She had regained almost a kilogram in the week to sit comfortably within the GWR and justifiably said that the AnOv had been absent the whole week. However, she still insisted from the PuPa that her son be angry with her for the many years in which she failed him as a mother. She insisted that the Child was "devoid of redeeming qualities" and said: "I was not so pure. I was not worthy and shouldn't have been around. There was no room for me." Although she claimed that she was speaking from the HeAd, she was, again, not willing to communicate such sentiment to the VuCh from the HeAd chair, admitting that it was cruel. Alison identified such cruelty reflecting her mother's voice, where the phrase "You are a nuisance" still rang as clearly in her head as it had some decades earlier. Re-established in the HeAd, Alison felt compassion for the prejudiced "little child" and, hence, berated the PuPa and DePa. "Shut up and don't interfere with my little child," she said as she began shedding tears for the child that she realised was being treated unfairly. She stood up from her chair, unable to tolerate her tears that were being forbidden by the DePa and asked to leave the room. I echoed the DePa message to stop being tearful, which had the intended effect of eliciting a response from the HeAd that it was "wicked" to deny the child her tears and that she was entitled to be tearful when in pain. From the HeAd chair she was able to appreciate and consolidate her stance in assuming the loving and protective role of a guardian to the VuCh. Pointing her finger to the chair reserved for the DePa and PuPa, she reprimanded them: "Don't you dare tell that child she is not worthy, and don't you stop me from being compassionate towards that child." She turned to the VuCh beside her and reassuringly said: "I will look after you physically and emotionally", all the while reflecting on the specific memories of hiding as a frightened child in her bedroom from her berating mother. But she flipped again, to question whether she was not entitled to criticise her own parents while she, herself, had failed her son.

It had taken almost two sessions for Alison to eventually allow her son to reflect his experiences of the way in which her ED left her "disconnected" from him, as he described it. Eric expressed his forgiveness of her and his appreciation (admiration) of the way in which she had bravely fought through her illness to progress to where she now stood. But Alison struggled to let this in, and her PuPa immediately lashed back, insisting that she was not entitled to such affirmation. Alison shed silent tears of relief when Eric expressed his joy for the deeper intimacy that they were now sharing. For the remaining minutes of the session, Eric embraced his mother.

Alison began session 88 in the PuPa but masquerading as the HeAd in strongly urging Eric to condemn her for her failure as a parent. "You must off-load and I'm strong enough to take any onslaught," she insisted, after which she said more forcibly: "Now let me have it!" Eric shed tears as he helplessly watched his mother urging him to punish her for the third straight session, despite his many previous reassurances that he felt completely resolved around the impact her ED had in blocking a warmer and more securely attached relationship between them. Alison

identified this urgency to be punished as reminiscent of a familiar feeling she experienced throughout her childhood in which she anxiously anticipated her mother's scolding. She had believed that her mother's punishment was "righteous", but had experienced deep anguish in anticipating it, and only felt relief once it had been dispensed. Alison recognized how she was re-enacting this process here with Eric. I reminded her that her son had repeatedly declined the need to be angry with her and asked whether at any time in the past this shamed and frightened child ever derived any value from being scolded. "No, nothing," she answered, describing that she felt degraded. However, she still felt compelled to urge Eric to be "madly angry" with her, reassuring us: "I won't fall apart, and I have a loving husband at home who'll support me." She became increasingly frustrated that Eric did not fulfil her wish: "Why won't you do it, Eric? I'm strong enough to take it… I can take what I deserve, and I'll be fine afterwards." While Alison urged her son to punish her, there was, at least, a healthy element in her relying on her "compassionate and loving husband" consoling her upon her return home. Alison realised that her compulsion to have her son scold her might bring the same relief she felt when her mother had finished scolding her throughout her childhood. I did not explore this further as I was intent on giving Eric an opportunity to speak. He began by saying: "I don't want to punish you and I want you to stop assuming this to be the case. It's far from what I want to do." He elaborated and encouraged the focus to be on the newfound joy he was experiencing in the authentic and emotionally intimate relationship they had recently developed. Although Alison continued for a while to be perplexed at the notion that her son had forgiven her and had no desire to chastise her, she realised that she was attempting to replicate the familiarity of her mother's actions. But she now realised that this shamed and frightened child deserved and required love and nurturance. Alison also reconsidered the prejudice unique to her VuCh mentioned earlier when I asked her whether any other child she knew had to earn love, or whether it was something that every child deserves. There was hope in her closing comment: "It's so tempting to receive Eric's love. I'm going to try and allow that."

Alison began the fourth consecutive joint session very proudly stating that she had gained a further 1.3kg in the week to be at her "best weight" in six months (53.5 kg). Although she found it "overwhelming" to be required to still have three daily protein shakes to maintain her weight, the HeAd knew this to be necessary, even though the AnOv voice in the distance echoed to the contrary. Alison resisted acting on a punitive voice that still criticised her "big breasts and stomach, and flabby arms". "It's like my mother's voice," she said, but knew to not act on it and hold steadfast to the HeAd. While the PuPa voice did briefly argue that it took too long to restore the weight and that credit should only be granted to the professionals treating her, I easily persuaded her to see it differently. The HeAd gave credit to the VuCh: "You've done really well, and you can now look at yourself as a normal, healthy, young lady and be proud of yourself and your body." She then proceeded to scold her mother for shaming the child: "Stay away from my little child. I am going to take this child away from you. She is an individual of her own. You were despicable. You had no right to open your contaminated mouth and say such cruel things to a child that was totally innocent. You made her do things that she shouldn't have had to do. That's wrong. That's wicked! It's

unacceptable! I'm appalled by you and I've got no time for you, whatsoever." Although Alison briefly considered flipping back into PuPa to encourage Eric to scold her for her failure as a mother, she quickly identified the PuPa saying this and reinstated the HeAd to speak compassionately and reassuringly to the VuCh of the unconditional love she had for her. Even her mother's messages that she should be careful to not over-indulge in pleasure did not intimidate "little Alison". The HeAd was able to dismiss scripts like "You'll end up in trouble if you go too far" and "If you laugh too much, you will end up in tears". Alison was able to see from a new and healthy perspective how her mother's religiously based penitential attitude was distorted and that Christ's message would never be that "love can become an over-indulgence". She realised that her mother's messages of self-denial "took the penitential thing to extremes… and was crap".

Both Alison and Eric expressed gratitude for the joint sessions and felt that they had benefitted from them. Even though Eric voiced very little during the sessions and spent the vast majority of the time observing me working individually with his mother, he did say that his attendance helped him to better appreciate his mother's past circumstances and that he had gained a better perspective on her current pathway to recovery. While the PuPa was deeply invested in having Eric chastise the shamed and frightened child for the effect the ED had on compromising her parenting abilities, it was difficult for her to hear his sentiment that was so contrary to that of her abusive mother's voice. The greatest benefit Alison derived from the joint sessions was to be able to consider her son's wish to focus more on their newfound emotional connectivity. However, it was clear that further work would be required to consolidate this healthier perspective, and that the urge of the PuPa for the child to be chastised had not been comprehensively neutralized. Chair work continued to provide an effective forum within which to recognize the contamination residing within the HeAd and also helped the HeAd to engage with the VuCh in a meaningful and authentic manner. While Alison's weight was now restored to its healthiest level, the marginalizing of the AnOv not only provided weight stability, but it provided a greater opportunity to prioritize protection of the VuCh from the DPM that encompassed the legacy of her mother. The HeAd, thus, provided a more stable environment for the VuCh to receive the nurturance that she deserved.

6.4.24. Brief Summary of Sessions 90 to 99

As already outlined, I chose to exclude sessions 90 to 99 from analysis due to limited space and the fact that these sessions did not provide any significant and new themes or processes to the therapy. These sessions were largely a consolidation and further strengthening of the HeAd mode and a grieving of the decades Alison lost due to the impact of her AN. Where Alison's mentalisation skills noticeably grew, the Child was less likely to be triggered and the HeAd more adept at objectively recognising any influence of the PuPa to shame or undermine the VuCh. Chair work reflected both the HeAd and the Child scolding the abuse of the PuPa without any hint of guilt and the far more entitled anger that had been suppressed for much of Alison's life. Many of these ten sessions involved a process of grieving. As Alison's quality of life and emotionally deeper relationships with family and friends

markedly improved after the dismantling of her ED, so was Alison able to experience the contrast of the previously insulated, isolated, and lonely life she previously experienced while anorexic. Sessions were used to grieve the lost decades. The VuCh was able to experience previously suppressed sadness as a now important emotion to negotiate her through the grieving process.

6.4.25. Therapy Session 100

In this, the final and 100th session, we addressed two events (one earlier in the week and the other a forthcoming one) which in the past would have evoked harsh PuPa response towards her VuCh. However, she now had the opportunity to demonstrate the compassionate care and nurturing nature that was being cultivated in the HeAd. The session, furthermore, provided an opportunity to see the extent to which limited reparenting was transforming the VuCh and AnCh into the happy and authentic Child; someone that was now contented, spontaneously creative, and who felt safer under the guidance and protection of the HeAd.

Although Alison continued to follow her meal plan diligently, she was still anxiously anticipating that in her next appointment with her dietician, who had been on leave for a few weeks, her weight may have decreased, for which she would be scolded. It revealed a frightened child that was reminiscent of early childhood memories in which she frequently anticipated her mother's scolding and condemnation, mostly for reasons unknown to her. However, Alison was now very invested in dealing with this fear in a healthy and constructive way, especially after I reminded her, as I had often done before, of the importance of being accountable for her compliance to the meal plan rather than her actual weight change. After all, the latter was something that was not in her direct control. She appreciated this reminder, felt reassured, and told me that she would go into her dietetic consultation in her HeAd and "lay her cards open on the table" to confidently state that she had complied fully with the meal plan. Alison was not only gaining insight to the childhood memories that continually triggered the VuCh, but she was now more readily implementing a HeAd stance in order to preserve safety for and engage with the child.

Satisfied that the anticipatory anxiety associated with her dietetic consultation was resolved, Alison shifted her attention to a positive experience she had on the afternoon following her previous session with me. She stopped at a children's play park while out on a walk alone. "I sat down on a park bench and sobbed my heart out. It was the most amazing (thing) because I was surrounded by these joyful little children." While her voice became increasingly excited and joyful, Alison explained how she responded "as though a friendly granny to them". When they dispersed, she described how she resumed crying, but this time in a way that felt calm and authentic. "It was a magnificent experience," she explained, surprised that she remained there for over forty minutes. After I expressed my own joy about her experience, she revealed a crucial insight: "I cried and cried because I was delighted. I just felt for that little child in me that didn't do all that." She even participated a little, pushing the swings and merry-go-round for the young children. "Wow, we were having fun; I was having fun," she said of the experience before walking home in a "quite calm and collected" state. When I enquired further how she now felt

looking back on the experience, she responded with indignation in her voice: “How can I be treating the little child in me (any different) to these little children that deserve all the fun and laughter and happiness that they can possibly get?” As her voice grew louder, she questioned: “Why should I deny myself and why did my mother deny it to me?” This was the clearest indication that Alison had yet made in insisting that she be entitled to the same loving care that should be afforded any child. She emphatically agreed with me that her tears reflected not only sorrow for what the VuCh had been deprived of, but anger for what she had to endure from her mother and relief that the needs that “little Alison” had were being met. It was notable progress that she sustained anger for all the maternal deprivation without the DePa intercepting the child and condemning her tearful display. I encouraged Alison to continue visiting the children’s play park for the purpose of cultivating a sustained corrective image of “little Alison” playing amongst the other children; something that she deserved. She delighted in this suggestion.

Alison realised that she was now in a comprehensively healthier state physically, emotionally and socially. For much of the remainder of the session we explored how she was still struggling to accept that her son had absolutely forgiven her for the “disconnection” that her ED had caused between them throughout Eric’s childhood. As she explained: “Graham, I’m just feeling overwhelmed by the compassion that out dearest, darling, loveable son is prepared to offer me.” Her PuPa then made a brief appearance as she added: “Who doesn’t deserve it!” When she questioned where her son’s good nature came from, I had the opportunity to point out that, despite her anorexic state, she had clearly still provided a quality of parenting that resulted in her son becoming a well-adjusted and loving individual. She agreed with me, stating: “He still was (my) number one even though I had anorexia. He was still my main priority.” Alison agreed with me that even though her AnOv had served to shield her from the anguish in her childhood, its blunting effect had ironically denied her from “embracing a loving marriage and embrace a very active and warm, loving motherhood”. While I said that “it tore away your ability to be vulnerable in your life”, she agreed: “Yes, I held back.” With that, the HeAd was able to acknowledge that “the child deserves to now be liberated” and that “little Alison” deserved the same compassion that she would afford anyone else. She was later able to address the AnOv: “I won’t need you, AnOv, anymore,” she said to the chair opposite her reserved for this coping mode. Instead, she now knew that she had loving relationships with her husband and son, as well as other family and friends that provided a quality and meaning that she had never before experienced in her life.

This session demonstrated Alison’s perseverance through the therapeutic process. She was showing her ability to more promptly assume the HeAd stance and alleviate the anxiety of the VuCh before her next dietetic consultation. Even more significant, her visit to the children’s play park revealed a Child that was now more willing to engage emotionally with the enormity of her deprived and abused childhood. Not only did she trust herself to express the sadness and anger about the way she had been deprived of joy and spontaneity as a child, but she bravely engaged with the corrective experience as her VuCh responded to the spontaneity of the playing children.

This capacity to experience her vulnerability would not have been possible without the strength and compassion in her HeAd that she has been building over the past months. While Alison still faced the challenge of fully accepting her son's forgiveness, she was beginning to conceptualize the notion that the VuCh was as deserving of forgiveness as any other child.

CHAPTER 7: QUANTITATIVE MEASURES

As with all participants in the study, Alison was provided with a large battery of questionnaires and surveys at the beginning of the study. Some were only administered at the start of the study for diagnostic purposes, while others were administered both at the start and completion of the study as a measure of the efficacy of the therapeutic intervention. She was also re-administered these measures at 5-year follow-up, throughout which Alison continued to be in therapy with me.

This battery included measures of her ED; personality pathology; broader psychiatric and physical symptoms; level of shame; clinical well-being, social functioning and self-risk behaviour; mood; and anxiety and stress levels; as well as EMSs and schema modes. Further to this, Alison was provided with a shorter battery of questionnaires to complete on a weekly basis to measure changes in the therapeutic alliance and severity of problems, as well as mood, anxiety and stress. Detailed descriptions of all these tools are outlined in Chapter 5. Lastly, results of the evaluation of the therapy narrative that Alison was requested to read are provided.

7.1. Eating Disorder Measures

Alison fulfilled all the criteria for a diagnosis of Anorexia Nervosa – Restrictive Type (moderate severity) at the start of the study. She restored the majority of the required weight during the CBT-E therapy preceding the commencement of ST. However, my reasoning for changing to ST was not related to her low weight, but due to her resistance to restore the few remaining kilograms required to reach a goal weight range of 52 to 54kg. This would place her within the goal weight range (GWR) and a normal body mass index (BMI) range of 18.5 to 24. Figure 18 on the next page outlines Alison's weight history preceding treatment with me, during the CBT-E phase of therapy with me, and during the 100 sessions of ST that defined the study period. Beyond the study and until now, Alison's weight has remained stable.

Completion of the Eating Disorders Assessment Survey (see section5.7.6b), confirmed Alison's diagnosis of AN-r. Alison also completed the Eating Disorder Examination – Questionnaire (EDE-Q; Fairburn & Beglin, 1994), which measures ED symptoms and attitudes over the past four weeks and contains four subscales: Restraint, Eating Concerns, Shape Concerns and Weight Concerns. The pre- and post-study results appearing in Table 14 on the next page confirm Alison's improvement on all four scales following the study. Scores upon re-administering of the questionnaire exactly five years to the day after the post-study questionnaire reflected zero scores on all subscales, indicative of no ED behaviour.

Figure 18: Alison's Body Mass History

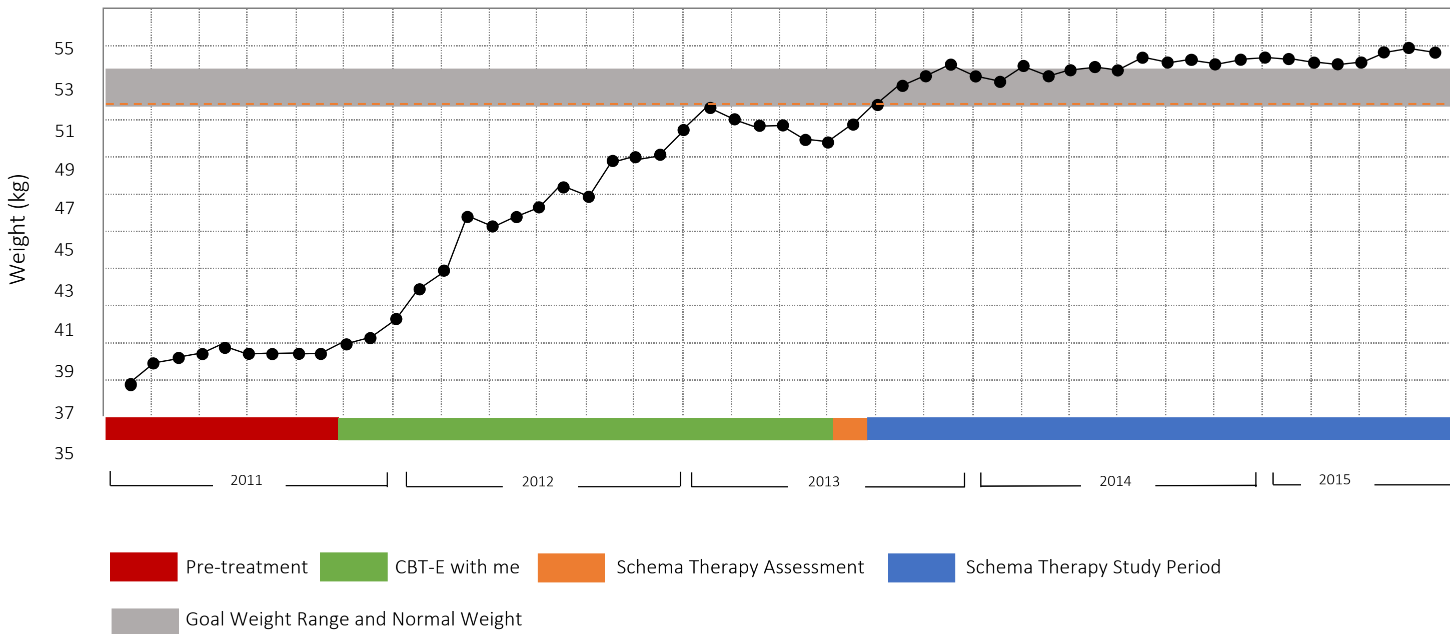


Table 14: Pre-and Post-Study results of the Eating Disorder Examination – Questionnaire (Fairburn & Beglin, 1994)

	Restraint	Eating Concern	Shape Concern	Weight Concern	Global
Pre-Study Scores	1.2	0.4	4.9	3.2	2.4
Post-Study Scores	1.0	0	3.5	1.8	1.6
Follow-up Scores*	0	0	0	0	0

* 5-year follow-up

Alison completed the Eating Disorder Quality of Life questionnaire (Fairburn & Beglin, 1994), where pre- and post-study results reflected an improvement on the psychological and physical/cognitive subscales. She scores zero on the financial and work subscales on both the pre- and post-study administrating of the questionnaire. She scored zero on all four sub-scales of the questionnaire at the 5-year follow-up administering of the questionnaire. This was further evidence of a complete elimination of all ED behaviours and beliefs. Results appear in Table 15.

Similarly, global scores for the Clinical Impairment Assessment Questionnaire (CIA 3.0; Bohn, Doll, Cooper, O'Connor, Palmer, & Fairburn, 2008; Bohn & Fairburn, 2008) pre-study, post-study and on 5-year follow-up were 20, 9 and 0 respectively, where a score greater than 16 is indicative of an ED. While the pre-study score was indicative of an ED, the subsequent global scores post-study fell below the threshold indicative of an ED. Interestingly, the global score at 5-year follow-up reflected no clinical impairment or evidence of an ED.

Table 15: Results of the Eating Disorder Quality of Life (Engel, Wittrock, Crosby, Wonderlich, Mitchell, Kolotkin, 2006)

	Psychological	Physical/Cognitive	Total Score
Pre-Study Scores	1.8	0.3	0.72
Post-Study Scores	1.3	0	0.48
Follow-up Scores*	0	0	0

*5 years follow-up

7.2. Shame

Level of shame was measured using the Experience of Shame Scale (Andrews, Qian, & Valentine, 2002), outlined in section 5.7.6j. The pre-study global score of 52 was in line with the mean score for females (52.96) (Velotti, Garofalo, Bottazzi & Caretti, 2017), while her post-study score of 36 was significantly lower than both her pre-study score and the mean for females. This suggests that Alison's feelings of shame decreased significantly following two years of ST.

7.3. Depression, Anxiety and Stress

The Depression Anxiety Stress Scale (DASS; Lovibond, 1983; Lovibond & Lovibond, 1995), outlined in section 5.7.6i, was administered once weekly throughout the duration of the study to measure the impact of ST on mood, anxiety and stress levels. It was also re-administered on a 5-year follow-up after an additional five years of ST. Results, which appear in Table 16 below, reflect no significant change in all three subscales throughout the 2-year study. Depression remained at a Mild level throughout, while Anxiety and Stress levels remained within normal levels throughout the study (Lovibond & Lovibond, 1995). However, a follow-up re-administering of the scale at 5 years, during which Alison continued to receive a once weekly ST session, revealed that the level on all three subscales has decreased significantly. Where the average for the Depression score throughout the study of 10.67 fell just marginally within the Mild level, the score on follow-up reflected a significantly decreased score of 2. Although anxiety and stress levels remained within the normal levels throughout the study, they still reflected significantly decreased scores on the 5-year follow-up. Where the averages for anxiety and stress during the study were 5 and 12.2 respectively, the scores on the follow-up were 2 and 4 respectively.

Table 16: Results of the DASS

Sub-scales	Sessions									
	1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100	F-U
Depression	10.0	10.8	11.0	11.0	10.6	10.8	11.1	11.1	9.8	10.3	2.0
Anxiety	6.4	6.2	5.0	5.0	5.4	5.0	5.0	5.0	5.0	5.0	2.0
Stress	9.8	11.8	12.6	12.8	12.4	12.8	12.3	13.5	11.8	12.3	4.0

7.4. Efficacy of Therapy in Resolving Problem Areas

The Clinical Outcomes in Routine Evaluation (CORE-OM; Evans et al., 2009), outlined in section 5.7.6k, was administered on a weekly basis throughout the study and, again, on a 5-year follow-up. Results of the pre-study scores and the 5-year follow-up scores are appear in Table 17 below.

Table 17: Pre- and post-study and follow-up scores on the CORE-OM

Sub-Scales	Cut-off*	Sessions 1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100	F-U
W	1.77	2.20	2.23	2.18	2.20	2.18	2.25	2.25	2.30	2.25	2.25	0.75
P	1.62	1.34	1.31	1.19	1.13	1.01	1.16	1.09	1.12	1.08	1.19	1.17
F	1.30	0.32	0.25	0.24	0.25	0.34	0.27	0.31	0.25	0.25	0.25	0.08
R	0.31	0	0	0	0	0	0	0	0	0	0	0
T	1.29	0.85	0.81	0.76	0.74	0.74	0.77	0.76	0.75	0.74	0.77	0.64

W = Well-being P = Problems/Symptoms F = Social Functioning R = Risk to self and others T = Total F-U = 5-year follow-up
* These are the norm cut-off scores between clinical and non-clinical female populations (Mellor-Clark, 1998)

There was insignificant variation in Alison's scoring across all subscales throughout the study, thus indicating no real shift in the severity of her problems. This may be partly due to her scoring within the non-clinical female population norms on all subscales, with the exception of the wellbeing subscale. Although there was little variation in her scores on this subscale throughout the study, it is interesting to note that an additional five years of regular once weekly ST sessions did see a substantial decrease in this score to well below the cut-off for the female clinical population. Although she consistently fell well below the female clinical population cut-off for social functioning throughout the study, her score of 0.08 at the 5-year follow-up indicates how well Alison had adapted to socially integrating and engaging the support of others.

7.5. Quality of Therapeutic Relationship

Three documents were administered throughout the study on a weekly basis to evaluate the quality of the therapy relationship. Some of the questions of the Session Bridging Form (SBF; adapted from Beck, 1995) enquire about level of engagement and connection to the therapist. The Working Alliance Inventory (WAI; Horvath & Greenberg, 1989), for which a more detailed description is outlined in section 5.7.6q of Chapter 5, measured three key aspects of the therapeutic alliance, namely the therapeutic bond, the mutual agreement on tasks and, finally, agreement on treatment goals. Finally, the Agnew Relationship Measure (ARM-12H; Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998) (outlined in section 5.7.6r) measures five dimensions of the patient-therapist alliance, namely bond, partnership, confidence, openness and patient initiative. Results of these three tools are graphically displayed in the tables and graphs below.

7.5.1. Working Alliance Inventory

Table 18 below reflects Alison's responses to all 12 questions on the WAI. Each cell is the average score over ten consecutive sessions.

Table 18: Results of the Working Alliance Inventory (Horvath & Greenberg, 1989)

Question	Sessions										
	1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100	F-U
1	6	6	6	6	6	6	6	6	6	6	7
2	7	7	7	7	7	7	7	7	7	7	7
3	2	3.2	4	4	4	4	4	4	4	4	6
4	1	1	1	1	1	1	1	1	1	1	1
5	7	7	7	7	7	7	7	7	7	7	7
6	6	6	6	6	6	6	6	6.1	7	7	7
7	2	2.7	3	3	3	3	3.6	4	4	4	3
8	7	6.7	6.4	7	7	7	7	7	7	7	7
9	7	7	7	7	7	7	7	7	7	7	7
10	1	1	1	1	1	1	1	1	1	1	1
11	6.1	6	6.4	7	7	7	7	7	7	7	7
12	7	7	7	7	7	7	7	7	7	7	7

Scores: 1 = Never 2 = Rarely 3 = Occasionally 4 = Sometimes 5 = Often 6 = Very Often 7 = Always F-U = 5-year follow-up

Alison consistently scores very favourably over the 100 sessions of the study and on the 5-year follow-up for all questions on the task and goals scales. This suggests that we had mutually agreed views on the joint tasks and goals for treatment. Besides always trusting me, two other questions on the bond scale suggested that there was a threat to our bond. Throughout the study, Alison answered "rarely" or "sometimes" to question 3 "I believe Graham likes me". Her response to my enquiry after the study revealed that she did not so much feel that I disliked her, but that she was generally an unlikable person. However, on the 5-year follow-up re-administering of the inventory she answered "very often" feeling this way. Similarly, where question 7 asks whether "I appreciated her", her low-scoring responses throughout were not about my character, but indicative of a still deeply entrenched sense of defectiveness that there was little to appreciate within her.

7.5.2. Agnew Relationship Measure

Table 19 below reflects Alison's responses to all 12 questions on the Agnew Relationship Measure (ARM-12H), which is described in section 5.7.6r. Each cell is the average score over ten consecutive sessions.

Alison's responses to all questions on all four subscales pertaining to Bond, Partnership, Confidence and Openness reflected positively to the extreme on the therapeutic alliance, including in the follow-up at 5 years. Only question 4 that reflected on Alison's "worry that she would embarrass herself with me" scored, on average, a "slight agreement" from sessions 31 until the completion of the study. However, she strongly disagreed with this on the

5-year follow-up. On enquiry, she reflected that this was not due to my actions but, again, a reflection of her sense of defectiveness and shame.

While these results suggest an extremely strong therapeutic relationship, it should be cautioned that Alison's strong subjugation EMS and associated CoSu coping mode might account for the extremely positive scores that she assigned to each question and that she was guarding against the possibility of criticising me and hurting my feelings. However, it should be noted that there was no evidence for this.

Table 19: Results of the Agnew Relationship Measure - Short (Agnew-Davies, Stiles, Hardy, Barkham, & Shapiro, 1998)

Question	Sessions										
	1-10	11-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	91-100	F-U
1	7	7	7	7	7	7	7	7	7	7	7
2	1	1	1	1.3	1.9	1	1	1	1	1	1
3	7	7	7	7	7	7	7	7	7	7	7
4	2.3	2	3.2	5	5	5	5	5	5	5	1
5	7	7	7	7	7	7	7	7	7	7	7
6	7	7	7	7	7	7	7	7	7	7	7
7	7	7	7	7	7	7	7	7	7	7	7
8	2.3	2	1	1	1	1	1	1	1	1	1
9	1	1	1.6	1	1	1	1	1	1	1	1
10	1	1	1	1	1	1	1	1	1	1	1
11	7	7	7	7	7	7	7	7	7	7	7
12	7	7	7	7	7	7	7	7	7	7	7

Scores: 1 = Strongly disagree 2 = Moderately disagree 3 = Slightly disagree 4 = Neutral 5 = Slightly agree 6 = Moderately agree 7 = Strongly agree
F-U = 5-year follow-up

7.6. Schema and Mode Measures

Three schema questionnaires were administered at the start and completion of the study, as well as at 5-year follow-up, during which time Alison continued to receive once weekly ST sessions.

7.6.1. Young Scheme Questionnaire

Research confirms a strong association between ED pathology and the presence of EMSs, of dysfunctional coping strategies, and the perception of dysfunctional parenting experiences. For instance, studies demonstrate higher levels of EMSs for ED sufferers compared with controls (Dingemans, Spinhoven, & van Furth, 2006), and that a higher number and type of EMSs predict the severity of ED symptomatology (Baba-ee, Khodapanahi, & Sedghpour 2007; Stein & Corte, 2008). Other studies suggest that the specific negative perceptions ED sufferers have of their parents during childhood influences the relationship between EMSs and the form of eating pathology (Murray, & Meyer, 2009). The study by Sheffield et al. (2009), for instance, indicates how the avoidant coping behaviour of ED

sufferers that serves to inhibit their thoughts and emotions is associated with a perception of an emotionally inhibited mother.

Alison inevitably developed many strong EMSs in her early childhood; many years before the manifestation of her ED in her mid-twenties. Results on the YSQ at the start of the study (see Figure 19 on page 262), a time when her ED was still very active, reflected significantly elevated scores on most of the 18 EMSs. Such results were consistent with the history gathered during the initial assessment that provided abundant evidence of a childhood punctuated by severe neglect, abuse and a significant deprivation of basic needs. This was despite Green and Balfour's (2020) cautioning that active coping modes can artificially hinder the exposure of EMSs on the YSQ. After all, Alison's AnOv accounted for much of her detached and isolated existence. Besides scores being extremely elevated on all of the EMSs in the Disconnection & Rejection domain, scores were also significantly high on the Failure, Enmeshment, Subjugation, Self-sacrifice, Emotional Inhibition and Punitiveness EMSs. This was expected, given Alison's self-doubt, submissiveness and the influence of her strict Catholic upbringing. Repeat administration of the YSQ upon completion of the study (see Figure 20 on page 263) reflected significantly decreased scores for all schemas in the Disconnection & Rejection domain. This suggested how effective was the limited reparenting in bringing about significant healing and resolve of core needs after reflecting on an original family environment that she experienced as extremely cold, detached, lonely, rejecting, abusive and, at times, explosive. It is likely that Alison's positive response to limited reparenting also accounted for growth in the HeAd mode and continued schema healing. Growth of the HeAd mode and a subsidence of the AnOv likely also accounted for a decrease in her score on the Vulnerability to Harm EMS, given that she stepped out of her insulated anorexic world and engaged in a more meaningful way with the world around her that posed no immediate threat. For many EMSs in the remaining four schema domains, however, scores remained static and, in some instances, even increased marginally. For instance, the three EMSs in the Other-Directedness domain (Subjugation, Self-Sacrifice and Approval/Attention-seeking EMSs) that manifest in CoSu and AASe coping mode behaviour remained relatively unchanged. So, too, did scores for the Failure, Emotional Inhibition and Punitiveness EMSs remain particularly high. Scores on the Pessimism and Unrelenting Standards EMSs in the Over-vigilance & Inhibition domain, however, reflected higher scores upon completion of the study.

While it is a priority to resolve AN pathology early in therapy for the purpose of limiting the severe mental and physical risks and complications associated with this life-threatening condition, it should be noted that such dismantling of the AnOv mode did not result in comprehensive EMSs decreases. Although Alison made significant progress early in ST to normalise her relationship with food and seldom fell below a normal weight range, it is an interesting observation that such dismantling of the AnOv coping mode still left many EMSs unchanged or even increased upon retesting on the YSQ at the end of the study. One explanation for this is that the lack of AnOv coping behaviour exposed schemas that were previously hidden. The study by Trottier and her colleagues, for

instance, demonstrated how the emotions and symptoms of PTSD were exacerbated once the suppressing effect of ED pathology had been resolved (Trottier, Monson, Wonderlich, & Olmsted, 2017). Chapters 8 and 9 provide clear evidence of how Alison's decreased ED pathology and concurrent HeAd growth brought significant engagement with both the VuCh and the AnCh. This more authentic engagement from the Child without the emotionally masking effect of the AnOv made for broader access to Alison's emotional injury, thus bringing deeply residing schema-based memories and experiences into focus that were previously in her blind spot. Furthermore, despite the AnOv being significantly curbed early in therapy, Alison still engaged, sometimes intensively, in other coping mode behaviour that was indicative of underlying schema activation. Persistent CoSu coping, for instance, reflected still strongly entrenched subjugation and self-sacrifice EMSs. Exaggerated scores for the Pessimism and Unrelenting Standards EMSs on retesting suggested increased schema triggering once the ED had been largely dismantled and the Child was more emotionally exposed.

Figure 19: Pre-Study results of the YSQ

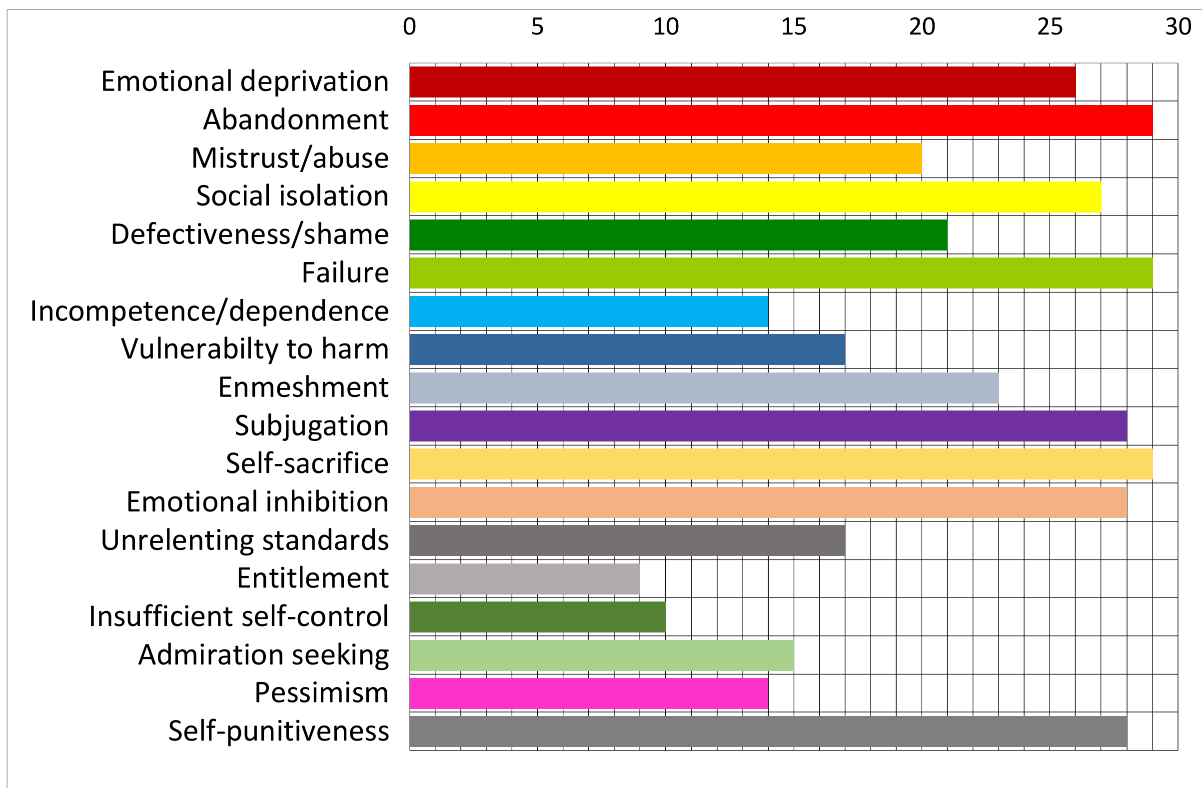


Figure 20: Post-Study results of the YSQ

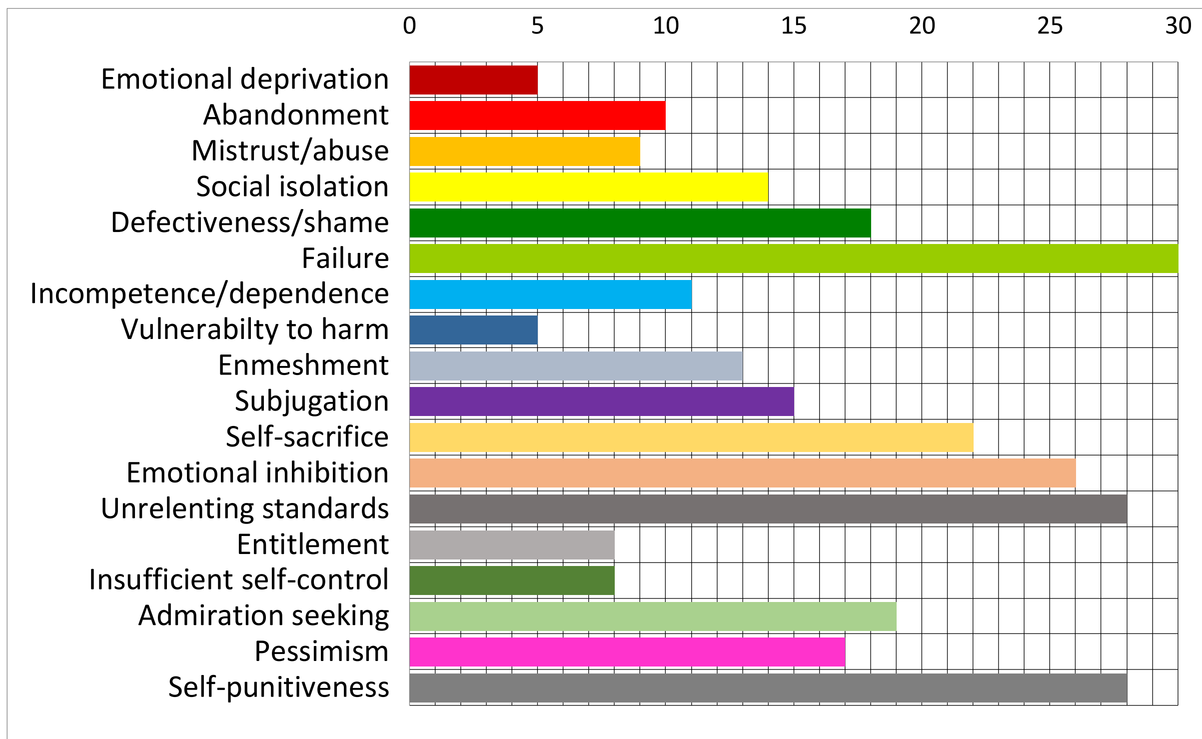
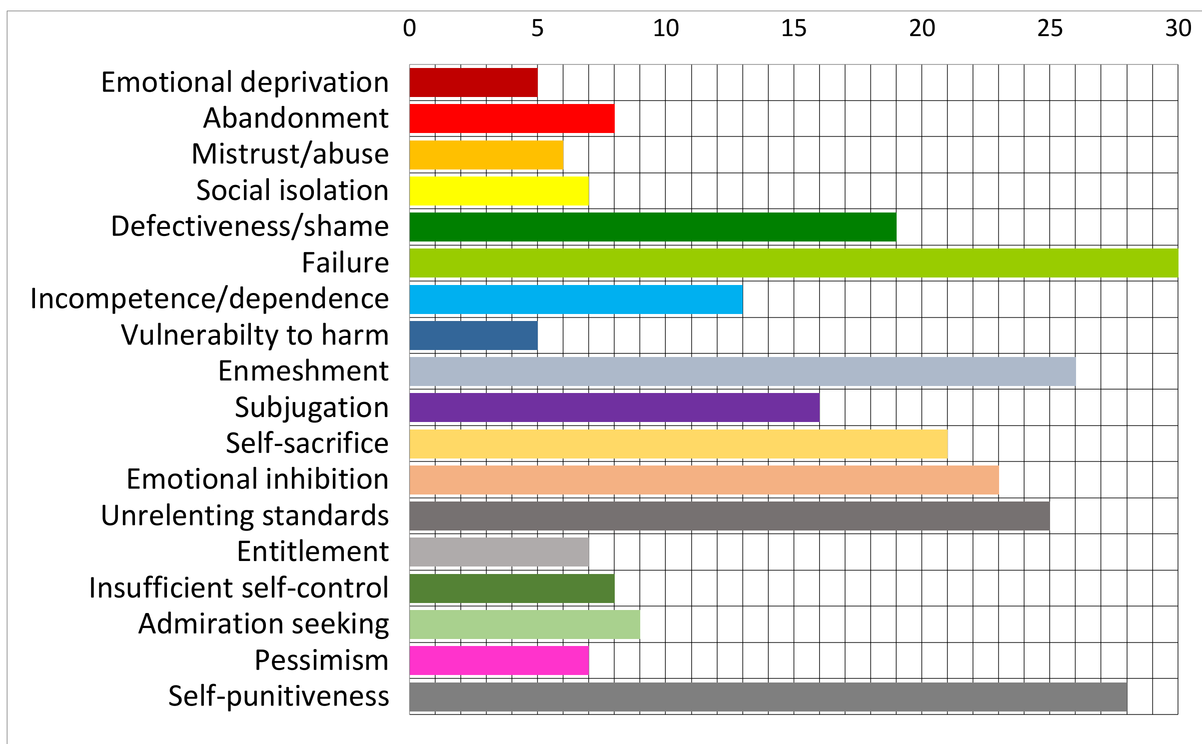


Figure 21: 5-Year Follow-up results of the YSQ



Two further possible explanations for unchanged or increased scores at the end of the study are the heightened insight that Alison experienced through the 100 sessions to be more aware of her thoughts, feelings and behaviour, and, hence, be more aware of her schemas. Another possibility for the higher EMS scores is that Alison had learned to trust me during therapy and was now more willing to be honest in her answers. It is also possible that her maturity allowed her to be more open and honest in acknowledging to herself where the wounding lay. A 5-year follow-up readministering of the YSQ (see Figure 21 on the previous page) reflected small decreases in the Abandonment, Mistrust/Abuse and Social Isolation EMSs in the Disconnection and Rejection domain, while Admiration Seeking and Pessimism scores decreased more significantly after another five years of ST. Interestingly, her score on the Enmeshment EMS increased quite markedly on follow-up. Reviewing her answers and discussing her responses to five questions revealed that Alison is not more enmeshed with her mother (or more pertinently, the introjection of her mother's ideals), but is more informed and aware of the manner in which she has felt compelled to listen to the introjected voice of her mother. Therapy has continued in the challenge to banish this introjected voice and for Alison to form her own, independent ideas and ideals. This is a good example of where one needs to be cautious in taking the results of such questionnaires at face value, but that one needs to often interrogate the reasons for many of the answers.

7.6.2. Schema Mode Inventory

For individuals that have a significant number of EMSs being frequently activated and blurring their psychological landscape, the development of the mode model emerged as a logical solution. Even though Alison did not meet the criteria for NPD or BPD for which the mode model was specifically created, the YSQ still confirmed a broad spectrum of EMSs. The mode model has become the default model for schema therapists in recent years and is the model that I was introduced to at the outset of my exposure to ST. It was, thus, natural that I would adopt this framework in treating Alison. Chapters 8, 9, and 10, together, address all of Alison's most prominent modes. While the 14 modes measured on the SMI include the PuPa and DePa, five child modes, select coping modes and the two healthy modes (HeAd, Contented/Happy Child), these did not comprehensively reflect my personalised case conceptualisation of Alison nor the collaborative mode map (see Figure 16 in section 6.3) that we built and periodically revised through the two years of therapy. It was essentially for the overcompensatory coping modes that the mode map deviated most notably from the 14 modes that are measured in the SMI. Alison's pre- and post-study results of the SMI (Z-scores in comparison with normal controls) did reflect some significant changes (See Table 20 on page 266).

While her DePa decreased from 4.07 to 3.07, her PuPa actually increased from 5.97 to 6.49. This latter parent mode increase was consistent with the high and unchanged scores for the Punitiveness EMS on the YSQ pre- and post-study results. The increase in the PuPa mode on the SMI was well-illustrated in sessions 86 to 89 where Alison

still continued to persuade her son to punish her for the way in which her AN had resulted in her emotionally neglecting him during his childhood. The high score also reflected the challenge that continued beyond the 100th session to curb Alison's compulsion to be punished for any perceived fault. It is also possible that the amplified PuPa was due to the now subdued AnOv, for which one of the functions was to self-punish in order to relieve guilt or shame. This concept has religious overtones where "penance … served to wash away the problem". This is akin to Simpson's (2019) Self-Flagellating Overcontroller coping whereby the AnCh is recruited by the coping mode and the anger turned inwards upon the Child. For Alison, this punitive function was now being exclusively held by the PuPa. Although Alison had gained a clearer metacognitive understanding of how cruel, dysfunctional and inappropriate was this echo of her mother's voice, we still faced the challenge of her being able to wholeheartedly banish this introjection and replace it with a nurturing and compassionate HeAd that would also help Alison to accept the love and forgiveness of others that she so deserves. Comparison scores on the SMI showed the CoSu coping mode to decrease the most significantly over the course of 100 sessions. Not only was the CoSu directly confronted on many occasions in chair work, but as Alison became increasingly confident and entitled to engage with the AnCh, so the need to be submissive and avoid conflict situations decreased. There were also significant changes in the Child modes over the course of therapy. Results of the SMI indicated decreases in both the Undisciplined and Impulsive Child modes by the end of the 100th session, albeit that both the modes were very repressed from the outset and always scored less than for normal controls. The Enraged Child also decreased over the course of therapy. However, it was the AnCh that decreased most significantly, where a Z-score of 2.27 at the start of treatment decreased to 0.6 over the two years of therapy. This is good evidence of the progress that Alison made in accessing her AnCh through the course of treatment, giving voice to a mode that was severely suppressed and hindered at the outset of therapy, and finding resolve. The SMI reflected similar decreases in the VuCh through the course of therapy, decreasing from a Z-score of 2.22 to that of 0.45. It should be noted, however, that the SMI measures the VuCh as a single entity, despite its numerous sub-categories that point to a broad spectrum of EMSs. Alison's VuCh, for instance, felt emotionally deprived, abandoned, wary, socially isolated, emotionally inhibited, ashamed, defective, a failure and pessimistic.

Much of the decrease in the VuCh Z-score after two years of therapy should be accounted to the significant decrease in all the EMSs of the Disconnection & Rejection domain, as confirmed in decreased scores on the YSQ after the 100 sessions of ST. Finally, Alison's healthy modes also showed significant improvement over the duration of the study. Where the Z-score of her HeAd was -2.32 at the start of the study, the subsequent score two years later of 0.0 indicates that Alison's HeAd mode was exactly aligned with the norm population. With even greater statistical significance, her Contented (Happy) Child mode was significantly lower than the normal control with a Z-score of -2.63 at the start of the study, but two years later was 0.7, indicating that her Child was more content and happier than the normal population by the time the study was completed. This was evident in the freedom, joy and spontaneity with which Alison was enjoying life in the latter parts of therapy.

Table 20: Pre- and Post-Study scores* on the Schema Mode Inventory
* = Z-scores compared to Normal Controls

	Mode Name	Pre-Study Score	Post-Study Score	Nett Change
Child Modes	Vulnerable Child	+2.22	+0.45	-1.77
	Angry Child	+2.27	+0.60	-1.67
	Enraged Child	+1.03	-0.69	-1.72
	Impulsive Child	-1.75	-1.96	-0.21
	Undisciplined Child	-0.73	-1.56	-0.83
Coping Modes	Compliant Surrenderer	+5.47	+2.66	-2.81
	Detached Protector	+0.36	+0.36	0.00
	Detached Self-Soother	+3.18	+3.57	+0.39
	Self-Aggrandiser	-0.53	-0.69	-0.16
	Bully and Attack	-0.54	-0.32	-0.22
Parent. Modes.	Punitive Parent	+5.97	+6.49	+0.52
	Demanding Parent	+4.07	+3.07	-1.00
Healthy Modes**	Healthy Adult	-2.32	0.00	+2.32
	Contented Child	-2.63	+0.70	+3.33

**Positive change in healthy modes indicates an improvement

7.6.3. Young Parenting Inventory

Results of the Young Parenting Questionnaire (YPI; Young, 1999) (described in section 5.7.6.) are reflected in Table 21 on the next page and identify parental influence in the development of seventeen of the eighteen EMSs.

Results of the pre-study YPI reflect notably low scores on many of the items that pertain to the development of Alison's EMSs that are highly evident on the YSQ. This is indicative of the extent to which Alison was out of touch with the negative influence of both parents. However, re-administering of the inventory post-study reveals a markedly increased recognition and acknowledgement of the extent to which her parents both contributed to the development of her EMSs. The most significant increases accounted to her mother were on the emotional deprivation, vulnerability to harm, defectiveness/shame, failure, subjugation, self-sacrifice, unrelenting standards and punitiveness EMSs. Similarly did she recognise at the end of two years of ST that her father played a central role in the development of her mistrust/abuse, dependency/incompetence, defectiveness/shame, failure, subjugation, self-sacrificing, unrelenting standards, entitlement, negativity/pessimism and punitiveness EMSs. These same increases were observed on the 5-year follow-up administering of the inventory. It is clear that ST did much to provide Alison with the insight and ability to acknowledge the pivotal role that her parents played in the development of her EMSs, especially for EMSs within the Disconnection and Rejection domain. It confirms Alison's early insecure attachment; something that is strongly associated with the development of AN (Tasca & Balfour,

2014; Pace, Cavanna, Guiducci & Bizzi, 2015; Treasure & Cardi, 2017; Zachrisson & Skarderud, 2010). Alison's insight to this formed an important part of the healing process, whether accessing the VuCh, engaging the AnCh or mobilising the HeAd.

Table 21: Pre- and Post-Study Scores on the Young Parenting Inventory

Schema (number of questions)	Pre-Study		Post-Study		5-year Follow-Up	
	Mother	Father	Mother	Father	Mother	Father
Emotional deprivation* (5)	2	4	5	5	5	5
Abandonment (4)	0	2	0	2	1	3
Mistrust/Abuse (4)	0	0	1	2	3	1
Vulnerability to harm/Illness (4)	1	0	3	0	3	0
Dependency/Incompetence (3)	2	0	3	2	3	1
Defectiveness/Shame (4)	0	0	3	2	4	1
Failure (4)	0	1	3	4	3	2
Subjugation (4)	1	0	4	4	4	1
Self-sacrifice (4)	1	1	4	3	1	1
Unrelenting standards (7)	4	0	6	3	5	0
Entitlement (4)	0	1	2	3	1	1
Insufficient self-control (4)	0	2	0	3	0	3
Enmeshment (4)	2	0	3	1	2	0
Negativity/Pessimism (4)	3	0	4	3	3	0
Emotional inhibition (5)	5	3	5	4	5	3
Punitiveness (4)	0	0	4	2	2	0
Approval-seeking (4)	0	0	2	0	1	0

:d scored compared with pre-study. * = a high score is 1 or 2 on Emotional Deprivation and 5 or 6 for all the other schemas

7.7 Evaluation of the Therapy Narrative

Alison was asked to read Chapter 6 in order to evaluate how accurate and comprehensive the three sections of this chapter were, namely the biographical summary, the mode map and, finally, the therapy narrative that summarised the 100 ST sessions that were analysed for the study. The Evaluation Form attended to each of these three sections separately and required answering either on a 1 to 4 Likert scale, with "Yes" or "No" responses, or with elaborated comments. Options on a 4-point Likert scale were to indicate either (1) "Very Inaccurate", (2) "Somewhat Inaccurate", (3) "Fairly Accurate" or (4) "Very Accurate".

Alison answered "Very Accurate" to all three questions pertaining to the Summary Biographical, whether the accuracy of information provided, the accuracy with which all important aspects of her life were outlined, or the accuracy with which her goals for therapy were outlined. Alison could find nothing where question 4 asked her to note any inaccurate information or facts in the summary biographical. She confirmed that the mode map that appears in Figure 17 in section 6.3. is accurate to the one that was used in therapy.

With regards to questions on the evaluation form pertaining to the therapy narrative, she answered "Very Accurate" when asked to rate the accuracy of the narrative reflecting her experience of the 100 sessions. She rated "Fairly Accurate" to the accuracy with which the therapy narrative reflected both her and my spoken word. However, this was only due to two occasions in which I reported her saying that she was "over-protective" of her son. She did not recall ever saying this. My review of the audio-recording of S43 confirmed that she did speak of her overly protective parenting. When I discussed this with her in our session following my review of her answers in the evaluation form, she conceded that she must have said this, but hoped that this did not reflect negatively on her intentions to be the best possible parent that she could be. Alison confirmed that no significant experiences that were addressed in the therapy were excluded from the therapy narrative. She could also not offer any suggestions on how the therapy narrative could have been changed to be more accurate or comprehensive. She also detected no bias in my comments. In her final comments, Alison reflected gratitude and a sense of privilege in being afforded the opportunity to read the chapter. She added "I have respect for my psychologist and hold his expertise in high esteem".

CHAPTER 8: BUILDING THE HEALTHY ADULT/VULNERABLE CHILD DYAD

By what processes did Alison develop a Healthy Adult mode to foster a secure dyadic relationship with the Vulnerable Child?

The Healthy Adult (HeAd) mode is the state of mind that exemplifies maturity and psychological health, and is synonymous with sound judgment in decision-making, responsibility in relationships, and sound self-care. Being more independent, rather than reactive or impulsive as the Child can be, the adaptive mental space of the HeAd mode ensures that the individual is well equipped to balance their personal needs with those of others (Roediger, Stevens & Brockman, 2018). When Young and his colleagues first developed the ST mode model, they described the HeAd as the healthy and functional, adult-like part of the self that performs an executive function relative to all the other modes (Young, et al.,2003). Whereas the DPM resembles a toxic parent, the HeAd mode reflects as a healthy guardian that ensures the expansive and long-term emotional well-being of a child whose core needs and values are well-defined and met. Haeyen (2019) goes so far as to argue that the HeAd need not be conceptualised as a distinct mode, but rather be viewed as the "integrated person" that the patient is. This is in line with Edwards' (personal communication, 2020) conceptualisation of the HeAd within the ST model as a "suite of modes" rather than a stand-alone and discreet mode. Similarly are an increasing number of schema therapists speaking of an "Inner Critic" (Simpson, 2019) or the Dysfunctional Parent Mode (DPM) as a suite of modes that have traditionally been separated out into distinct Punitive Parent (PuPa), Critical Parent (CrPa), and Demanding Parent (DePa) modes. Whatever one's personal preference, the HeAd essentially describes a mode that encompasses a multitude of health qualities, the task of which is to stand guardian over the Child.

The most obvious arena from which a patient can develop the HeAd mode is through modelling their therapist's behaviour and values in sessions. This is best demonstrated through two distinct ST tasks. The first of these is the therapist's provision of loving nurturance to the VuCh mode in order to ensure that all the Child's needs are adequately met. The therapist's other task is that of guardianship or protection of the Child by combating dysfunctional influences, be they internal or external. Roediger (2020) describes these therapist roles by way of a series of continuums in the "therapy relationship field" (See Figure 22 in Appendix 18). At the extreme of one of these continuums the therapist instils in their patient a sense of acceptance through the process of reparenting the Child in a manner that is loving and nurturing. At the other end of the continuum lies empathic confrontation. This is epitomised by appropriate limit setting of the Child and the interruption of dysfunctional modes in order to bring about change in a manner that is direct, but still very caring and understanding. Where these hallmark therapeutic tasks of limited reparenting and empathic confrontation are central to ST, it is the therapist's task to facilitate the internalisation of these roles in assisting their patient to build and strengthen their own HeAd mode; a mode that, in its dyadic relationship with the Child, ensures the safe and confident autonomy of the individual.

The qualities of the HeAd mode are also reflected in Carl Rogers' concept of the "fully functioning person". He explains how such individuals embrace "existential living"; leading life to the fullest and, very importantly, living mindfully "in the moment" (Rogers, 1962). They understand, trust, and resonate with their deepest and innermost feelings and desires, and experience a sense of inner freedom, while simultaneously embracing creativity, excitement, and challenges (Rogers, 1963). As is reflected in Roediger's (2020) therapy relationship field model, Bernstein and van den Broek (2009) also point to the HeAd mode's capacity for flexibility; evaluating a situation in a balanced manner by integrating thoughts and feelings while shifting back and forth between "experiencing" from one vantage point to "reflecting" from another. Such "mentalisation" (Fonagy & Bateman, 2008), or what Acceptance and Commitment Therapy (ACT) calls "defusion" (Blackledge, 2007), is a vital feature of the HeAd mode; this ability to meta-cognitively step externally from the heightened emotions of the vulnerable, impulsive, or angry Child in order to accurately and objectively appraise a situation before guiding the Child to safety and resolution. Roediger (2012, 2020) and Cousineau (2012) also highlight the "here-and-now" mindful nature of the HeAd to emotionally detach from the Child's experience in order to effectively reappraise the internalised DPM cognitions, interrupt maladaptive coping behaviour, before finally engaging in supportive and nurturing self-instruction to prompt and maintain a healthy and functional dyadic engagement with the Child. As Roediger (2020) poetically explained in his recent webinar: "Mindfulness is the air that the HeAd breathes."

Bernstein (2020) recently developed iModes – a ST toolkit that comprises cards that describe a broad range of schema modes. He comprehensively identifies eighteen distinct HeAd qualities within four categories that relate to self-directedness, self-regulation, interpersonal connectedness, and transcendence. This excellent psychoeducational tool is a useful way of informing patients about the qualities that their HeAd mode should aspire to. He has further assigned his list of 48 Personal Strengths to the eighteen HeAd qualities, all of which can be usefully measured on the Bernstein Strengths Scale (2019) to give a quantifiable measure of the HeAd mode. Table 22 outlines a description of Bernstein's (2019) qualities of the HeAd mode while Table 23 outlines the personal strengths assigned to each of the HeAd qualities.

Bernstein's 48 personal strengths largely echo Harris' (2009) extensive list of "healthy personal values" which are listed in Table 24. This list provides an individual the opportunity to identify those values that they regard as most pertinent and important to themselves, thus reflecting their most prominent HeAd traits. Where ACT practitioners emphasise the importance of clarifying the values that guide their committed action, Roediger et al. (2018) also integrate this into schema therapy's concept of the HeAd mode.

While there is a surprising paucity of published work on the subject of the HeAd mode since the development of the ST mode model almost two decades ago, there appears to be growing momentum on this subject, especially via the influence of the third wave of cognitive and behavioural therapies, of which ST is one. Cross-sectional studies conducted by Brockman and colleagues have found the HeAd mode to correlate with mindfulness,

awareness, psychological flexibility, self-compassion, and valued living (Lazarevic, Hough, & Brockman, 2013; Ryan & Deci, 2017; Remond, Hough, & Brockman, 2013; Wieczorek & Brockman, 2016).

Table 22: Qualities of the Healthy Adult and their respective Strengths (adapted from Bernstein, 2020)

Factor 1: Self-directedness Sets and pursues their own life course	Factor 2: Self-regulation Regulates emotions, impulses, thoughts, and behaviour	Factor 3: Connection Forms meaningful, mutual relationships	Factor 4: Transcendence Pursues higher purposes or meanings in life and other relations
Identity Has a clear sense of self and of the qualities that make them an individual. Self-reflection Is able to look at themselves and to examine their feelings, beliefs, and behaviours. Self-confidence Believes in themselves; trusts their abilities, qualities, and judgement. Self-assertion Stands up for themselves and their rights, needs, and beliefs. Imagination Is creative and resourceful; can use their mind to explore problems and solutions, and picture future scenarios.	Emotional Balance Stays centred, keeps emotions in balance, recovers quickly after emotional triggers. Resilience Handles stress and difficulties; bends, but does not break, and bounces back. Self-control Stops and thinks before acting; can put off immediate wishes and handle frustration. Self-care Takes care of their emotional and physical health and well-being. Reality testing Checks if their ideas, feelings, and perceptions are real, objective, and rational.	Empathy Feels and understands what other people are feeling; can experience things from the other person's perspective. Compassion Wants to ease the suffering of other people; shows kindness, caring, and a willingness to help others; directs compassion towards themselves. Humour Playful, funny, fun-loving; shares jokes and laughter; appreciates the absurd in themselves, others, and life. Responsibility Reliable, trustworthy, dependable; takes their roles and obligations seriously.	Thankfulness Grateful, happy for what they receive; appreciates things, rather than taking them for granted. Wisdom Seeks truth, knowledge, life lessons; shows good judgement; learns from experience.

Table 23: Strengths associated with each quality of Healthy Adult mode

Factor 1: Self-directedness Sets and pursues their own life course	Factor 2: Self-regulation Regulates emotions, impulses, thoughts, and behaviour	Factor 3: Connection Forms meaningful, mutual relationships	Factor 4: Transcendence Pursues higher purposes or meanings in life and other relations
Identity Authentic ● Genuine ● Real Self-reflection Self-reflection ● Introspective Self-Aware Self-confidence Self-confident ● Self-reliant Self-assured Self-assertion Assertive ● Bold ● Forceful Imagination Creative ● Imaginative ● Resourceful	Emotional Balance Centred ● Well-balanced ● Stable Resilience Resilient ● Stress-tolerant ● Flexible Self-control Self-controlled ● Patient Self-disciplined Self-care Self-nurturing ● Physically fit ● Healthy Reality testing Rational ● Objective ● Realistic	Empathy Empathic ● Understanding Perceptive Compassion Compassionate ● Kind ● Caring Humour Funny ● Playful ● Witty Responsibility Responsible ● Trustworthy ● Reliable	Thankfulness Grateful ● Thankful ● Appreciative Wisdom Wise ● Learned ● Spiritual

Table 24: Harris' List of Values (Harris, 2009)

Listed Alphabetically
Acceptance • Adventure • Assertiveness • Authenticity • Beauty • Caring Challenge • Contribution • Conformity • Connection • Cooperation • Courage Creativity • Curiosity • Encouragement • Equality • Excitement • Fairness Fitness • Flexibility • Freedom • Friendliness • Forgiveness • Fun • Generosity Gratitude Honesty • Humour • Humility • Industry • Independence • Intimacy Justice • Kindness • Love • Mindfulness • Order • Open-mindedness • Patience Persistence • Pleasure • Power • Reciprocity • Respect • Responsibility Romance • Safety • Self-awareness • Self-care • Self-development • Self-control Sensuality • Sexuality • Spirituality • Skilfulness • Supportiveness • Trust

In a chronological review of the 100 ST sessions conducted with Alison designated for analysis in this study, select extracts have been chosen to best illustrate the challenges we both faced and the progress Alison achieved in developing her HeAd mode. While Roediger et al. (2018) remind us that almost everyone has some capacity for healthy adult functioning, this is often more outwardly than inwardly directed. This is where Alison's engagement with her husband and her son often reflected far more healthy beliefs and values than she held towards herself. It was, thus, important that her HeAd development involved identifying and building on the foundation of what was already present, even though dysfunctional modes often diluted her quality of engagement with such family members. Extracts from select sessions that follow identify many of the abovementioned HeAd qualities and values that were incorporated into Alison's HeAd over the approximately two years of therapy. While not all of the instances pertaining to the HeAd theme over the 100 sessions could be detailed in this analysis, those that have been selected best illustrate the developing process and the challenges faced in building this important mode.

Alison was an existing patient of mine prior to participating in the research study and commencing ST. As such, even during the initially CBT-based treatment for AN, there was already a well-established therapeutic relationship and alliance. However, it was with the migration to the ST mode model of treatment that our therapeutic relationship was brought more sharply into focus; my role as the model HeAd more deliberately serving as a protective, supportive, compassionate and empathetic figure with the quest of engaging with and healing the injured Child. It was these qualities that I was tasked with instilling in Alison to build a robust HeAd mode that would stand guardian over the Child. While traditional CBT treatment primarily focusses on the dismantling of AN as an intrusive diagnostic entity, the therapy with Alison shifted the emphasis beyond the dissolution of anorexic behaviour toward cultivating a trusting relationship with the emotionally injured Child. AN was now conceptualised as a means of coping; an inauthentic personality component serving to shield the Child from the powerful emotions that she considered intolerable. Rather than being simply viewed as an intrusive foe, AN was now being more broadly conceptualised as an overcompensatory mode that blocked fear, sadness, anger, or any other powerful schema-driven emotion in the Child. This is what made the therapeutic alliance so pivotal, where the trust and collaborative nature of the therapy relationship was the foundation upon which eliminating anorexic behaviour was one of many tasks.

8.1. Session 1

The very first therapy session already demonstrated the priority we faced in needing to dispel Alison's very distorted idealised notion of her mother that she introjected as the core of her DPM. As therapist, it was my responsibility to empathically confront this threatening voice that was totally eclipsing the almost non-existent HeAd and chastising the Child. With the absence of HeAd, it was important that I modelled and fulfilled the role of proxy HeAd; assuming this essential voice that Alison would ultimately need to develop to vehemently defend, protect, guide, and lovingly nurture the Child. In this first extract, I had already helped Alison to identify this

scolding voice as her "Punitive and Critical Parent" mode, and my priority was to educate her to the importance of a healthy parental figure being required to banish this threat:

Extract 1 from Session 1

Graham: Right! And it is totally unacceptable that the criticism and scolding of this little Child here (I point to the VuCh on the mode map) be allowed to happen. This is a mode (I point to the PuPa mode that she had already identified on her mode map) that we are going to have to get out of your life. Right out, okay! Because it carries a viciously destructive anger; an abuse that is NOT okay. And this little child here does not deserve this kind of treatment. This anger towards the Child is NOT okay. If anything, it is the Child in you that has every right to feel extremely angry at your mother; not the other way around. Do you get that, Alison?

Alison: Yes, I do hear what you are saying.

Graham: What I am saying to you, Alison, is that it is absolutely unacceptable that your mother treated you the way she did. We were, just a moment ago, looking at how unacceptable she was as a mother. It's actually incredible just how dreadful she was. As you said, she WAS cold, she WAS unaffectionate, and vacant. And she never showed you the love that you really needed and that you really deserved; hmmm, and still deserve. And, you know something, I think that it is really good that you are already able to recognise and say out loud that she failed you. I hear you say it hesitantly, but (pause) that's a big thing; and not easy for you to say out loud right here. And you are right that she WAS strictly controlling and dreadfully authoritarian.

Alison: Yes, I suppose you are right there. But, it doesn't feel right saying that, though.

Graham: Sure. I get that. This critical voice in you says that you are not allowed to, well, criticise your own mother. But, again, I want to say that it is so interesting how this other voice inside you that is so critical and punishing – this critical and punitive parent mode of yours – it's so damn similar to how your mother was towards all of you. This part of you is critical like your mother, and so punitive like your mother was. So, here is this voice that is a part of you, and it echoes you mother completely. Right?

Alison: Yes, I can see that. I suppose you are right. I know that you are talking about how I should be allowed to be angry with my mother for the way she treated us, but here is this same voice inside me that speaks and thinks just as my mother. So, are both of these not good for me?

Graham: Yes. Definitely so. So, this is exactly where I was going with this. You are absolutely right; this destructive critical voice that had its origin in what you learned and observed in your mother is AS unacceptable as your mother's treatment of you when you were young. This voice inside you has taken over the destructive job your mum held. Right? (Alison hesitantly nods) They are the same. And so, this dreadful parent voice inside YOU needs to go; it needs to get out. It needs to be absolutely banished. And it is my job for now to make sure that this is what happens; well, at least until you have developed a healthy enough voice inside you that can stand up for the child in you that needs to be looked after and loved.

Alison: You are going to look after this child part of me?

Graham: Yes; ABSOLUTELY! Until your Healthy Adult part (I point to the HeAd mode on the mode map) is strong and also confident enough to protect and care for this child part of you, I am going to hold the fort. And while I do that, I want to also help that loving adult part of you to grow; to grow in confidence and learn how to take care of this little child in you that didn't receive the loving care that she needed all those years. Does that make sense? (Alison nods).

Only as the ST unfolded would I realise how deeply entrenched and insidious was the DPM, and how ill-equipped and under-developed was Alison's HeAd mode to challenge it. It was imperative that I modelled the HeAd perspective from the outset; campaigning hard in protection of the Child, and instilling the idea that building Alison's HeAd mode would be an important collaborative process. She would need to eventually possess this

sturdy and loving guardian figure in order to feel safely protected, guided and loved. While there was already very intense emotion in the session from both of us, my input was mostly educational; introducing the building blocks to what was healthy and helping Alison to see that her mother was the primary architect of the DPM. She would need to see that this introjected parent mode and the voice of her mother were essentially one in the same.

Further in the same session, Alison demonstrated how her parentified childhood and strict Catholic moral code were easily misconstrued as healthy. She assumed unreasonable responsibilities for her parents from an early age, and these unrealistic and unfair expectations were inevitably incorporated into the DPM as healthy and righteous qualities. Where Alison found it hard to sustain connection with the sad VuCh that I had partially engaged with earlier in the session, the PuPa intervened and the Child's emotion was lost:

Extract 2 from Session 1

Alison: Look, penance is there to bring healing, you know.

Graham: Hmm, so just like you said a moment ago about punishing yourself to make you feel better; this is all very interesting. Alright, so tell me then, Alison, this punishing yourself, has it ever really, really helped you to feel emotionally better, or helped bring healthy change into your life? Ever?

Alison: (Long pause) Well, it was important that I continued to be responsible. It was important that I did everything possible to keep my mother happy; oh, especially after my father died. Look, this was my task; it is what I needed to do. And if my mother failed, it's only because I did not let my needs be known.

Graham: Wow! So, like Catherine of Siena who we spoke about earlier, you saw your role as being this all provider, sacrificing your time, and being restrained?

Alison: Well, I cannot compare myself to her. She was saintly. But I tried to do so to the best of my ability. This WAS my task.

Graham: And the need for penance. Needing to punish yourself?

Alison: Well, that is the right way to be. That is what we were taught.

Graham: Look, I hear you, but I think it's important that we can look at all of this from another angle. You know, where you describe your mother as being all saintly, I see it from a very different angle, given what we have already discussed and learned about your mother and your father. As I see it, I do not think your mother was anything close to saintly. Quite the opposite, in fact. As I see it, no little child should be expected to show her mother how to do her job properly. I think she was dreadfully neglectful and critical of you, and I think she tasked you with way too many responsibilities while you were just a young girl who needed to be able to have fun and play. It was exploitative. Tell me, is it not possible that you hold so tightly to these views so that you can push away the feelings underneath; perhaps sadness and fear? Or even your angry Child within?

Alison: Well, it would be true to say that I am scared; scared of this anger that I might feel. Very scared. (Alison shifts into overcompensatory coping, creating a delusional idealising narrative of her mother) And it just does not feel right to say that she was wrong. She was my mother. And she should be respected.

Graham: Well, I think we need to look at that very carefully. But it really concerns me that you have this inner voice that says that you should unconditionally respect your parents when, after all, they were unbelievably negligent and unloving. And this notion of needing to be punished and penance being good is something that I'd like us to really challenge. I fear that this voice inside you comes from a harsh place that weighs down on you; just as I think your mum did, with her expectations and pressures. We were talking about it earlier now.

Alison: Well, this is how I was raised, and this is how I believed I should be.

Graham: I hear you, Alison, and I understand why you locked into these beliefs all of your life. After all, this was normal to you. It was the way that you were raised. But I think that it all needs to be looked at through a different lens now, and we need to re-examine your mother's whole way of being. As I see it, these religious principles by which you were raised were outright cruel and negligent; not the way that a healthy, loving, and protective mother should be towards a child. Are you open to exploring this through another lens?

Alison: Well, all I can say is that this is what I have always seen as the right way. I don't really want to question my mother's way, because I think she did her really best.

Graham: Look, Alison, I am not asking us to launch in and condemn or judge your mother right now. What I am suggesting is that we look at the way she treated you and your brothers through another lens – look at it all from another vantage point – and see if her approach was healthy or not. Are you open to that?

Alison: Well, I suppose I need to trust your judgement. It's just very uncomfortable to be turning everything I was taught upside down. But to be true, I guess I did feel unwanted, unloved, and uncared for.

Graham: I'm really pleased you can see that. And, Alison, I totally get what you were saying. And I think it's very brave of you to allow us to question someone's actions who you have admired and respected all your life. But we cannot afford to leave the child feeling this way.

Alison: Well, I have always blamed myself for not having a close relationship with her (mother). I thought that I was an utter failure as a daughter and that the only way through this is to attend confession. You know, penance is meant to wash away the problem.

Graham: And which part of you do you think is saying this?

Alison: Oh, I think that is the healthy part of me; my Healthy Adult part.

Graham: I see. Alison, I think we are going to need to rethink this, and I think we are going to need to consider whether this voice is not so much from a healthy loving parent part of you, but rather coming from that other parent voice that is extremely demanding, critical and punishing. And something in you seems to need to protect and preserve this punitive voice. It seems these have all gotten a bit muddled up.

This extract reflects how deeply ingrained was Alison's introjection of her mother's pathological and rigid value system. Conceptually, there are layers to this. While there is one aspect, the DPM, that is the introjected parent, there is another part of Alison that believes this code and yet another part that acts on it; an overcompensatory coping that is self-harming. I repeatedly and still very empathically confronted the manner in which this was normalised throughout her life, knowing that it was essential that I instil the idea that we would need to carefully and non-judgmentally re-examine this belief system in a collaborative fashion. I was less forceful in this latter part of the session as it became clearer to me how deeply entrenched was this self-destructive element within her. A significant challenge lay ahead for me to convince Alison of how unhealthy and destructive were the parenting styles that she modelled on her mother and now imposed on the Child within. Although I did allude to the presence of coping behaviour in my final comment, I did not want to explicitly address the self-flagellating attitude that was inevitably recruited from the DPM or the evidence of self-sacrifice and subjugation manifesting in CoSu coping. There was a risk that such an analysis would dilute the emotional energy already harnessed in the session or leave her confused with an overload of information and theory. My priority was for her to recognise the

presence of a threatening DPM force lying within her, and be certain that she not misconstrue this as her HeAd – a vitally important mode that would need to be the antithesis of the DPM that so cruelly influenced the inner Child.

8.2 Session 2

As early as the second session, Alison was already willing to participate in experiential work. We had been reflecting on some painful early childhood experiences and an opportunity arose to do some imagery rescripting. I created an emotionally corrective experience by introducing an exemplary model HeAd figure into her previously cold and sterile memory of childhood. This would serve as a valuable blueprint by which Alison could envisage her own inner guardian that would need to serve as the primary caretaker of the inner Child. The traumatic memory that we chose to rescript involved a little 6- to 7-year-old girl who felt neglected, lonely, frightened, silenced, and angry with her mother for being absent, and neglecting to see her daughter's anguish:

Extract from Session 2

Graham: Okay, so here is little Alison all alone on the floor of her room, playing with her dolls. This is not okay. So, someone needs to come through the door to take proper care of little Alison. If you feel comfortable to continue with your eyes closed, I want you to take a moment to consider who you would like to see come through that doorway to come and comfort you. It can be anyone you like. Maybe someone in your life when you were young. Or maybe someone in your life today. It could even be me if that would help. It could even be someone you create in your imagination. So just give that a thought and tell me when you are ready.

Alison: (With closed eyes, she pauses briefly) Well, you know, at that time I had immense respect for the nuns that taught me at school. So, if I had a nun at home and in my room with me, I would have felt safe and secure.

Graham: Ah, okay, that's excellent. So, I would like you to paint the scene and imagine one of the nuns gently opening the door and coming into your bedroom right now.

Alison: Actually, you know, Graham, that doesn't really feel very realistic to me.

Graham: Okay, that's fine. So, don't hurry this, but you give some thought to maybe another person who you would best wish to see coming through that door to comfort you. And don't hurry. Take a moment until something comes into focus.

Alison: (After another brief pause). Well, I think I'd like Michael (her husband) to be there.

Graham: Okay, that's great. So, is this Michael as he is today?

Alison: Well, yes, as he is now. Can I do that? (I say "yes, of course") Yes, Michael today. But I have to say, Graham, that I am still feeling very insecure, frightened, and that there is nobody that I can really confide in. I'm still feeling that this little child is unloved and very vulnerable, yes, vulnerable.

Graham: I absolutely understand. So just pause for a moment, and let little Alison take a few deep breaths. And it's good that you keep your eyes closed so that you can really step into this inner world.

Alison pauses for a while and lets out a deep sigh of relief, which gave me the cue that she was more ready to resume the rescripting experience.

Graham: Alright, are you ready for us to continue?

Alison: Yes, I think so.

Graham: Okay, so I'm also sitting with my eyes closed, by the way. I'm also building my own image of this. Alison, I want you to imagine your bedroom door opening very gently, and there in the doorway you see your loving Michael. He looks at you with kindness in his eyes.

Alison: (Spontaneously interrupting me) I run up to him and I hug him. And you know something, I could have never done that with my mother, because she would have never tolerated that sort of act.

Graham: I'm not surprised that you say that, but let's just keep our focus for now on Michael being here with you. What are you experiencing in this scene?

Alison: Oh, I throw my arms around his heart-warming embrace and I feel so protected, comfortable, and secure in his arms. He's like the parent I never had.

Graham: That is lovely. So, what do you want to say to him?

Alison: Oh, I would just love to tell him that I love him. But, you know, I just can't bring myself to say it.

Graham: So, remember, Alison, you are just this sweet, little 6-year-old child, and Michael is providing you with all this loving warmth and protection. He's like a loving parent to this little child of six or seven. Stay with this. And you can say something to him if you like.

Alison: Oh, okay. Yes, I feel so pleased to see you, Mike. But you know something, I am frightened (pause), timid, and nervous. I, I am unsure of myself, and I am so frightened for when my father will come home and comes into my room in a drunken state.

Graham: Oh, little Alison, I want you to know that your drunken father is simply not going to be allowed to come into the house in such a state. Alison, Mike is right here, and he is saying to you right now: "Alison, you are safe now. I am here to love and protect you, to guide you and listen to you, and give you all the love and affection that you deserve, but never had in your life before." Do you hear Michael saying this to you?

Alison: (With eyes still closed, and a broad smile on her face) Mmm, that is SO heart-warming. (Pause) But I don't feel worthy, and I don't think I deserve this. This all seems to be too good to be true.

Graham: And Mike is saying to you: "I want you to trust me, my little child, and allow this love that I have for you. You are safe now."

Alison: I will allow it, even though I am having difficulty letting myself go. I am going to try and accept this, even though it is hard.

Graham: That's wonderful, Alison. I want you to absolutely trust Michael's love, as he has always been so trustworthy and caring. He has always been here for you. Just try and breath into this and allow him to love you.

Alison: Oh, well, I will just flop into his arms.

Although this was not the culmination of the imagery rescripting exercise, what it demonstrated is the vivid and powerful emotional response that Alison had to this very effective experiential exercise. It was clear that she had formed a significant emotional engagement with her former 6-year-old child, given the real ambivalence she felt towards accepting Michael's love. It was important that I acknowledged this, given how foreign this would have been for her six decades earlier in a home environment that was so cold, empty, and abusive. In concluding the imagery rescripting, Alison was able to express her love for Michael. Afterwards she described Michael to be "somewhat as a father-figure" to the young child within her. It was valuable that I provided a clear script for Michael's role, given her still very unformed notion of the HeAd mode and her unfamiliarity with such loving intimacy. This particular imagery rescript was revisited a few times in the coming weeks, where she demonstrated increasing ease with receiving loving affection. She was less reliant upon me scripting the corrective dialogue

between her and her husband. Alison's response to imagery work already suggested that experiential work was going to be an effective medium in which to gain emotional access to her. Even though she was quickly gaining cognitive insight to the qualities and functions of the HeAd, it was at an experiential level that she would experience absolute engagement with the Child and fully experience the intensity of an inner loving guardian. I was beginning to appreciate the potential for an experiential therapeutic arena to evoke very powerful and authentic emotion and how this could facilitate significant growth in the HeAd dyadic relationship with the Child.

8.3. Session 3

Early in this session, there was an opportunity to directly deploy the HeAd in chairwork for the purpose of confronting the AnOv coping mode's threat on the VuCh. While Alison cautiously occupied the HeAd chair, I was able to heighten her understanding on the role and qualities of this essential mode:

Extract 1 from Session 3

Graham: Okay, Alison, so here you are sitting in the chair of your HeAd. Your VuCh is seated here between the two of us, and there on the other couch over there is your AnOv who is trying to convince your little child here to disregard Elliene's meal plan. But before we start, I'd like you to describe yourself; this HeAd. Tell me about your role and qualities. Tell me what you do and what your purpose is.

Alison: Well, now, I need to give that some thought. I remember you saying to me before that the HeAd looks after the Child mode. Right; she is loving and caring and protects her from those other destructive parent modes that are critical or ask too much of me. Um, she is kind and caring.

Graham: Okay, that's a great start. You are quite right. The HeAd is like a guardian to this little child; protecting her from harm, whether the bad parent modes that are overly demanding, critical, and punitive, but also pointing out to the child when she is emotionally highly triggered and starts turning to coping mode behaviour. It is your HeAd mode that realises this and steps in to provide the Child with much more healthy and constructive care. I also think that the HeAd helps to build up the Child's confidence through encouragement and helps her to have a sense of her own independent sense of self; you know, her own identity. And the HeAd is also there to keep things emotionally nicely balanced and moderated; keeping things real and sustainable. So, you see, the HeAd is a loving and guiding parent; do you remember how Michael was in the exercise we did last week? He was compassionate and empathetic to your little child and took responsible care of you so that you could be playful and have fun without feeling anxious. I know that is quite a bit to digest, but does that make sense to you?

Alison: Yes, I think you have just described the perfect parent.

Graham: Yes, that's right. Well, I am not sure if there is such a thing as a perfect parent, but a good parent, or a good enough parent. So, while we sit here either side of your little Child, what would you like to say to this Anorexic Overcontroller sitting there (I point to the couch opposite us already designated for the coping mode)?

Alison: (In a high pitched, but forceful voice) Well, I want you to move out of the way and as far away from this space as possible; and allow me to get better. Allow me freedom and stop interrupting what I am planning to do. Just out of the blue you step in!

Graham: Wow, that was FANTASTC!

Alison: Well, I just feel angry about the way this anorexic just jumps into this child's life and takes over.

Graham: Well, well; now this is a very healthy anger that you are expressing. Yes, the HeAd, of course, is a protector and you are rightfully angry in telling the anorexic off.

Alison: (While Alison unexpectedly shifted directly into the AnCh mode, I let her continue from the same seating position so as to not interrupt this unfolding development) You have no right, whatsoever, to step into my life. You are not needed and not wanted, and you are a useless part of my life. You must get away! I want to be rid of you!

So confidently had Alison become with the presence of the HeAd that the extremely elusive AnCh was bold enough to be heard, and significantly so. Of course, this very quickly elicited the guilt-inducing DPM (gi-DPM) to shut the AnCh down, but for that brief moment, Alison was confidently able to express herself due to the presence of a healthy protective mode that carries authority and strength. In fact, her AnCh was triggered later in the same chairwork session to forcibly reprimand the AnOv: "The AnOv has no right to be in my life, and I've been immensely wronged. I have been grossly violated!" The chairwork also offered an opportunity for me to explore Alison's own perception of her HeAd mode. Where her concept was still very rudimentary so early in the therapy, it provided me a chance to elaborate on its ability to mentalise a highly dysregulated state, provide sound guidance, moderate the emotional situation, and instil a sense of personal identity. Where I alluded to Winnicott's (1973) notion of a "good enough parent", I was challenging her notion of a perfect parent; an idealising trap that she was very prone to, especially in her distorted perception of her mother.

Upon audio-review of the session for the purpose of making notes and transcripts for analysis, I was struck by how deeply I was emotionally resonating with Alison's VuCh. Not only had the experiential nature of the chairwork assisted Alison to make a strong emotional connection with the anger and vulnerability in her Child, but I discovered that the chairwork enhanced my empathy with her child modes. Chairwork was going to provide a valuable platform for the therapeutic relationship, and more specifically, the reparenting process. While, at times, I felt a strong sense of collaboration and alliance as we confronted the AnOv, I also felt an immense sense of warmth and kinship towards the VuCh as I engaged with her pain.

As the session had started, so it ended with chairwork. For much of the session, it facilitated Alison's engagement with anger from both the HeAd and the Child for the harm that her ED had caused her. Behind the anger, she was able to re-engage with compassion for the Child. I knelt beside her as she re-occupied the HeAd for a final engagement with the VuCh who was represented by a cushion positioned beside her. With the AnOv on the periphery, the three of us remained in the room. I was only briefly required to initiate her loving engagement with the VuCh, where Alison showed deep warmth and compassion from a blossoming HeAd:

Extract 2 from Session 3l

Graham: Hey, little child, we really want what is best for you. It has been such a long time that you have trusted and connected with that anorexic voice. But it has been tiring for you, and it has left you lonely and miserable. It has not really protected you or kept you safe. Alison, do you want to come in here?

Alison: Well, I have the will power to do this, and I am determined that I will banish the AnOv from your life. I don't want you to depend on any of those things, like having to eat so little and being forbidden to eat certain things in order to be thin and be noticed.

Graham: And I think it is important to be reminded that this little child was neglected from getting the nourishment that she needed this week.

Alison: Well, I will have to make sure that this child gets fed properly this week. Yes, I can see that she needs this complete meal plan that Elliene has set.

Graham: Yes, here was this AnOv saying: "Hey, you must not eat that. It will make you fat and out of control."

Alison: Yes, I can see that this is so wrong. And you know something, I have absolutely no respect for the AnOv. I cannot excuse any of that behaviour. It must get out! It's a sham. It is just not real.

Graham: That is really good, Alison. So how does it feel, now that you have said this?

Alison: Well, it actually feels very liberating.

Graham: And so, what more do you now want to say to this little child seated next to you?

Alison: (Holding the cushion that represented the VuCh on her lap) Well, I want you to feel comfortable by the fact that I love you dearly. I want to protect you, give you love and affection, and help you to feel safe as you grow up. You know, it is right that you grow up and mature. You don't have to stay as a child. You can become a teenager and have fun, and then an adult, and you don't have to feel stuck as a pathetic little girl. You need not be subordinate to all those figureheads. You can be their equal; not a subordinate, submissive creature. So, I am going to help you to grow up and be able to appreciate the wonderful things of adult life.

Although the session was not without frequent interferences from the DPM, this first extended experience of chairwork provided Alison with an immensely powerful opportunity to represent the HeAd very successfully and engage in a very nurturing way with the VuCh. She reflected some of the important elements of the HeAd mode, particularly asserting autonomy and encouraging an individual identity. Where I had knelt beside the HeAd, I had intuitively reflected the advice Roediger (2020) makes to therapists to be very astute to their own body posture and proximity to the patient during chairwork. He points to the importance of the therapist only challenging dysfunctional modes face-on, but when engaging with the HeAd and Child modes, to hold a more supportive and nurturing posture by standing behind, sitting next to, or kneeling beside the Child or HeAd.

Alison commented a few weeks later how both the mode map and chairwork were very helpful in differentiating between her modes and better conceptualising the array of modes in her personality make-up. As much as the AnOv still managed to frequently reassert a dominant position, Alison grew in confidence, repeatedly occupying the HeAd chair to disrupt the AnOv and engaging with the VuCh. While accompanying her husband to a cocktail party, an acquaintance commented to Alison on her healthier appearance. Through the AnOv lens this was interpreted to mean that she was "fat and unattractive", but upon scrutinizing the mode map in S7, Alison's HeAd reality testing was able to reformulate the situation, commenting: "I can now see that our friend was giving a compliment, and that it was my issue that made me see it differently. Okay, I know that I need to be conscious of those unreasonable thoughts and see the importance of eating properly on my plan." The flash card that we composed together in S7 (see section 6.4.4.) served as a valuable reminder when in her home environment to ultimately seek the HeAd perspective when the Child was triggered.

Through the following month (S8 to S11), Alison became increasingly reluctant to occupy the AnCh chair as she was finding it increasingly difficult to tolerate this powerful emotion in this Child state. It provided an opportunity to address anger from the HeAd perspective; a mode that had already grown in stature and was more willing to sustain the authority and permissibility of expressing emotion that the AnCh still felt both forbidden to express and feared would become uncontrollable. Every advantage was taken to express feelings and thoughts from the HeAd, who was immune to the contaminating influence of the DPM and the coping modes.

8.4. Session 12

An incident in S12 well illustrates the contamination of Alison's HeAd mode. The scenario is detailed in chapter 9 as it pertains to accessing authentic anger in the AnCh. Where angry coping associated with the AnOv was front stage, the true AnCh was backstage; subjugated and undermined by the expectations of the treatment team to follow her meal plan. Alison had misconstrued the conviction of the AnOv for HeAd assertiveness. In this extract, Alison had already become aware that the authoritarian voice convincing the Child to eat less was that of the AnOv, and not that of the HeAd. This exemplifies the ACT notion of "defusion" whereby Alison managed to mindfully step back and consciously disentangle herself from the grips of a rigid internal cognitive drama to be transported to a "world of direct experience" (Harris, 2009). As such, she would be able to observe her internal processes more clearly and better identify the Child's core needs:

Extract 1 from Session 12

Graham: Okay, that's fine. Now, look, I'd like you to come and sit here in the Healthy Adult place for now. (Alison moves to the HeAd seating position beside me) I would like you to just reflect with me on this little child sitting right here, and see how that feels, while you protect this child here. What's coming through?

Alison: Well (pause), I want to push in the way and give this little child freedom.

Graham: Yes, say more.

Alison: She wants to be heard and listened to and given a place. She's not non-existent. She's somebody! Oh my, but my heart is actually bursting with anguish.

Graham: I can see that. I can see and hear how strongly you are feeling. You are very angry for what this little child has been through.

Alison: Yes. You know, I am stuck with this feeling of such anger for my mother, but I don't think that I am feeling that same feeling for you and the team now. Oh my; yes. Alright, I can see now how you are all actually very different, even though I started by being angry with you all. But it is my mother – you are right – my mother is the one that I am so, so furious with right now.

Graham: Yes, Alison. I think it is so good that you are seeing this the really proper way. The legitimate place for this anger is really your mother. This is where you really feel it?

Alison: Oh yes, so completely.

Graham: So, Alison, I want to know if you would be willing to sit here in the AnCh, again, and really own that anger that you are feeling right now. Would you be willing to do that?

Alison: Yes. I think that I can do that. But I still don't think that it is right for me to be angry with my mother. She should be respected at all times.

Graham: Alison, I know how tempted you are to go back to that rule of honouring your parents, but I think it's really important now that you allow this little child to be angry for what was done wrong to her. This is not about a disrespecting or a dishonouring of your parents. It's about it being wrong that you were so strictly over-controlled. And the angry child in YOU needs to be acknowledged for this. Right?

Alison: Okay, I do know that. It's just difficult after all these years.

Graham: I know, Alison. I do appreciate that. But for now, I want to take you back to where we were earlier; the little 10-year-old child denied the freedom to make some of her own decisions. Can we do that?

Alison: Yes, we can.

The HeAd had demonstrated one of its pivotal roles in legitimizing and encouraging the AnCh to have a voice for the way she was abusively denied her needs throughout her childhood. But once such anger had found an outlet, it opened up more space for the VuCh to reveal the sadness associated with abuse and loss, thus revealing another vital role of the HeAd in providing empathy and compassion for the Child's plight. Soon after Alison reflected on her experiences as a 10-year-old, she gained important insight. Even though decades of detached coping had shielded her from the full impact of childhood abuse and neglect, such coping behaviour was being exposed for its temporary and disingenuous qualities. Instead, Alison was beginning to experience the genuinely warm and loving relationship that was developing between her and her husband. Such deeper emotional connectivity was equally galvanising growth in the therapy relationship:

Extract 2 from Session 12

Alison: I directed it (anger) at you (the team), but it was something inside me that was to do with my parents. You know, my mother was actually an iceberg, and I think that I did the same with my own emotions for many years. I just shut down all feeling. It was too difficult, and safer to be disconnected. But I truly feel that things are different now. When I look at my relationship with Michael now, I feel so much safer showing my love for him and I feel his warmth and affection in a way that I didn't allow before.

Graham: Wow, Alison, I think it is just so wonderful how your little child has found safety to step out and allow this amazing connection to grow. Yes, you did cope by disconnecting your feelings – by detaching – but now, because you are starting to trust more and you are building a part of you that is a loving parent – this HeAd part of you – your little child is feeling safer to be vulnerable and connected with Michael. And, you know something, I can feel that connection with you as well. If I think how things were a few months ago compared to now, I feel so much more connected with you in every way. I feel your HeAd developing all the time and, more importantly, I feel the connection with your Child. While it is still very difficult for you to stay with the healthy anger in your child, I think we will find a way forward here. But I feel so much more connected in a real way with you now.

Alison: Yes, I think you are right. I do feel that too. I really am feeling safer to share, right here, my inner thoughts and feelings. Goodness, I was never able to do that with my mother.

Graham: It's really excellent that you are feeling this way. I hope you know that you are safe to share any feelings right here. So, Alison, I'm wondering whether you would be willing to come and sit next to little Alison over here and show her the love that your mother was unable and incapable of showing you when you were much younger. And just express how you feel towards her. Would you be okay to do that?

Alison: Yes, you want me to sit in the adult, the HeAd chair space again? (I nod and Alison moves next to me to occupy the HeAd chair, withdrawing from her pocket a small pewter angel which she keeps there permanently as a symbolic reminder of her VuCh) Little Alison, I want you to know that there is no more reason to feel frightened and insecure. You have been feeling very angry with your mother and father, and you have had every right to feel like that. You are a good, good person and you have been made to feel like a nuisance (pause); unwanted, and insecure. You are an innocent little child that deserves to be loved. I love you dearly, and you needn't feel ashamed. In fact, you have every reason to feel proud of who you are. You are now safe, and you have nothing to fear from your mother and your father. (In a whispered voice as she looked down at the pewter angel) And you know something, you can play. You can have fun and feel safe to be spontaneous without that dreadful interference from your parents. You do whatever YOU want to do.

After a long pause to allow Alison to remain engaged in this tender moment, I stepped in, reassuring her that I would continue to support the HeAd in taking loving care of the Child. Significant progress was being realised where the HeAd absolved the Child of any self-blame for the distress she experienced when she was young. Validating and endorsing the Child's anger was an equally important process, even though this was going to take many months to consolidate and fully internalise. Alison's HeAd was notably internalising what I was providing by way of limited reparenting.

Over the next two months, during which there was a fortnight suspension of sessions due to my annual vacation, Alison's HeAd continued to grow in stature, with a great deal of focus on the protection of the Child and banishing of the DPM. Our therapeutic relationship also continued to grow markedly, enhancing her trust in me and the therapeutic process. This made the VuCh so much more accessible.

8.5. Session 18

The dominant theme in this session involved deeper access to the AnCh (discussed in chapter 9), but it also provided an opportunity for Alison to further define the nature and qualities of her HeAd mode. While her deeply entrenched and destructively punitive Catholic belief system did much to define her DPM, an opportunity arose in the session to draw on her religiosity in a beneficial way:

Extract from Session 18

Graham: So, Alison, I know that we have spoken quite a few times before about your religious beliefs, and how your mother instilled this very strict Catholic philosophy about leading a penitential existence and denying all frivolity and so on, but I want to ask you something: I've heard you often describe what your mother expected, and how you run off to confession with the slightest concern if you think you have committed a "sin" (I gesture inverted commas with my pointing fingers). But I wonder; what would Jesus, Himself, be actually saying to you? Let's for a moment put aside your mother's views that sit inside your head; you know, that part of you that is critical and punitive and demanding to the little Child part of you much of the time, and ask: "What would Jesus, HIMSELF, say to you if He was sitting right here in the room now with you and me? Do you get what I am saying?

Alison: Yes, I think so. What is the word of the Lord, right?

Graham: Well, yes; sort of. So, when your mother has scolded you or neglected you when she has left you alone in your bedroom for ages, and you are left feeling sad or angry, what would Jesus, if He was here with us in person, have to say about this? Would he say: "Oh, yes, Alison, you have no right to be angry about the situation you are in. You should be just tolerating your father's drunkenness and see it as just

okay. And your mother's sometimes cruel behaviour; it's actually alright. Just honour them, okay?" I want you to imagine Jesus sitting here with us in person. Not just the word of God, but Jesus the man. Here, in person.

Alison: Well, when you put it like that (pause).

Graham: So, instead of going with this notion of "you are sinful for being angry" and "you must just blindly forgive all your parents' actions", I want you to just think for a moment, "what would Jesus say to Little Alison over here?"

Alison: Well, now I think you have a point here. You are absolutely right that Christ is the shepherd, and we are all His little children. He is a loving God; gentle and caring.

Graham: Right. So, what would Christ say to you as He sits here with us and reflects on your situation?

Alison: Well, I suppose, He would say that it is alright for you to feel angry and upset.

Graham: In fact, isn't that what the priest said to you just last week; that you've every right to be angry about their behaviour? Sorry, carry on.

Alison: Yes, you are right. He did say that. I think you are right, though. Christ would be loving and kind, and I think he would be gentle with me, and loving all of the time.

Graham: So, maybe the church got a few things wrong over the years. This notion of having to hide being playful and joyful, and everything having to be punished. You know, I've this image of the monk in the basement of the monastery flagellating himself for his sin and to supposedly be closer to God. Does that really make sense?

Alison: Well, I think that relates to the passion of the Christ. But, I do hear what you are saying. I don't think that Christ meant for us to suffer as He did.

Graham: So, let's get back to how Christ would engage with Little Alison.

Alison: Well, he would be all love and gentle and ensure that I am protected from harm. He would be compassionate and present. A guardian to the fullest.

Graham: Right, so which mode do you think you might be describing here?

Alison: Oh, I think it is obvious. We are talking about the loving parent; the HeAd mode for sure.

Graham: Right! And I think this is my point. When you think about the HeAd mode, I think it would be very valuable for you to think of how Jesus would be towards the child in you. And that is what your HeAd mode can be for Little Alison. Not so?

Alison: Oh, I think that is excellent. That is such a helpful and beautiful thought. That my HeAd – you have actually called her a guardian many times before – that my HeAd can be Christ-like in being all loving and gentle. And guiding me towards a fulfilling life. Thank you; that is so, so helpful, Graham.

Graham: Yes, I think that is a wonderful sort of blueprint for the HeAd. So, instead of getting stuck on some of these archaic Catholic notions of punishment and all this penitential stuff, I want you to rather go to the source, so to speak; what would JESUS say or do for the little child in you.

There were more occasions throughout the therapy where I would return Alison to the notion of Christ as a protective and loving inner guardian; the quintessential HeAd. Despite a risk of threatening her religious beliefs, I grasped the opportunity to cognitively challenge the introjected views emanating from her exposure to strict Catholicism and attempt to replace such an overcompensatory entity with sound values that define and reflect the

HeAd mode. I was, thus, utilising Alison's religious beliefs to create a positive context for the way the Child could and should be treated. While I respected her overall spiritual orientation, there were more occasions in therapy where I challenged some of the archaically strict and punitive aspects of the Catholic code. As such, I often reminded her of the exemplary image of Christ as an exemplary HeAd.

8.6. Session 22

Sessions 21 and 22 exemplified the repeated challenges that the HeAd mode faced before being able to engage with the Child. Not only was the HeAd required to repeatedly banish the DPM, but its task was also to neutralise coping behaviour, most notably that of the AnOv and the CoSu. An extract from chairwork in S22 addresses the role that Alison's ED played in suppressing her sexuality, given the immense guilt and shame induced by the DPM that echoed her mother's sexually suppressing religious values. Alison entered the session reporting that she had lost a full kilogram in the preceding week due to restrictive eating patterns. This was not surprising, given the strong emotion evoked in the focus on Alison's suppressed sexuality in the session a week earlier. Alison is seated in the VuCh chair as I empathically confront the sequence of coping modes that compromise her safety:

Extract from Session 22

Graham: Okay, Alison, so we have put quite a lot on the table here. I think that it's really good that you are able to see that the CoSu mode is also a very dangerous coping mode in you. It stops you from asserting your needs and makes you focus always on meeting others' needs so that you don't feel disappointment or feel unworthy. And when you are only following your meal plan because you are in the CoSu mode, it's a bit ironic. Yes, you are setting aside the dangerous AnOv, which is good, but your main motive for following the plan is about meeting others' needs, which is where the CoSu coping mode has got you pinned down. We spoke earlier about how important it is for the HeAd part of you to make sure that the meal plan is followed properly, because it ensures that you are being properly looked after. But this part of you doesn't feel so strong today. You seem to be caught more in a battle between the AnOv and the CoSu – both coping modes – and both bringing a threat to you – the Child. I think that we should pick up on that CoSu another time really soon, but right now, I am more concerned about the AnOv still getting a grip on you, given what has happened this past week. I can see that you feel a bit frazzled right now, so I was wondering whether you would prefer me to have a firm word with your AnOv over there and you just stay there. I'll be the HeAd for now and stand firm to look after your needs? Would you prefer that?

Alison: Oh, I think that would be very good. Yes, I am rather in a tired state right now. So, yes, that would be just fine.

Graham: So, AnOv, I'm pretty upset with you right now. Here is this little child who you have been supposedly trying to help for so many years. You've convinced her that she is going to be more in control and more powerful, that she is going to be much better off being thin and, the thing is, it seems that you have also thought it best that her starvation makes her feel disconnected about becoming a woman. All those things that her mother said to her that were so shaming and so dreadful when she was growing into a young woman, this convinced Alison here that it was shameful turning into a young woman and developing a woman's body. That's not okay. That's just not okay. You are a brute and so deceptive in convincing Alison here that she was better off following your rules. NO, that is not the case! You have actually made her life miserable. You haven't really been helping her at all. All you have done is squash her down and sucked all the life out of her, creating a prison around her and convincing her that she was not good enough for the world around her. Well, that is absolutely not true. It's actually appalling what you have done to suck all the confidence and joy out of this child's life. You are the one who should be ashamed for what you have done all these years. So, I'm going to tell you right now what I am going to do. (Placing my hand on Alison's shoulder in order for her to sense my support) I WILL stand between you and her, because she needs and deserves my genuine love and protection. So, Alison?

Alison: Wow, that is quite something.

Graham: So, how does it feel to hear me sock it to that anorexic over there?

Alison: Well, it really makes me feel safe. I wish I could talk to it this way.

Graham: Oh, I think you have already won a few good rounds in the ring with this con artist. But that's what I am here to help you to do; to help your own HeAd get to be as forceful as this and protect you at every turn. Remember, your HeAd is both loving AND protective of the little child in you; the essence of who you are. I want to help your HeAd to become as forcefully protective as I was here. And I also want us to be able to get to that place where the only mode that is driving the meal plan is the HeAd in you, and that she is driving the process, rather than your CoSu having you follow the meal plan only because you don't want to disappoint others. Do you get what I mean?

Alison: Yes, I certainly do.

The chairwork culminated in Alison throwing the cushion that represented the AnOv into the corner of my office where we, together, stamped on it, repeatedly. Doing this together reflected the importance of our collaborative effort in protecting the Child. Having sensed her tiredness and vulnerability earlier in the session, I suggested that I assume the protagonist role in scolding the AnOv for the deceptiveness and brutality it imposed on the Child. It provided an excellent opportunity for me to demonstrate the forceful protective role that would need to eventually be instilled in Alison's HeAd mode to stand guardian over the Child.

8.7. Session 25

In the sessions for a month prior to this one, Alison's long-suppressed sexuality was the dominant theme. Her compliance to the meal plan remained fairly steady, allowing for a closer examination of the roles the ED played as a composite coping mode. This is where its role in suppressing Alison's sexuality was an important focus. Unsurprisingly, it was her mother's strict Catholic values that accounted for the interruption of Alison's normal and healthy progression into adolescence and young adulthood as a sexual being, creating much shame and guilt with anything sexually related. Chairwork with Alison in S25 provided an opportunity for introspection and a re-evaluation of her personal identity; these being two important qualities of the HeAd relating to self-directedness. While Alison was occupying the VuCh chair, I was trying to gain deeper access to the teenager:

Extract from Session 25

Graham: So, what is this young 14-year-old teenager really feeling right now?

Alison: Well, obviously, with my body slowly developing, I was just left always feeling such guilt and shame for the way my body was changing. My mother drove such fear into me with her constant comments.

Graham: What sort of things do you hear her saying to you?

Alison: Well, I would be thinking "I can see that I am physically changing into a young woman (long pause) and surely this is good? This is right to be happening; Right?" (I nod in agreement, while she is sitting close to the edge of the couch, becoming almost tearful) But I don't want to be crying about this.

Graham: But hold on now. Surely you feel this way because we are reflecting on really dreadful abuse that you experienced when you were young. I have to say that I am actually feeling really sad and angry for the teenager in you right now. Are you not feeling something as well?

Alison: Look, I don't want to be tearful now. You know, it's still a sign of weakness and, to be truthful, it will still make me feel a loss of control.

Graham: Alison, I really do understand that you are being held captive by that parent voice that forbids you to be tearful, forbids you to be upset, forbids you to show any feelings that would be inconvenient for your mother. But I want you to know that in this room, right here, I want to encourage you to really share the true feelings that sit inside you. This is how I can get to really understand and appreciate what you are feeling, and what you have been through. I know it is very difficult for you to just automatically shift away from what you have been doing for decades, but it's highly abusive to shut the Child down like this. And I want to help you to see how it's not only helpful to let your feelings out, but that it is your right to have these feelings be heard. Does this make sense to you?

Alison: Yes, I do hear what you are saying. Thank you.

Graham: Okay, so let us go back to what you are really, really feeling when you reflect on this impact your mother had? What was happening? Alison, I want you to really just try and trust this process of staying with what you are feeling. This is the hidden truth that has been denied for so long.

Alison: Well, you were asking what my mother was saying. So, I hear her saying: "Sex is dirty and bad, and I'll tell you something, bad things happen!"

Graham: You know, this is just appalling. The way your mother shamed such a healthy and natural development in you is unbelievable. It's bizarre, and it's just outrageous! It's just terrible how you've been feeling ashamed all this time. (Pause) So, what do you want to say to her right now? I really encourage you to boldly say what YOU actually feel. And I will support this. I'm right here.

Alison: Well, you have no right to put the fear of sexual attraction into me. (Long pause) Sex is something good and sacred, and a gift from God. (Another long pause as she looks distressed)

Graham: You look uncomfortable, Alison? Tell me, what's happening right now?

Alison: Well, I just don't feel really comfortable or safe saying this. It's all just a bit too much. (I gesture her to continue explaining) Well, it feels wrong to be reprimanding my mother like this. I don't really like doing this, Graham. I don't like this therapy, right now. I want to stop this therapy (she's referring to the session).

Graham: Alison, I really understand that this is very, very difficult for you, and I don't want to force you too much beyond what you can cope with right now. But I want to say this to you. I think that you are neither dirty nor bad, and you are certainly not irreparably damaged. You are just an innocent and good young person. And I want to help you to see things the way I see them, without your mother's blurring influence. Alison, I think you have been so brave and bold saying what you already have. To stand up to your mother and tell her that she was wrong is a really bold move on your side. And you are right; totally one hundred percent right that you should be able to celebrate your sexuality and throw away your mother's archaic and ridiculous notions. I'm guessing that your own mother probably felt very compelled to deny her own sexuality, and these faulty attitudes were then dumped onto you. Do you hear what I am saying?

Alison: Yes, I think so. It's just all a bit overwhelming to be standing up to her like this.

Graham: I get that. But, I tell you what, would you be willing to come and sit over here in your HeAd right next to me and, well, try saying something to your mother from this place that already carries a lot more authority? Remember, by sitting right here, you would be speaking for young Alison. Would you be willing to do that?

Alison: Yes, perhaps I can do that. (I direct Alison to sit in HeAd)

Graham: Now, from this place of authority – remember, you and I are protecting young Alison here and we are her loving guardian – I'd like you to put out what needs to be said. Remember, I am here to help you. We are a team; you and me. Can you try that?

Alison: Yes, I suppose I can if it comes from this place.

Graham: Okay, so you start in your own time while young Alison sits here on your lap (Alison had already taken the pewter angel from her pocket).

Alison: Graham and I won't let you feel unclean and contaminated. You are a pure and beautiful child, well, young woman, and an innocent little child, and we will take care of you. We are here to protect you and make sure that you are safe and secure. And we are here to make sure that you feel loved and valued. That is so important. I, the healthy adult, will make sure of that to the best of my ability. (Pause) I am so angry for the way you were treated for so long. It's just not right. Not right at all. And I understand that you are sad. And it's okay that you feel that. I feel it too.

Graham: That's great, Alison. Now, how does it feel saying this?

Alison: Oh, it certainly feels much easier from here (in HeAd). It's really strange how the feeling shifts when I come to sit in this place. It's definitely much easier from here.

While I had hoped that the Child would be able to confront the punitive voice that echoed her mother, Alison was feeling very vulnerable and clearly edging outside of her window of tolerance. Even my repeated acknowledgement of her difficulty in this task did not give the VuCh the impetus to speak. This disruption from the DPM was interfering with an important therapeutic process. Not for the first time, by deliberately shifting her into the HeAd mode, I enabled her to access the necessary authority to neutralise the DPM that the VuCh was not yet prepared to exercise. This clearly worked with Alison noticing the significant shift in confidence once she assumed the HeAd position. I also reinforced the collaborative effort that her HeAd and I could make in providing the Child with sufficient support. It was clear that Alison's HeAd was growing significantly in confidence, but this needed to be sustained.

8.8. Session 29

In the few weeks preceding this session, the feud persisted between the DPM and the HeAd mode regarding the legitimacy of Alison's sexual identity. Despite the HeAd steadily gaining the ascendency, there were still occasions when Alison was aware of the influence the DPM was holding over the Child in this arena. In this session the HeAd stepped up to allow Alison to embrace and celebrate her newfound sexuality.

Extract from Session 29

Alison: You know something, Graham, it is absolutely, absolutely unacceptable that I have denied Mike all these years. All these years! It's deplorable that I have left him waiting patiently all these years. I've really denied him sexually. And that is certainly not alright. It's just not right. He didn't deserve this.

Graham: Well, I think we know where this critical voice is coming from. But, of course, we have spoken about how delighted Mike has recently been with the two of you growing so much closer as your recovery has come along. I remember you telling me not long ago that he is so happy with the way in which you have so quickly grown so much closer to him intimately, in every way?

Alison: Well, that is true. He did say that.

Graham: And I think it is really important that you do not get caught in that dangerous trap of being criticised for something that was so completely out of your control, and very much due to the way in which anorexia shut your life down in such a big way. You really need to

consider it from this angle. You have never been selfish or denied anyone anything. Sadly, it's the child in you who has been denied so much for so many years. Can you see how we need to push past your PuPa and the coping to allow your Child to come through and feel again, connect again, and make meaningful connections with others?

Alison: You know, Graham, there are these times when I just don't feel that my HeAd has it in her to step forward and fight for this. Sometimes I really feel confident, and then there are moments when it just does not feel to be sufficiently there. This other voice is sometimes so loud. Do you understand this?

Graham: Yes, I really do, Alison. But which voice do you know is going to take proper care of you? Which voice are we trying to make more powerful to take to the stage?

Alison: Well, the HeAd one, even though this other voice is so strong at times.

Graham: Look, Alison, I completely understand what you are saying. But I think that your HeAd has been quite amazing at times; really fighting forcefully for the little child in you, as well as the young woman that you were turning into during your teen years. But I get that you sometimes feel quite overwhelmed by the impact that your mother had, and the voice inside you that so brutally condemns and shames that part of you that is sexual. I really get that. I do. But, you see, this is the issue; I think that it is high time that the woman in you be given a voice and have a chance to really celebrate her sexual side. It's a very important and natural part of your own identity that was hijacked for decades. It is so wrong that you have lived with such shameful thoughts and feelings, and that you feel it necessary to deny the sexual and sensual parts of your being. So, as much as you get weary – as exhausting as it gets – I want us, together, to battle through and liberate the woman that sits inside you who is married and has a loving husband with whom you deserve to have a lovingly intimate relationship; emotionally and sexually. Right?

Alison: Yes, I hear you very clearly, and that healthy part of me agrees, completely. Yes, this is so. I know that I have to very deliberately go towards the HeAd voice. I can so much reflect now on all the wonderful things about Mike and my relationship. Although I sometimes slip back to that destructive thinking, you know, Graham, we really are growing closer in a warm and relaxing way. It is so rewarding. It's wonderful how we engage with each other in all ways. It's lovely.

Graham: Absolutely. So, now that you are connecting from a really healthy place, I think it might be a good time for you to come and sit right here in the HeAd chair and engage with the womanly side of you; this young woman. Can you do that? Just speak to her with kindness and care.

Alison: Okay. You have nothing wrong with you, and you even have a loving husband who does not find fault with you. Your physical relationship with your husband is wholesome and good, sacred and pure. (She turns to the PuPa) Leave her alone to allow her to enjoy naturally what was given to her by God. She has a loving husband. And you must leave this young woman to grow and be equal to her husband. You have no right to contaminate this marriage with your derogatory remarks. (Alison appeared to be addressing her mother directly) Look, you have no right to impose what was your own damage onto this woman because she does not deserve it. You are the one that is taboo, not me!

Graham: I am not going to allow you to cripple this child anymore.

Alison: I am NOT going to allow you to cripple this child anymore.

Graham: Of course, it is likely that your mother was never going to change, and her voice that sits in you needs to be banished, right?

Alison: Yes, I know this to be the case. This is true.

The chairwork culminated in Alison viewing the voice of her mother and the PuPa as parallel entities, each represented by a separate cushion. At my suggestion, the cushions were bound together with a computer cable in

order to immobilise them – something that she experienced as a very empowering ritual. Her final comment to me was: "They are not going to interfere with the woman in me, and they are not going to interfere with me (the HeAd) either, because they are not going to return." This extract showed the ease with which Alison was managing to very consciously shift from the PuPa to the HeAd mode and engage instantly in a protective and nurturing way. My facilitation in acknowledging her progress and encouraging her to occupy the HeAd chair was central to the shift. With the addition of recommended reading material for Alison and her husband to explore a more authentic and healthier sexual relationship, it was clear that their marriage was discovering newfound levels of intimacy and meaning. For a theme that was suppressed with immense guilt for decades, Alison and Michael were finding joy, light-heartedness, moments of humour, and an ever-deepening level of intimacy. Even within her broader social circle Alison was growing in confidence and building a stronger sense of personal identity. Although subsequent sessions reflected still further resurgence of the DPM challenging Alison's emerging sexuality, the HeAd demonstrated growing resilience in the stand-off between these two authoritative figures.

8.9. Session 41

As she had done in recent sessions, Alison demonstrated immense resilience in ensuring that the HeAd increasingly prevailed over the destructive influence of the DPM that was often guilt-inducing. In this session, Alison recounted an incident earlier that week where cooking oil ignited a small fire on the hob while she was preparing dinner for herself and her husband that triggered much self-condemnation and judgment. Despite persistence from the DPM to amplify guilt and the notion of an "irresponsible and careless" VuCh, the rebuttals of the HeAd were proving increasingly effective. At one point, I attempted to access and mobilise the HeAd from another vantage point:

Extract from Session 41

Alison: (in VuCh) As I see it, it's not just this terrible incident, but it has to be said that I have failed in all respects. I have failed Mike and even Eric (her son). He can't even trust his own mum. (At this point, she flipped back into HeAd) But it has to be said, I do suppose that when I am calm, which isn't often, I want to protect the Child part of me.

Graham: Okay, this is good. I sense that the HeAd part of you has just stepped in to rescue the situation.

Alison: That might be so. (She flips back into the critical mode) Look, I hear what you are saying, Graham, but I can't help but see that even my HeAd is too irresponsible and unreliable here. I really, really do not think that I should be let off the hook, as this would be too easy a cop-out.

Graham: Wow, now just hold that in focus for a moment, Alison. I'm hearing quite a back-and-forth shift going on here. This critical voice in you seems to be very intent on you being punished. Repent! Repent! Right? And not even the HeAd seems to be able to protect you. You seem to be saying that under no circumstances should the Child not be punished and condemned in some way. It's the only possible outcome?

Alison: Well, yes, it was a terrible thing that I did. I do think that I was in that very frightened child mode in that situation. But it was a gross mistake. Wholly unacceptable!

Graham: Do you really feel that this is a fair assessment of the situation. We spoke just a moment ago about how what happened in your kitchen can happen to anyone. You know, I remember a similar kind of incident happening in my home a few years ago. Even when we are careful in the kitchen, these kinds of things happen. They are accidents. They happen.

Alison: Well, I still think it was grossly negligent on my side.

Graham: Okay. Alison, I'd like us – just for a moment – to look at this from another angle. I hear the condemnation of your Child from the punitive place. Now, tell me, how did Michael respond to the incident the other night?

Alison: Well, he saw that I was trembling like a little child and he just hugged me. He held me tight and didn't let go. Yes, he first put the fire out and said "that was that", or something like that. Like it was normal. Then he held me.

Graham: Okay, so you can see that Michael's response was swift in putting the fire out, and no harm was done to the kitchen or you. But he hugged you. Right? He did not scold you or reprimand you like your PuPa mode is so intent on doing. I cannot imagine how your mother would have behaved in this situation. But, as you know, she is echoed in your PuPa mode – just nasty and cruel – and intent on punishing. So, look at how Michael responded to the situation. That's normal and caring, and an appropriate and caring response. And no harm was done. Now, I want to ask you this: If it was Eric who had done this in your house, whether it was now or years ago when he was young, how would you have responded to him? Would you have scolded him and called him incompetent and careless? Would you have shouted at him that he was grossly negligent?

Alison: Oh, but of course not. That would not be fair. He's not incompetent. I would be concerned that he, maybe, hurt himself. I would NEVER scold him. I would tell him it is a dreadful mistake that he had every right to make.

Graham: And if my own daughter – okay, she's too young to be cooking on the stove now – but if she did something that resulted in something like this happening, let's say, flooding the bathroom floor because she mistakenly left the basin tap on. Do you think that I would scold her and remind her how incompetent she is?

Alison: Oh, good God, now. She is a lovely little child. And you would certainly not do that to her. I know that you are a caring and loving father to that dear little child.

Graham: So then tell me something, Alison, why should YOU be treated any differently?

Alison: Oh, but that is different. I am not worthy of forgiveness. I'm anorexic and I'm garbage.

Graham: Hold on, which voice just stepped in here and calling you this?

Alison: Truth be told (pause), that is the punitive and critical parent voice.

Graham: And sounds like?

Alison: Oh, that's my mother's voice all right.

Graham: So, what I am asking, Alison, is this. When you look at how you were and are with Eric, or if it was Michael, and how it would be with Sophie (my daughter), because I have told you quite a bit about Sophie and my relationship before, is there actually any justifiable reason why Little Alison should be treated any different? Why on earth should there be a different set of rules for Little Alison compared to everyone else?

Alison (Pause) Well, when you put it like that; I have no answer. I see where you are coming from. Of course, yes, you are right. And you have repeatedly said that I deserved to be looked after like any other child. So, yes, I see what you are saying that there is no reason for me to be treated any more harshly than anyone else. So, yes, you are right. I would have never been unkind to Eric. I wouldn't be like that with anyone, for that matter.

Graham: Right. So, I think this is a big opportunity to see that you are no different to anyone else, and that it is criminal for you to be subjected to harsher rules than anyone else. It's only because you had such a critical mother, and you internalised this into being your own internal critic throughout your life, that you are so automatically harsher on yourself than to others. And yet, there should not be a different set of rules for you. Just as you are with Eric or Michael, and just as I am with Sophie (my daughter), or how Michael and Eric are with you, so it is important that the little child in you receive the same loving care and forgiveness from your inner loving parent when mishaps occur. That is what it was: a mishap. Do you see where I am coming from?

Alison: Well, as I said earlier, when you describe the situations this way, I see it so much, much more clearly. And when I step out of looking at my (internal) Child, and see how I would be with others, it makes sense that I be kinder and more understanding towards myself. Yes, this is VERY useful. I suppose that I am so used to knocking down the little (Child) me, that I don't think twice to see it in another way.

Graham: It's so good to hear you seeing it this way. Now, I know that you understand this. It's in your head now, and you've made that clear. The challenge now, is how we move that realisation to an emotional level in you so that you can truly own and live this belief that you are deserving to be treated as well as you treat others, or how anyone should be treated with respect and understanding. Does that make sense?

Alison: Yes, I hear what you are saying. I know that I often shift back. I think you are right that this is about it needing to really sit tight in me.

Graham: Yes, that's right. But it is excellent that you have come to this realisation that you deserve equally loving treatment as much as anyone. So, with that, what can you say to this little child part of you right now?

Alison: Oh, I should also be compassionate to this little child that got such a fright.

Graham: I'd like you to talk directly to her, Alison.

Alison: (Spontaneously retrieving the pewter angel that she keeps in her pocket to remind her of her VuCh, placing it on her lap) You are an innocent little child who made a dreadful mistake, and I want you to know that you are not a failure, and that you made a mistake. A mistake like anyone could make. These things DO happen. And you do not deserve to be scolded for it. Yes, it was just an unfortunate mistake.

Where the chairwork continued beyond this extract, there still persisted an undulating clash between the HeAd and the DPM battling to win influence over the VuCh. However, as was illustrated in this extract, the HeAd was gaining ascendency over the DPM in most of these clashes; a slow, but steady shift that witnessed growth in the HeAd and more timeous banishment of the DPM concept. However, the extract illustrates the ease with which the HeAd was still contaminated, and how persuasive was the doctrine of the DPM that still cast ambivalence on Alison's pathway forward.

By drawing Alison to reflect on her own experiences as a mother, on her husband's treatment of her, and by drawing light onto my own relationship with my daughter, I was able to illustrate the incongruence between her treatment of others and her treatment of herself. This illustrates Roediger's (2018) view (outlined in the chapter introduction) that the therapist should harness that aspect of HeAd that sits in almost every individual. Where Alison had always reflected a healthy and loving nature towards others, so it was an important challenge that she duplicate and re-direct such love inwardly to her own VuCh. As expected, she could not provide any credible reason why she should be treated differently to others. As obvious as this was to me (and others), it was a startling insight for her in light of the habitually distorted view she had maintained. However, I still felt it necessary to remind her that integrating this at an intrinsically emotional level would still pose a significant challenge ahead of

us. Perhaps, I was not only cautioning Alison, but also myself that the undulation between Alison's "good and evil" would inevitably persist, but that the insight she gained to afford herself the same level playing field as everyone else was a pathway worth persevering in the heart of both the HeAd and VuCh modes.

Throughout the therapy, I had disclosed to Alison quite substantially of my personal life, especially of my relationship with my young daughter. My view is that this disclosure served as a good example of a loving parent, and that this could only contribute towards Alison trusting my reparenting of her inner Child. It demonstrates the value that self-disclosure can bring to therapy when used appropriately to enhance the goals of therapy. In sharing anecdotally of my family and personal life, as well as my worldviews on some topics, I provided Alison with a window as to who I was beyond the confines of the therapy room. I believe that this added a very credible layer to the trust in our therapy relationship and accounted for the level of disclosure she brought to me in sessions. This challenges the conservative psychodynamic training I received in the early 1990s, whereby we were strictly cautioned against any personal disclosure, and to remain a "tabula rasa" to our patients. This has never sat comfortably with me. The encouragement of appropriate self-disclosure in the ST model is one of the qualities that drew me to it. This is something that I feel adds a substantial dimension to the quality of work that I have done with Alison and others.

8.10. Session 45

Despite us having worked within the ST model for almost a year, Alison's HeAd was still very susceptible to being displaced by the AnOv. Although she had already demonstrated her capacity to sustain her minimum goal weight for some months, the AnOv had not yet been permanently dismantled or neutralised. As had happened previously (in S12), when the AnOv emerged, Alison easily misconstrued it as the HeAd mode speaking. It was imperative that she developed a clear and accurate concept of the HeAd, and that the Child not be guided by a coping mode that was being mistaken for a healthy mode. In this extract, Alison was convinced that she had a supposedly credible reason to exclude the two supplementary protein shakes from her daily intake. It was my task to help her see that this was the AnOv, and reinstate the authority of the genuine HeAd to ensure proper compliance to the meal plan:

Extract from Session 45

Alison: So I truly think that, at this point, it would be right for me to now discontinue the two shakes from my daily meal plan.

Graham: Well, it goes without saying that I am very proud of you for having sustained your goal weight for much of the time recently; and that it is so, so important that you not let your weight drop below the 52 kilogram mark. But have we – both Elliene and I – not often had this discussion with you about the importance of those protein shakes forming a very important part of your meal plan to KEEP you inside your goal weight range? Look, your meals and snacks have been coming along very nicely. I'm not disputing this. But these protein shakes have also played a really important role in not only getting you to your goal weight, but helping you to sustain yourself inside this narrow range; you know, of 52 to 54 kilograms? Is that not so?

Alison: Well, yes, I do recall that discussion. You've often said this, but I really think that it would be a healthy decision for me to try things without those extra shakes right now.

Graham: So, given what I have just said about the protein shakes being an important part of what helps you to REMAIN inside your weight range, please tell me which mode do you think is making this request? And think about it carefully.

Alison: Well, I think it has to be said that I am talking from my HeAd mode.

Graham: Okay, so how about we test this out in the chairs right now?

Alison: Yes, we can do that.

Graham: So, I want you to come sit over here, and I want you to look at Little Alison who is sitting over here and say to her: "Right, you have been quite consistently staying at your goal weight. It's still quite a low weight for someone of your age and height, but it's just good enough that no harm can come to you, physically." Okay, can you say that for now?

Alison: (Seated in the undesignated chair) Well, as you can see, you have been remaining at the right weight for some time now. Valid, it's only just a good-enough weight for you to stay at, but you have stayed there very nicely of late.

Graham: So far, so good, I'd say. Okay, now I want you to say this, and please tell me if you think it is not okay. So, I'd like you to say this to Little Alison over here: "Your dietician and Graham have often said that these protein shakes are an important part of your daily intake to keep you AT goal weight, but I (I point to Alison in an undesignated chair) think it would be a good and worthwhile experiment to take away these protein shakes. Hey, your weight might go down, which is what Elliene and Graham have always correctly predicted would happen, but I think it's a worthwhile venture. Let's see what happens?" (Pause) Can you say that?

Alison: Well, now that you say it like that, you are obviously saying it is an unnecessary risk. Oh boy. Yes, I see what you are saying now.

Graham: So, are you willing to sit there and say that?

Alison: Okay, you are being really smart here. So, no, I now get what you are saying.

Graham: So, which chair do you think you are sitting in right now?

Alison: Well, I can only be talking from the AnOv in this place, right?

Graham: Yes, you are quite right. The HeAd does not contemplate taking unnecessary risks that could jeopardise Little Alison's recovery. So, it's pretty obvious which mode is going to come up with this idea to take the shakes away?

Alison: Yes, you are right. It is obviously only the AnOv that would be willing to put my Child in danger.

Graham: Absolutely. You see, I think it is a very valuable lesson that you be very careful when you hear a voice that speaks with authority, and not automatically assume it to be the authority of the HeAd mode. Right? (Alison nods in agreement)

Alison: Yes, I see where you are coming from.

Graham: Remember, Alison, what I have said before that is a good rule to always use when you hear a voice talking to the Child, is to ask yourself: "Is this instruction or information helping the Child to feel genuinely safe, love, and protected? Not an illusion of safety, like 'losing weight will give you control' but, will the Child really thrive and be happy and free following this message?" Does that make sense?

Alison: Well, yes, that is so right. Oh, Graham, I don't know what I would do without these ideas. Can I really do this?

Graham: Alison, I believe that these ideas do already sit right here inside your own HeAd. It's just a matter of making it habit to always be asking what is genuinely going to help the Child thrive. Right?

Alison: Yes, I do understand this.

Graham: So, you remember to always ask the question: "Is this good and healthy for the little Child in me?" You'll know the answer if you remain and stay truthful to yourself.

Again, it was the elegance of chairwork being able to separate out the modes that helped Alison recognise the dissonance in her supposedly HeAd voice. Without making this differentiation of modes explicit, Alison would possibly have struggled more to identify that there was a threat within, making it a greater challenge to expose how the Child was being compromised by a reduced meal plan. Now that she was clearer on the qualities and roles of the HeAd, it was obvious that this mode would not be willing to pose a risk to the Child by removing the protein shakes. While all along I had a clear understanding of Alison's mode conceptualisation, the waters were obviously more muddied for her. This dissonance technique brought forth the clarity that it was the AnOv that was motivating for a reduced meal plan. By encouraging her to implement a line of inquiry that would solely focus on the well-being of the Child, I was working towards an emotionally protective and nurturing engagement between the HeAd and the Child.

The traditional Fairburn CBT-E model (Fairburn, 2008) would have been more inclined to highlight the irrationality and risks associated with anorexic behaviour. However, there would have been a greater risk that a conflict would have ensued with Alison vehemently holding onto the anorexic agenda. Instead, Alison's focus was to engage positively with the Child's needs; this emotive process carrying more credence than a potentially conflictual rationally-based debate.

Despite Alison's insight and awareness of the importance of meeting the Child's needs, she still chose to exclude some protein shakes from her meal plan in the coming week. This was another reminder how insight, alone, provides no assurance of change. I would need to repeatedly remind her of the Child's needs in the hope of bringing about consistent change. Alison wanted to cancel the next session, an avoidant coping that reflected her fear of condemnation for not having followed her meal plan. Thankfully she did attend and her HeAd was again able to show strength and resilience in assuming its protective and nurturing role towards the Child. Within the framework of the ST approach it made sense to encourage Alison to focus on building a sturdy HeAd/Child dyad, rather than appealing to her rationality to combat her anorexic behaviour. I realized I would need to revisit this dyadic relationship regularly in order to cultivate a permanent healthy shift.

8.11. Session 47

Likely the result of the strong focus on mobilising the HeAd in the preceding sessions, this session reflected how Alison was now more inclined to maintain a HeAd connection after sessions. She was thus drawing more readily on this protective mode in the confines of her home environment. Triggered by her imminent birthday in the coming week, a myriad of traumatic and lonely childhood memories were brought back into focus. This evoked emotion that had always been strictly forbidden by her mother. It provided an opportunity for the HeAd to re-consider whether her mother's attitudes (manifest in the DPM) were justified:

Extract from Session 47

Alison: So, I was sitting in the conservatory at home and I suddenly realised that I was having a conversation between my inner little child and my HeAd. And I was brought to tears, in fact, we both (the HeAd and the VuCh) were. I was thinking of how empty my birthdays were when I was young; actually, none of us (in the family) really celebrated birthdays in an special way, and my HeAd was saying to Little Alison that she can trust me, that I will take care of her, that I will look after her properly, that I will be there for her emotional side, and that if she felt like crying, she could do so. You know, I had to nurse the little child because she was upset.

Graham: Well, I think it is wonderful how you are starting to have these discussions; these dialogues between these important parts of yourself at home. And, you know something, I am particularly pleased to hear that your HeAd is taking charge of things and looking after Little Alison. This is great. It's brilliant! The fact that it brought you to tears is quite something, because that is something you have always said was so forbidden by your mother. And, ja (yes), you've very seldom come close to tears here in our sessions. There's always been so much shame attached to it. And then you cut the feelings off.

Alison: Well, I'm definitely seeing things more clearly now. Yes, it's dreadful how my mother so forbid (sic) any sign of feelings at home; ALL feelings. We were not allowed to show ANY weakness of emotion. (Alison pauses as her eyes start to well-up with tears) Oh no, but I am not going to allow myself to cry here right now. Remember, that I don't allow.

Graham: Hey, Alison, this is my point. I really want you to just gently allow the child in you to stay with these feelings right now. Please just try and stay with this and not let your mother in. It's so important that you can now just stay with is. This is your REAL inner little Child expressing herself. Your mother was so wrong about blocking this.

Alison: I still always feel that I must keep my emotions under control, especially here, where I have such immense difficulty preventing myself from crying. I just don't want to do it, and I am not going to do it. That's the voice I hear inside my head.

Graham: Yes, and we know whose voice that is. She's not welcome here. Alison, I want you to know that I feel very comfortable with your tears, and any emotions that you are feeling. I'm so comfortable with you staying with what brings you to tears here. In fact, it makes me feel even more closely connected to the pain inside you. I really get a sense of real sadness inside you right now when I look at you and see what Little Alison is going through. And it's okay to share that here.

Alison: Oh, I am just so used to automatically needing to dry these tears up. It's so exhausting.

Graham: I know it is, Alison. I know. I get it. But I want you to hear me when I say right now that it is absolutely safe and good for you to just stay with your feelings and your tears. They are very safe here with me and, I'm sure, with Michael and Eric too.

Alison: It's just so difficult. I just always here that voice telling me otherwise.

Graham: I get it, Alison. And I think you know just who it is that's very unwelcome here, don't you?

Alison: Oh, it's obvious.

Graham: And what is she saying to you right now?

Alison: Oh, my mother is telling me that I am a weak character, and that I am not worth much if I just cry and take self-pity. Self-pity is not to be indulged in. These tears are deplorable. That's what she would be saying to me if she were alive today.

Graham: Well, the reality is that she is kind of alive today. It's like a recorded message going on inside your head that echoes your mother. I want you to know that your mother is not allowed in here at all anymore. And, Alison, these are not tears of self-pity. These are tears from the little child in you. They are very real. And I want you to know that your tears here today really help me to connect to the terrible loneliness and despair that you still carry inside you today. Alison, this is the realness that's so important to connect with. Right?

Alison: Yes, I do hear you. And, and I thank you for that (We remain silent for an extended time, reflecting on this powerful shared emotional experience).

Graham: Okay. (Pause) That's really good, Alison. Really good. You know, another thing, Alison; we both know that Michael is very emotionally connected, and he gets tearful very easily. How do you feel about him being so emotionally connected?

Alison: Well, for him it is fine. He's always been like that.

Graham: Yes, I know. But what is YOUR feeling on this, given that he is so emotionally connected and easily gets tearful?

Alison: Well, I'm not saying that he is weak, if that is what you are asking. I have always loved that he is able to show his feelings so easily. It's just who he is.

Graham: Precisely. And do you see him as "weak" for being so connected?

Alison: Absolutely not.

Graham: So, like we spoke about a few weeks ago, is there any really justifiable reason why you should be subject to a different set of rules to him? Why is it weak for you to be tearful, but for Mike it's a quality you love about him?

Alison: Well, I guess it's just that I have always heard my mother's voice saying I have to button-up my emotions; that it's a sign of weakness to cry.

Graham: And is it not really, really important that we continue to question and challenge your mother's rules? I think there is much to re-evaluate, now that your HeAd is getting stronger, and is now able to see things from a much more healthy place?

Alison: Yes, I know this to be so.

Graham: And, I think it's really important for you to be able to see that by allowing the child in you to feel safe showing her feelings, she will be more easy to connect with. It will make for more real and more deeply connected and more meaningful relationships.

Alison: Well, yes, you are right. In fact, I was brought to tears the other day when I called you on the telephone, and you assured me that you weren't going to be cross with me if I was still struggling with the meal plan. I was expecting that you should be very angry and cross, but when you said that you will support me, whatever the case, it just overwhelmed me that you would still be just so kind and caring. In fact, you saying that is probably what mostly made me make sure that I stuck to the plan 100% of the time. I just felt so safe that you understood what I was going through. I said to the little child in me "this dear little child is not going to be punished or deprived; and I do not want this little child to be frightened of punishment anymore."

Graham: And that is exactly it, Alison. If your HeAd can also adopt this non-judgmental and loving approach towards Little Alison, then she WILL feel safe. And these tears will just be a sign that you are an emotional being, just like Mike; a real feeling person.

Even though Alison was consciously aware that it was relieving to be tearful in the confines of her home environment, the indoctrination by her mother still sustained a deeply entrenched belief that any public display of tearfulness would be associated with self-pity and weakness. Therapy with Alison had already often brought home that insight, but this was still not enough to dislodge such a conditional belief. My office provided a safe environment for an unfolding and, yet, uncharted process to convince her that such shared displays of emotion were not only permissible, but essential in building deep and meaningful interpersonal and intrapersonal connections. The emotion-focused work in the session prior to this extract had the effect of drawing Alison ever closer to the despair that she experienced as a child. By persisting to hold her in her eventually tearful state and being empathetic towards her, I hoped that she would feel increasingly safe and comfortable to be more vulnerable in my presence. Only by repeatedly inviting Alison into these deep emotional states would she

normalise these moments and make them permissible. It was, however, a significant breakthrough that the mode dialogues were being carried home and that the HeAd was fulfilling its role in caring for the Child. Again, Alison had an opportunity to reconsider whether she should have been subjected to a different set of rules to everyone else. She needed to own what she was already very comfortable with in her husband's own emotionally connected nature.

8.12. Session 49

The role-play exercise in this next session provided a further opportunity to promote HeAd assertiveness. This classic CBT technique reminds us of the evolutionary roots of ST, and is a tool that well augments chairwork in specifically identifying the HeAd and providing it with explicit guidance in asserting the needs of the Child. The electronic reading device that Alison received from her son for her birthday the preceding week left her feeling daunted. Not only did she feel undeserving of this generous present, but she was extremely intimidated by the perceived complexity of the electronic device. Chairwork evolved into a role-playing scenario in which I urged Alison to request her son, who was visiting later that day, to help her understand how the new device worked:

Extract from Session 49

Alison: Look, Graham, I am too old for this. These are the kind of things that only you younger people can work. Oh goodness, I'm way too old for this kind of thing. It's beyond me, I'm so intimidated and so nervous when I hold my Kindle in my hand. It's in control of me. I don't even know how to move the pages.

Graham: Look, Alison, I completely get what you are saying. I think that many people like you and me who were not born into this computer generation are easily intimidated by these electronic gadgets. So, I get that; it's very understandable. However, remember how just last week you felt the same about your cell phone, and it did not take much for you to learn very quickly how to work the basics on your phone. And now you have that one sorted. So, why would this not be the same?

Alison: Well, it's just that I get automatically thrown by anything new?

Graham: Sure. It's that anticipation we have always spoken about. Remember, it was even the same thing early on with you being anxious and considering whether you were going to restore your weight. Remember how anxious you were at first to start gaining weight? And, as we can see, your goal weight has not done anything harmful to you; well, quite the opposite. So, what if we brace ourselves and move forward on the Kindle?

Alison: Well, at first I was anxious and frightened of this monstrosity, and I was thinking that I'd have liked Eric to just take the thing away with him. But maybe you are right; I need to move forward on new things. Yes, that makes sense.

Graham: I propose we do a little practice for when Eric is visiting this evening. It's a role-playing exercise; maybe you've heard of the term before? (Alison nods) So, I'm asking that we practice you speaking to him this evening about stepping into the world of Kindle. How would that be?

Alison: Hmm, alright. Well, I know that you are right on this one. You've been right before.

Graham: Okay. So, I want you to be playing assertive, healthy, grown-up Alison – you know, HeAd – to say what needs to be said to Eric. I can be Eric on the receiving end, okay? Is that alright with you?

Alison: Yes, let's do that.

Graham: First, I think it would be good for healthy Alison to express appreciation for the present; you deserve a wonderful gift, so your gratitude is also part of saying: "Thank you; you care to give me this lovely gift; I appreciate and value what you have done for me." Try that out?

Alison: Eric, I am most grateful and thankful for your generous gift, but I have to tell you that I was feeling so terribly anxious and frightened by this contraption device when I first opened it … I am anxious about how to work the device. (Pause)

Graham: Okay, that was great. So, what would make you feel less anxious in learning how to work this Kindle out?

Alison: Well, you know I am stupid. I need this explained very carefully to me. I am slow and it will take much patience from Eric to teach me in a way for me to have the slightest chance of understanding and taking it all in.

Graham: Alison, not good that you call yourself "stupid". That's not the case. We are not going to allow that critical voice into the room right now. You – out of here. (I gesture the DPM to leave the room) You are not stupid, Alison. You're actually very smart. Now, maybe it's more important that he explains it to you carefully and slowly at a pace you can handle. Why not go there?

Alison: Okay, Eric, you know that I am slow on these kind of things. I ask of you very kindly if you would be patient with your mother here. I am anxious that you will need to be very gentle and slow in the way you explain each little step to me. I know that you have always been marvellously patient with me, but I will need to let you know the soonest I do not feel that I understand what you are explaining to me. Would you be alright with that?

Graham: Alison, that was really excellent. Well done. I don't think I could have said it any better myself. You were clear, direct, and you conveyed to him that you would appreciate his patience and that you would halt him the moment you feel thrown. Well done.

Alison: Well, the way I am feeling right now, I'm going to do this Kindle! And at my own pace.

Graham: So, are you ready to take this to Eric this evening?

Alison: Yes, I suppose I am. It's actually so much easier than I had expected.

Alison left the session in a buoyant mood, and the following week she explained to me how her new morning routine involved rising a little earlier to have a read on her Kindle. The session demonstrated Alison's crippling anticipatory anxiety, and how important it was to engage at this level to bring about behavioural change. Just as Alison always anticipated catastrophe prior to gaining weight, so at a more generalised level was her anticipation of change central to her anxiety. Yet, this appeared to dissipate with the efforts she made. It was important that I first acknowledged and normalised Alison's anxiety. However, discussing it at a cognitive level was never going to be as effective as compared to the experiential impact of engaging in assertive behaviour, even if through rehearsal. Again, designating the HeAd as the chief mode of this behavioural exercise reiterated the importance of this mode's task gaining ascendency in guiding a safe pathway for the Child's needs to be met.

8.13. Session 56

In this session, Alison revealed how she was still susceptible to misconstruing the determined voice of her AnOv as that of an authoritative HeAd. She had lost weight that week, distracted from her meal plan due to the attention

she was giving her grieving husband, whose sister had died a few days earlier. She was adamant that she would not regain the lost weight, asserting that she was doing so in her and her husband's best interest.

Extract from Session 56

Alison: Now, Graham, you cannot label me as AnOv as I absolutely have to be in HeAd for Mike, and I have to maintain my (lowered) weight. But I am not going to gain. I am not going to regain my weight!

Graham: So, tell me, Alison, which part of you is saying this?

Alison: I am going to maintain it as a HeAd.

Graham: That's very odd. Tell me, do you not think that this is actually the voice of your AnOv?

Alison: Absolutely not. The only reason that I have eaten less this week is because I have been required to put all my efforts into supporting Mike at this difficult time.

Graham: Alison, it seems a little ironic that your ED has been such a source of worry and concern for Michael over the years, and now you seem to think that his grieving should not be affected by you eating less and losing weight this past week. In fact, it seems that you are actually justifying your decreased intake on Michael's circumstances. I'm really concerned about this.

Alison: Oh, I think you should see that I am being healthy here. This is healthy adult. Michael needs my undivided attention right now.

Graham: Oh, okay; I hear you. (Using a paradoxical intervention) So, then, Alison, I'd like you to come and sit right here in Healthy Adult and I'd like you to repeat after me to Little Alison sitting right here next to us. (Alison positions herself in the requested seating) Okay, repeat after me: "Look, for the moment I am not going to give you the full meal plan."

Alison: (After an extended pause) Oh, no, no, no, you know that I can't do that. You are very clever the way you put me on the spot. Very sneaky of you.

Graham: Sorry, why can't you decrease the plan?

Alison: Well, you are making me see that this would leave the child feeling rather abandoned, very lonely, and all on her own.

Graham: I see. So, what do you think just happened here?

Alison: Well, I can see now that I was mistaken. What I thought to be a good intention is actually a betrayal of the child. I can see that now. I have to say that I did not see that before. I do not know what I was thinking.

Graham: Alison, that's okay. Remember, I have always asked you to please ask the question: "Is this going to be good for Little Alison; good for her in the long-run?"

Alison: Yes, I must try and get into the habit of asking that question. It really does put things in the right direction.

While this paradoxical manoeuvre had the desired and immediate effect of confronting Alison with the blatant presence of her AnOv mode, it did not stop her from again seeking justification later in the session to dismiss the importance of restoring the lost weight of the previous week. However, this short intervention did demonstrate how quickly Alison responded to the priority of meeting the Child's needs and that any compromising of the meal plan was incongruent with appropriate Child care. I applied a similar paradoxical exercise a few minutes later in the session in suggesting that Alison throw the cushion representing the VuCh out of my office. She had, again, flipped into the PuPa to condemn the child to punishment for her failing as a wife. Luckily, it had the same effect as in the

above extract. She instantly flipped back into HeAd, exclaiming "No, no, no, no, no! Please, Graham, give me another chance to make amends with this little Child." This time, I empathised with the VuCh while kneeling beside Alison. She soon joined in, acknowledging that "… this child was starved of affection… safety and a feeling of being wanted", which even had the effect of bringing her to tears, something she seldom did in my company. She empathised with the sad VuCh. While empathic confrontation might have been the more conservative route to challenging the presence of the AnOv, my provocative stance did show the value of sometimes pushing hard to bring about change. However, it was concerning to me that Alison was still so easily misconstruing a threat to the Child as the HeAd, and not automatically applying the default question pertaining to the mode's impact on the Child.

8.14. Session 61

Alison continued to struggle to differentiate between healthy and unhealthy voices in this session. The HeAd was easily muddied by the influence of the AnOv and the DPM. Chairwork drew focus to the role the AnOv played in hiding the shame associated with her newfound sexuality. Restoring and maintaining her weight to within the GWR brought about renewed and harsh body dissatisfaction, especially pertaining to her sexual identity. This necessitated a strong HeAd rebuttal to challenge the mode shaming Alison's new sexual identity as a fundamental part of her adult identity.

Extract from Session 61

Alison: I have a distended, bloated, and undesirable stomach that is out of proportion. This is not where I should be. I suspect that should I be in a consultation with a gynaecologist, he would assume that I was already three months pregnant. Well, my HeAd says that I am too distended and the HeAd knows what she wants in having a healthy-looking body. In my opinion, my stomach should at least be flatter to stop me looking so fat and ugly.

Graham: Well, that's quite something I am hearing you say. Tell me, though, can you tell me one credible way in which your current shape – how your body looks today – is making your life in any way more difficult? In other words, how is your body in its current shape counting against you. Is there any evidence at all for this critical voice to be there?

Alison: Well, yes, I feel utterly out of control. If I am going to change that, I have to do something in resolving an unacceptable, big body. My stomach needs to be flatter. This is an unacceptably big body. I need to do something to stop feeling so utterly out of control.

Graham: Hmm, I don't really want to go down this road, though. Look, Alison, I 'm more interested to know if Michael's feelings about how your body has changed have anything to do with what you are feeling right now.

Alison: Well, I think you are right. He seems to think that my body is quite normal now. But I think he's got the wrong conception (sic) of what normality is. He just sees my flesh and body as healthy. And I told him that he should please stop saying that I feel so good (to him), because, oh my God, that's how fat I am. There's that voice that says to me that this is so bad; that it's wrong for me to be engaging in such physical matters. It's just so wrong. And, yet, there is another part of me that says that this is good. It feels very good. In fact, I love it when I am able to hear the warmth of the expression that Mike conveys. I want to just hold onto it. Oh, I want to grasp him closer to me.

Graham: So, I am hearing something of your healthy side being able to engage and hold this new and wonderful physical relationship you have with Michael. This is, surely, very good and wonderful.

Alison: Well, that might be so, but then there is also something there that is no good. It says that I am fat and ugly.

Graham: Well, it is very clear that there is this shaming voice that comes up against this new and healthy part of you that is embracing this wonderful part of your marriage.

Alison: Oh, you are right. You know, I don't even know where I am. I don't even know that I am in bed. My mind is just overwhelmed by his glorious, loving relationship with me. And I want to grasp it more and more. So, yes, I am glad that he doesn't just feel my bones. I don't want him to. (Long pause as she flips modes) Oh, but I don't think that I should be thinking of such matters.

Graham: Oh, I think it's important that you stay with these positives that you have just been describing. You know, this is all part of the wonderful healing happening inside you, and I think it is very valuable that you allow this important part of your life and your relationship come through. This is the healthy and real part of you that is coming through. And that critical and shaming parent voice needs to be thrown out of here.

Alison: Well, I'm lifted out of myself into another situation. Our love for each other is a most beautiful thing. You know, it's so liberating that nothing else counts; nothing else matters. Oh, I just want things to stay like this forever.

Graham: Well, this is good. So, I want you to just stay with this. Can you just close your eyes for a moment, and feel that warm embrace that the two of you share?

Alison: (Choosing not to close her eyes, but looking down into her lap) It's all-absorbing. You know, I lose concept of all my surroundings and everything else. It's a truly miraculous feeling. (Alison suddenly flips again) But, you know something, Graham, I have to put myself into a logic position here, and what Mike is actually saying to me is that I have become fat.

Graham: Alison, hold on. I'm seeing a pattern here. It seems every time you connect with the wonderfulness of your intimate connection with Mike, that intrusive voice has to come through and threatening what is wonderful and good. I'd like us to stay with what is good and healthy here. Let's do this consciously, okay? So, let's stay with what it feels like to have this wonderful connection. What is it like to be in that deep embrace?

Alison: Well, I have to say that I feel cared for just like a little child by my husband. And then, again, I also think that I do not deserve to be loved.

Graham: Are you able to see that this is a very abusive and punitive parental voice that interrupts what is good and right?

Alison: Well, perhaps, but I know that I need to stay in my Healthy Adult. But the condition needs to be that I do not have to be required to take my weight up anymore.

Graham: Umm, this suggestion sounds not very healthy. This seems like a harsh condition being imposed on Little Alison. I think that it is time now to sit right here in the HeAd chair space, and let's focus on what the Child here really needs from you. There should be no threats placed on Little Alison. Come, let's hear what you have to say to Little Alison. Remember, whichever mode is talking to Little Alison, it is not the HeAd if it is not what is good and wholesome for the Child in you. Anything that threatens the Child is not going to be your HeAd mode. This is the question I ask you to always ask of yourself when there is an inner dialogue going on. Okay, you speak from HeAd now.

Alison: (Placing her pewter angel on her lap) Well, it is my role to be loving and supportive of you. Yes, that is my sole job. I want to remind you that you deserve to feel safe in the arms of Mike, and that he loves you in a way that you truly deserve. You deserve to feel loved and supported. And I love you. You are a most lovable child. So, yes, most of the time you are safe with me.

Graham: Alison, that's lovely, but what is this notion of "most of the time"?

Alison: (With a knowing smile on her face) Well, yes, I suppose I am saying that the weight needs to be kept stable.

Graham: Hmm, I thought so. Alison, can you see how the AnOv just slips in, always edging in for some say in the matter. This is not where Little Alison feels truly loved; unconditionally loved, like Little Alison should be able to feel. Now, I want you to be conscious of remaining at all times in HeAd and your job is to ensure that Little Alison here feels consistently safe under your care. I will help you to stay on track, okay. What are you, as HeAd, going to do for Little Alison? Can you say?

Alison: Sure. Yes, you please help me if I go down that wrong pathway. Umm, so, I am really sorry about what was said earlier. Graham is going to help me to stay on the right path. Little Child, you deserve to be held so tight. I am here to keep you safe and help you KNOW that you are deeply loved. I am here to make sure that your needs are always going to be met. I am also here to help you feel in balance and I will take very careful care of you at all times. I am a much better guide than those other modes. I am here to listen to you and make sure you feel heard. And, Little Alison, I am here to make sure you grow up to be wise to always do the right; the things that are right for you, not your mother. That is very important. You are my little girl.

Graham: But, do we need to do something about the stomach?

Alison: No, Graham. That doesn't fit. No, no, no, that does not fit. We are not going to put that burden on the little child here.

Graham: So, which voice was saying earlier that you have to flatten that stomach.

Alison: Well, I don't really want to say.

Graham: Come on Alison, I think it's important we can identify who does that.

Alison: That's the DePa and the PuPa, but we banished them the Hell out of this place.

Graham: Well, I think you are right about where the origin of this voice lies. All this criticism does come from an internal critic. But remember, the AnOv is the coping mode that tried to carry out the instructions to make that inner critical voice shut up. It's just that this coping mode has a job to always make you eat less than you should be, and it's always criticising your body as too big or fat, even if you are slim. But it's less important to know exactly which mode it is that is saying this. What's important, and you recognised it here, is that it came from a place that is not okay for Little Alison. Remember what I always asked you to put out: "Is this comment good for Little Alison?" And the answer is …?

Alison: Of course not. Yes, it can't be the HeAd voice in me if it is going to bring harm to the child in me.

As Alison proceeded to scold the modes that threatened the Child's safety, she was brought to tears of anger. Her deeply sincere engagement from the HeAd to the VuCh reflected both the nurturing quality of the HeAd as well as it's protective nature in being capable of expressing healthy anger towards anything that threatened the Child's well-being. Alison was gaining a more comprehensive familiarity with the myriad of qualities required of the HeAd. The dyadic relationship between this guardian mode and the Child was definitely maturing to a deeper and more authentic level. While it was concerning that the DPM and the AnOv were still capable of subtly ambushing the Child, Alison was more readily intercepting this process to ensure that the HeAd assumed the ascendency. She was recognising and calling out these voices without automatically engaging with them. It was important that the newly physically and emotionally intimate relationship that was developing between Alison and Michael continue to flourish, and not be hindered by fear, shame, or guilt.

8.15. Session 63

Therapy resumed following my fortnight of annual leave. During this time she managed to take exceptionally good physical care of herself and maintained her goal weight by being compliant to her meal plan. She expressed how she had a clearer understanding of the way in which her AnOv had masqueraded as the HeAd in S61 a month earlier. This cognitive understanding was an important step towards preventing the Child from being exposed to modes that posed a threat to the Child. However, such intellectual insight was not enough, as this session reflected how unknowingly susceptible she still remained to flipping modes and posing a threat to the Child. While, at one moment, she was describing excellent self-care and deeper levels of intimacy in her marriage, she suddenly flipped into a mode rationalising a supposedly valid reason to self-punish:

Extract from Session 63

Alison: … and so I can truly say that I have been more adventurous and outgoing. And what this has done for our marriage is remarkable. It is more intense, honest, and open. And this has made the relationship so much more deeper at an emotional level. It's more intimate, and we both feel so, so much more safer with each other. And we are so much more supportive to one another. There's no comparison to how it was before.

Graham: I am so relieved and so pleased to hear everything that you have been doing to look after yourself so well. That's fantastic! And it is good to hear that you are being more gentle to Little Alison and stepping so much closer to Mike. Is this the intimacy that you are talking about; that you are being more loving towards each other and towards yourself?

Alison: Well, yes, that would be right. But you know something, Graham, for Mike and I it is not exactly the same. It's right to punish myself if I have to, but I have no right to punish Mike. And I think that is what I have been doing, but I am not doing that anymore. Look, what I have allowed myself to do to myself is one thing, but it is sinful to do it to another person. No! No, I cannot punish Mike along with me. He deserves everything, but I failed him.

Graham: Phew, I'm really quite thrown by this, after all the good things you have been saying about your self-care and how closely you have both come together. I was sensing how much closer a connection you were making between the little Child and your HeAd part of you. But this doesn't sound right what you are saying right here. Okay, look, I'd like us to use the cushion here to represent Little Alison, and I want to remind you of some of the dreadful things that happened to you when you were young. (I recounted events and circumstances that Alison had previously described, especially of her mother's abuse) So, Alison, when we look at this need to punish yourself, where do you think it all started?

Alison: Oh, it's pretty clear it all began with my mother; and now it's from this critical and punishing parent mode.

Graham: And who do you see is on the receiving end of this punishment?

Alison: Well, I am.

Graham: Yes, but which PART of you is being attacked?

Alison: Oh, I see what you mean. Well, that would be the little Child; Little Alison here.

Graham: And, tell me, what exactly makes it so okay for Little Alison to be punished? Why is it any more acceptable for her to be punished, compared to Michael, who you say shouldn't be punished?

Alison: Oh dear. You know, as I was saying it, I realised that I need to be looking after this dear little child part of me. You are right. There is no way that we can find that commendable. (However, she flips yet again) But this can only be said due to the will of God.

Graham: Umm, Alison, I think that it goes beyond God's will. As I see it, little Alison is unconditionally deserving of love and protection. I think everyone's little inner child deserved love and protection. I don't think it should merely be according to God's will. I don't know; what are your thoughts about that?

Alison: Hmm, yes, I hear what you are saying. And you are right; everyone deserves this care. Yes, this is what my HeAd sees.

Graham: So, what do you need to say?

Alison: Well, my mother's voice must shut up!

Graham: Go on, say more.

Alison: Well, if truth be told, I still hear this voice saying that the best thing to do is to punish this little child for what she has done to Mike over all the years for when I was anorexic. This is the right way. I hurt him with my eating disorder. And this is what is in my head, and it is the truth.

Graham: Sorry, which mode is saying this now? I'm getting a bit confused here.

Alison: Well, this is not a healthy voice, but it is that other voice that speaks loudly. I must be honest in saying that this voice does not want to go away. It still speaks out really loudly. It's just been there for such a long time.

Graham: Ah, okay. Look, I appreciate you being open with me. It's good that you can speak frankly with me. Yes, it has familiarity in your life. (Pause) But if the PuPa mode is going to hold centre stage, then I would really like you to come and sit over here in PuPa and tell this Child off.

Alison: Oh, I am most definitely not going to do that to the child. No, that would be so wrong. I refuse. I am not going to allow any harm to come to this innocent child over here. Yes, I can see clearly that this is not alright.

Graham: Well, I have to say that I am relieved that you did not take me up on that offer. I'm pleased you are choosing to stay where you are (in HeAd). So, I would like you to say something to that PuPa over there. What needs to happen?

Alison: Oh, you have abused this child ENOUGH! This is ABSOLUTELY enough! And I won't give you a minute longer to interfere with the child. So, Graham, I do think that I see clearly now that everything that my parents did wrong is what a part of me is still doing to the Child in me. It's becoming so much clearer. And it is not acceptable.

Graham: That's really good. I am pleased that you can see where this destructive part of you comes from. And it is not okay. (I recounted the imagery rescripting exercise that we did in the previous session in which Michael came to the rescue of her parents' abuse) So, where does that leave you?

Alison: Well, yes, you are right. And I do hold them both completely accountable for the way in which they treated me. So, you are right, I will never allow this child to be terrorised like this again. You know, I want to get her away from all that sordid, obscene, brutal upbringing, and put that behind her. I really want to take good care for this Child. I have the dearest little girl under my loving care now. I need to remember this always.

Graham: Okay. So do you see the importance of always keeping an eye on little Alison. It's really important that, just as you keep the (pewter) angel in your pocket at all times, that you always be conscious of this little child being beside you in HeAd. As the loving parent, you need to be conscious of the little Child always being beside you who you have the responsibility of protecting and guiding, loving and nurturing. Does that make sense? (Alison nods) Remember, the question to be always asking yourself: "Is this good for Little Alison?"

Alison: Quite right.

While this extract demonstrated how susceptible Alison was to still flipping modes, it was also evident how responsive she was as soon as I confronted her with the vulnerability facing the Child. Again, it was her understanding of the conceptualisation of multiple voices that allowed her to identify these opposing forces within. As soon as she was consciously aware of the vulnerable and abused Child, so was she instantly willing to occupy the HeAd stance. The design of chairwork in creating a distinct setting for each mode facilitated dialogue in which Alison was able to emotionally engage with the VuCh from a clearly designated HeAd stance. As like actors on the stage, each mode was individually providing an opportunity to stand front stage and be heard. It was mine and the HeAd's task to steer the drama towards ensuring the safety and nurturance of the Child. I continued to remind Alison to always ask what was best for the Child within as this needed to become habitual.

8.16. Session 86

Sessions preceding this one focused on the impact that Alison's ED had in suffocating her personal development and, similarly, the quality of her interpersonal relationships. As she grieved these lost decades, she more clearly appreciated the role that the AnOv served as a means of coping with unresolved childhood trauma. Her ED had impacted significantly on her closest interpersonal relationships, most notably, those with her husband and son. By this point she was willing to confront this in a series of conjoint sessions with her son, Eric. This was the priority for her, given that her marital relationship was flourishing. Sessions prior to this one helped Alison to see that her husband was not harbouring unresolved feelings about the past. Despite Eric having reassured his mother, upon being invited to attend a conjoint session, that he harboured no negative feelings, Alison was not convinced by this. It was the gi-PuPa mode that really needed to be confronted.

Extract from Session 86

Alison: Now, you two (referring to Eric and me), I want to start off by setting down some clear ground rules for this session. Firstly, I want to say that there should be no tears from my side. What I am saying is that if I am on the verge of tears, I want both of you to sternly reprimand me and tell me that this is absolutely not necessary.

Graham: Ouch! Alison, I am already quite concerned about your rules and where they are coming from.

Alison: Well, Graham, as I have told you before, when I return home after sessions with you and I have been tearful, I am saying to myself that I'm weak, useless, and selfishly seeking sympathy. And I don't wish to indulge these tears I shed in sessions. Look, I know that this comes from a place where my mother would think it appalling that I leave the sessions crying.

Graham: And is this who is telling you off when you go home in this state?

Alison: Well, I know that this is that PuPa part of me that is saying that I'm disgusting. Oh, and don't get me wrong, Eric, you and your father are worthy, selfless, and warm in character; and you are both most certainly entitled to be tearful, while I am devoid of redeeming qualities. That is for sure. Oh, and I owe it to your father to be strong, what with his recent loss.

Graham: I have to say that it is very uncomfortable hearing your PuPa muscling in so strongly to this meeting. And I can see from Eric's expression that this is not very nice.

Eric: Oh, I just think it is horrible to hear you thinking like this, mom. You are being so cruel to yourself here. And, and I want to really just focus more on how much nicer it is with you being kinder to yourself with your eating at all.

Alison: (Addressing the VuCh) You have nothing to cry about!

Graham: (After briefly explaining to Eric the fundamentals of chairwork and the concept of modes) Okay, back to you, Alison. Look, I want you to come and sit here in the HeAd place, and I want to see if you are prepared to speak in the same way as this abusive part is speaking now.

Alison: You always do this to me, Graham.

Graham: Well, it's my job to bring HeAd into the front and help this Child from being repeatedly hurt. Right? Hey, if you don't do this, then I am forced to take charge of situations like this. Okay, you speak. You carry on now, Alison.

Alison: Oh no, you know that I cannot say this from here. It's cruel to stifle the tears. So, maybe we need to treat this child the way she deserves.

Graham: Oh, okay; this is more like it. And remember, Alison, I want you to please get into the habit of always pushing the HeAd into the front whenever you are tempted to go to that dark side. This needs to become a reflex; automatic. Right? The HeAd needs to be automatically stepping up and taking charge of the situation. Okay?

Alison: Yes, you are so right. So, should I continue from here? (I nod) I want you to know that whatever you are feeling, you CAN actually shed tears. (Alison becomes tearful) You know, this little child never received a hug. She was so deprived, hidden away, and not seen. And, yet, Graham, I hear that voice over there saying that the little child has to earn her love, while my love for Mike and Eric is so unconditional and so easy to provide.

Graham: Yes, and I can see you are realising that this is not right.

Alison: Yes. You know, if I could transfer the love I have for Eric to that little child (VuCh), then that would be heaven on earth. Yes, yes, I see that everyone and even me deserve this kind of love. But you know something else, Graham, I have to be very careful that I do not over-indulge this child of mine. That is something I need to be very careful about.

Graham: Well, Alison, what you are absolutely right about is that Little Alison deserves exactly the same love that you, as a mother, have for Eric here. So we need to really, really, really help Little Alison to feel safe and deserving of this love. She really does deserve it after all these years of being lost. Right? (Alison nods) But you said something else now that's really interesting; this whole thing about over-indulgence. I've heard this fear before. It so reminds me of some time ago when you said to me that you were really scared of letting go of anorexia because it would then become gluttonous. Am I right?

Alison: Well, now that you remind me of that, yes, I suppose you are right. If I do not maintain control, then my fear is that things can get very out of hand. And, yet, I also see that this is not true; that it's nonsense.

It was disconcerting to me how this far into the therapy Alison was still so forcefully engaging with the DPM. Even though she was readily interrupting its full impact and hastily reasserting the HeAd's position to protect the Child, it concerned me what I might be doing wrong as a therapist. It was no surprise that this evoked my own Defectiveness and Failure EMSs, not to mention the Unrelenting Standards EMS that I was repeatedly tackling. However, I am certain that this is how many therapists are left feeling when their patients do not make the progress they were expecting or hoping for. Supervision reassured me that Alison had a severely entrenched DPM that was not going to be easily dismantled. I would need to persevere by repeatedly accessing and empathising with the pain and anger residing in the Child, and usher in the HeAd to hold the Child. I also needed to appreciate

that Alison had remained anorexic for over four decades, and that her remission from this very complex condition was relatively swift. Once the ED was marginalised, however, it brought into focus the deeply wounded Child. Now that the AnOv was mostly neutralised and no longer distracting the Child from her vulnerability and anger, the real healing process of the Child could begin in earnest. This healing was not going to resolve quickly, and I knew that we would both need to be patient as this process unfolded. Sessions like this one (of which there were many) are a reminder of the value of supervision in exposing one's own myopic view of the therapy process and having it viewed from another vantage point.

8.17. Session 87

Alison demonstrated in this session how susceptible the VuCh remained to being victimised by the DPM. However, she was becoming increasingly adept at bringing the HeAd front stage to dispatch the DPM's hold on the Child. Sessions in the months prior to this one significantly focused on hastening Alison's recognition of any modes that ambushed or assumed the disguise of the HeAd to threaten the safety of the Child. I continued to emphasise the importance of the HeAd automatically assuming ascendancy to protect the Child. In this extract, Alison had briefly flipped into the PuPa mode, again, feeling ashamed for having failed her son as a mother:

Extract from Session 87

Alison: So, Eric, as I said to you last week, I certainly believe that you have very good reason to condemn me as a mother. You have every reason to be enraged with me. And I really have to insist that you give me a good talking to.

Eric: Oh, mum, you know that this is not how I really feel. I don't want to and I really don't wish to say anything like that. I said this last time as well.

Alison: It has to be said that I was not so pure. And I was not worthy and shouldn't have been around. There was no room for me. I know that I have always been devoid of redeeming qualities. It has to be said that I failed you.

Graham: Alison, are these the words of your HeAd, because that is where you are meant to be sitting right now.

Alison: Well, I do think that this is all true. So, yes, this is the honest truth.

Graham: And you are willing to say this to Little Alison next to you?

Alison: Oh, I know that this is not something to be said to the child part. That would be utterly cruel. Graham, before you even say it, I am going to tell you that I have learned a thing or two recently. I know that this harsh voice is the PuPa coping mode, sorry, adult mode. And I know that this comes straight from my mother. I can see her saying "you are a nuisance". I hear this in my head, just as I have for decades, and I know it to be wrong, wrong, wrong. Truth is, from here I feel such deep love and feelings for this little child part of me. So, yes, I am seeing this more clearly. The voice might be there, but I know that it needs to be kicked out of the backdoor and into the street. I am HeAd, and I am in charge here. I am the one that is going to be looking after you, little child of mine. And as far as you are concerned (Alison looks to the default position reserved for the DPM), you need to shut up, and don't you interfere with my little child. (Alison became tearful as she reflected on the plight of the VuCh) Oh, you have been treated so unfairly. (Alison stood up, overcome by the emotion) Graham, don't I need to leave the room while I feel like this?

Graham: Oh, Alison, come now, you are feeling for Little Alison here, and you know that it is actually this very unfair voice over there that has always forbidden you to be tearful. It's such nonsense. Really ridiculous.

Alison: Yes, I think I knew it as I said it. It is ridiculous. Yes, and even that is just wicked. It IS ridiculous that I should not be allowed to shed tears, and it is certainly wicked that this little child has always been denied her feelings and her tears. It's appalling. Yes, I am here for Little Alison. These two parts of me belong together. Graham, that is what you have always been saying to me. We two are the whole of me that is good; me in HeAd right now and this little child who deserves to be loved and protected at ALL times. (Turning, again, to the DPM) So, don't you dare tell this child she is not worthy, and don't you stop me from being compassionate towards that child. (Turning, again, to the Child) I WILL look after you physically and emotionally. Ah, but Graham, I still hear this voice saying that I have no right to criticise my mother and father when I failed you so much, Eric; as a mother.

Graham: Well, hold on. Eric, I think this might be a good time for you to really describe your experiences as a child with your mum. Would you be ready to do that?

Eric: Yes, absolutely. So, mum, this is what I want to say. I won't lie and not say that your anorexia often made you disconnected, and I think there were times when we were disconnected because of that. You know, mum, I know that you did put everything into being a good mum. So, even with your illness, there is nothing you didn't do to be the best possible mum. So, obviously, I forgive you. But even that feels strange, because this is not something you purposely or consciously did to bring harm to anyone. And, yes, it hurt you deeply. But I actually just want to appreciate the way you have worked so hard with Graham and others to bravely fight through this illness. You were stuck in that illness for over forty years, and now you are out of it. And I really admire what you have achieved. I think it is brilliant, and that is really all that I want to focus on. It's what lies ahead that is important. Mum, just look how we are now?

Alison: Oh, Eric, I certainly don't think I am entitled to what you have just said.

Graham: Alison, let's hold them off (I'm referring to the DPMs). Can you just hear what Eric is saying? (Alison nods)

Eric: But, mum, I do think it is amazing where you are now. In fact, I think it is quite astonishing what we have now. We are so much closer now. We share so much more and you are connected and real.

Graham: Alison, I want you to please just absorb what Eric has just said. Allow Little Alison to feel connected. And hold onto that.

It was at this point that Eric consoled his tearful mother with an extended and warm embrace. This was a significant moment in which her tears of relief reflected some acceptance of Eric's encouraging words. With minimal intervention from my side, Alison more effectively neutralising the DPM and stepping into HeAd. I remained concerned that she was still too frequently flipping into the DPM, a mode that was proving very difficult to permanently banish. It was valuable having Eric attend these sessions. Not only did it provide him with insight to his mother's therapy process, but it gave him a chance to voice his honest sentiment. It was useful for Alison to hear his first-hand opinion, which echoed what I had hypothesised and shared with Alison before he attended the sessions.

8.18. Session 88

Despite Alison's acknowledgement of the poisonous effect of the DPM, she was still stubbornly intent on recruiting Eric into the proxy role of enacting this dangerous threat to the Child. Again, it was demonstrated how insight, alone, was never going to sufficiently provoke a permanent re-write to the mode map. While Alison had undoubtedly become more emotionally engaging in her HeAd and Child modes, it was going to require deeper therapeutic work to gain traction in the challenge to permanently disable the DPM.

Extract from Session 88

Alison: Now look, Eric, I know what you said last week, and that's very kind of you. But I really must insist that you tell me off for what I did to you. You must off-load, and I am strong enough to take any onslaught. Come now. Let me have it.

Graham: (Aware that Eric was becoming tearful in response to his mother's unrelenting pursuit) Okay, Alison, I know that there is a part of you that is insistent on you being scolded and punished. It's a powerful force. But I can see how it's created a wedge between Little Alison and your HeAd, just as much as I think it might be doing the same here. Maybe, Eric, you can say a little bit about how you are feeling right now? And Alison, please, please, I want you to just listen. Listen to what Eric has to say. This little child in you needs connection. Okay, I've said enough. Eric.

Eric: Well, it's just so sore and painful listening to this barrage to make me lash out, when that is actually the last thing that I want to do. I am just not sure why you need to keep doing this, mum. I think Graham's quite right when he says that it is like a wedge when you go into this attacking yourself mode. Look, I'm not too familiar with all these modes, even though I have learned quite a bit these past few weeks. But this wedge that you speak about, Graham, I feel that this self-attack actually creates a wedge between you and me, mum. When you ask me to be angry with you, it just makes me feel unable to connect with you; like you are not allowing me through to where I want to be. It's really painful watching you do this attack on yourself, mum. It really is. Haven't you attacked yourself enough all those years with your anorexia?

Graham: Alison, I think it is very important that you hear what Eric is saying here. It's very important for you to see what is happening here. So, Alison, I want you to just sit back on the couch and reflect for a moment. I want you to connect to this feeling you have inside you when that PuPa attacks you. What is that feeling really like? (Pause) Just take a moment and listen to how your body responds when you feel that attack coming on. And don't hurry your answer. Just take a moment and wait for it to come into focus.

Alison: (After an extended pause). Well, if you are asking what it feels like physically, it makes me feel blocked in my chest and throat. Yes, I think that is the feeling. It's as though I am stuck. It makes me not breathe very easily, actually.

Graham: Okay, that's a good start. Now, just stay with this and hold to it. Stay here for a little while. (I pause) Now, Alison, I want to see if there is an image that comes out of this feeling. Again, don't hurry it. I want you to just see if an image, um, maybe a memory or something comes through when you stay with this stuck, blocked feeling; like you can't easily breathe.

Alison: (She pauses for an extended time, clearly processing this) So, this is strange, but I have this image of waiting for my mother to scold me. It's more that feeling of waiting before she criticises. Does this make sense?

Graham: Yes, absolutely; it completely makes sense. Is this feeling just before the PuPa whacks you the same feeling you had waiting for your mother to scold you? Is that what you are saying?

Alison: Yes, exactly. Clear as daylight. That is EXACTLY it. So, you know, I felt that my mother's punishment was righteous, but that did not stop me from still feeling so anxious, actually, an anguish in anticipating her wrath. I think the expecting of it was almost worse than the punishment itself. I would feel relieved once she had finished shouting or criticising me. It was that build-up that I hated so much. It was coming. And I would think "Oh, please get it done and let it be over with."

Graham: Well, I think this is very relevant. So, would it ring true to say that your PuPa is compelled to punish you so that you can reach that place of relief afterwards?

Alison: Oh goodness, that is exactly it. And I think you are saying that I am doing the same with Eric here right now.

Graham: Well, yes, I am thinking that. But I see that you have come to the same realisation. Perhaps your PuPa attacking little Alison does actually get that anguish of waiting for a scolding over with. Might this be what you want to have happen, here with Eric?

Alison: Yes, I think so. Eric, if you can scold me harshly, then there is this part of me that will feel that it is all over and done with. And then I can be relieved it is all over and done.

Graham: Right. But, of course, Eric has repeatedly told you that he does not wish to scold you, or punish you. He's not feeling the urge to do that, despite your repeated invitations. I mean, is there anything that Little Alison has ever benefitted from in this scolding?

Alison: No. Nothing. Actually, it leaves me feeling absolutely degraded. And yet, I can still hear that other voice inside me that says "Eric, I need you to be madly angry with me for where I failed you. I mean, I won't fall apart and I have a loving husband at home who'll support me. Why don't you do it, Eric? I'm strong enough to take it. You know, I can take what I deserve and I'll be fine afterwards." Hmm, this is what I am hearing inside from this other voice.

Graham: But can you see where this voice is coming from, and what it hopes to achieve?

Alison: Yes, I think so. There is that part of me that would feel relieved if he would just get angry and finish it.

Graham: So, let's not automatically go there. Can we give Eric a chance to say what he wants to say? (Alison nods) Okay, Eric?

Eric: Well, it's exactly as I said before; I don't want to punish you, and I want you to stop assuming this to be the case. It's far from what I want to do. You know, mum, all I really want is for the two of us to continue with things the way they have been recently. It's just so nice to see you looking more healthy and being genuinely happy and open. And connecting with us. It's so nice having you around and joining in on things. I know that dad feels the same. So, mum, please, please, stop this need for me to be cross or angry with you. It's just not where I am or where I want to go. And I think Graham has just helped you to see that by you trying to make me angry with you is really just an old thing where you couldn't wait for your mum to be angry and get it over with. I mean, it really makes sense why you do that, but it's different now. I don't think anyone is angry with you now.

Graham: (I look at Alison) Right, except a part of you inside that punishes you. And a little child who cannot wait for the horrible stuff to just be all over. Right?

Alison: Phew, I just find it so difficult to think that you do not resent me. It's just so strange to think of it being this way. But, yes, I see what I am doing on the inside; re-doing things that happened a long time ago. And, yet, I do know that this little shamed and frightened child part of me – I know this – deserves and needs love and nurturance. Just as you have always been saying, Graham.

Graham: Like every child?

Alison: Yes, Graham, like any other child. I think I am seeing it so much more clearly now that my child, Little Alison, deserves all of this, like any child (does). I don't have to specially earn it. It should just be there. (With a smile on her face) You know something, it's so tempting to receive your love, Eric. Yes, I am going to try and allow that from now.

This session reflected substantial growth, in part due to Eric's presence, but also because Alison was willing to engage in emotion-focused work to identify the blocked bodily sensation and she then linked with the childhood anguish of anticipating her mother's scolding. More than the experience of being scolded, Alison had identified the dread of anticipating her mother's scolding as the main source of anguish. And it was only once she had received the scolding that she felt relief. Alison was able to link this anticipatory anxiety to the urgency she had in persuading Eric to scold her. Not only did Alison believe that she deserved to be rebuked by her son, but the sooner he did so, the sooner she would have the relief of it being over. While it still seemed almost incomprehensible to her that her son chose to decline the opportunity to exact justice on his failed mother, she was eventually able to see that her VuCh did not need to be punished. Her HeAd was able to see that she more

appropriately deserved unconditional love and protection. Not only was Alison far less frequently flipping into the DPM, but she was very effectively reverting to a healthy perspective and identifying the needs of the Child. It was also significant that Alison was more readily defusing a threatening situation. With regards to the punitive inner voice urging Eric to scold her, she was now hearing it inside her, voicing its presence, not automatically engaging with it, and recognising its destructive nature.

8.19. Session 89

In this, the fourth and final conjoint session with Eric, Alison reflected what she learned from the preceding sessions to consolidate ascendancy of the HeAd. Not only was she proud of her sustained adherence to the meal plan to reach her best weight in six months, but she was consciously intercepting all attempts of the DPM to influence the Child. While I had often been required to identify and initiate challenges on the DPM and coping modes, Alison was now more readily and automatically applying her HeAd in its guardianship role.

Extract from Session 89

Alison: And I am really proud and happy to report that my weight at Elliene's on Monday was 53.5kg; the highest it has been in about six months. And, you know something, Graham, I hear the AnOv voice in the background, but I am just not listening to it at all. Yes, I am still finding the amount that I need to eat overwhelming; what, with all these protein shakes every day, but I am not going to budge from it. It's quite clear I need to have these shakes every day. And, oh yes, even though there is a voice saying that I have big breasts and a big stomach, and flabby arms, I am ignoring that because I know that it cannot be true. It's like an old scratched record, and as long as it keeps playing, I am going to say "NO." It's like my mother's voice, but I know to not act on it. I must just not listen to it, and stay in my healthy head.

Graham: Well, Alison, I have to say that I am so happy to hear what you are saying, and I am so, so proud of what you are achieving.

Alison: Mind you, it did take an enormous amount of time for me to get my weight right up to where it belongs, and I think I only have you and Elliene to thank for that.

Graham: Actually, Alison, I don't think it took a particularly long time to get to your goal weight, once we were doing this (schema) therapy. It hasn't always been easy, but we have been pushing to undo 44 years of anorexia. And without your courage and hard work, you would never be where you are today. Your weight is safe, and your life is so different now. It really is an amazing transformation, so beware the PuPa trying to dilute your efforts and your own hard work.

Alison: Well, yes, you are right. I shouldn't discount what's been done. Yes, it is hard for me to feel that I have achieved this as well, but I guess that it is the PuPa saying otherwise. And that is a voice that I need to ignore; boot away.

Graham: Well, I am very relieved that I do not need to initiate a full-scale battle on your PuPa right now. It seems that you are packing it away pretty well on your own these days. Alison, I really am so proud of what you are achieving. Do you remember me telling you some time ago that it is often said that for anyone who has had an ED for longer than seven years, it becomes a really uphill battle to ever really put it away? And here you are; 45 years on, and you have pretty well stayed within your goal weight for about a year plus. So, what does your HeAd have to say about that?

Alison: (Talking to the VuCh) You know, you've done really well, and you can now look at yourself as a normal, young lady and be proud of yourself and your body. (Turning to the PuPa) Yes, and you, you mother, you stay away from this child. I am going to take this child away from you. She is an individual of her own. You were despicable. You had no right to open your contaminated mouth and say such cruel things to a child that is totally innocent. You made her do things that she shouldn't have had to do. That's wrong. That's WICKED! It's

UNACCEPTABLE! I'm appalled by you, and I've got no time for you, whatsoever. Oh, and Eric, I even hear this voice over there trying to tell me to have you scold me for being a poor mother, but I am not going to let that happen because we need to move forward with what we have now. I need to be in charge of Little Alison from now on. I'm not even going to listen any more to my mother's voice warning me to be careful to not overindulge. That's nonsense as well. You know, I think back on the kind of things that my mother used to say that, now, I see as absolute nonsense. "You'll end up in trouble if you go too far," she would say. Oh, and, "If you laugh too much, you will end up in tears." Such nonsense. It's just so much clearer to me now. It's strange.

Graham: Yes, I am very relieved to see that you are seeing through all of these nonsense ideas of your mother's. I think some of her religious attitudes have been so distorted and destructive, and been terrible for you.

Alison: You are right, Graham. I really took to heart when you asked me a while back what Christ would do. That made me really re-think so much of what my mother was saying through her Catholics ideas. I actually agree with you that my mother, and maybe even the church, really got things wrong. And if we read the Word of God, then it really does say to me that Christ's words and actions would be of love and care. How would He have ever said that love can become an over-indulgence. I think that my own mother lived a very self-limiting life and I think she took penance to extreme. Oh, oh, and that was CRAP! Just NONSENSE! Yes, Graham, I'll use your word for once, because it is true. I can say now that I am seeing things in a very different way now. And it feels good. It really does. I always remember you saying that Christ should be seen as the perfect HeAd. Ah, none of us can be like Christ, but we can aspire to be Christ-like. I hear that message often during mass.

This session reflected the growth that was sustained in subsequent therapy sessions. Whereas Alison had often previously made significant breakthroughs and lapsed within a few days, she was now showing more sustained progress through a stronger and clearer HeAd. The HeAd/HaCh dyad was growing stronger and remaining front stage. Not only was this parent mode providing unconditional nurturing and love for the Child, but also protectively blocking any threat to the Child's well-being. Alison was also joining me in acknowledging and affirming her progress; something that was a forbidden indulgence for most of her life. It was especially significant that she was replacing the punitive Catholic code that was instilled by her mother with a Christ image that epitomised the ideal and loving HeAd. It was particularly satisfying to see an arena that was such a dominant source of punishment now transforming into one of love and nurturance.

8.20. Session 100

This, the last session allocated to the study, reflected continued and consistent care for the Child. The extract below outlines Alison's recollection of an experience a few days before the session while she was out on a walk at the nearby promenade. Upon reaching the children's play area and remaining there, she was struck by the contrast between her perception of these playful children and her own childhood experiences. She was also able to appreciate the extent of authenticity and growth in her own inner Child; someone that could now be playful and spontaneous, emotional, and engage securely in the loving relationships she now had with those closest to her.

Extract from Session 100

Alison: So, I stopped there and I sat down on a bench and sobbed my heart [out]. But, no, it was the most amazing (experience), because I was surrounded by these joyful, little children. And you know something, I started to talk with them, and I was as though a friendly granny to them. And when they all had to leave – I think they must have been a preschool group on an outing – I sat there on the bench and I just

carried on crying. But, Graham, these were tears that were so real and calm. It was a magnificent experience. And I must have just remained there for about 40 minutes or so. It was peaceful and good.

Graham: Wow, Alison, that is really amazing to hear. You know, I have to say that I sense such joy when I hear you describe this experience. For someone who was cruelly taught to never connect with her feelings and NEVER be tearful, I am so, so happy to see you allowing yourself to connect with Little Alison in this way. It's wonderful.

Alison: But, you know, I cried and cried because I was delighted. I just felt for that little child in me that didn't do all that.

Graham: Yes. So, your tears were more than just delight for what Little Alison has now. Perhaps you were also feeling sadness for everything that you were denied in your own upbringing. You didn't have these kind of experiences when you were young. Right?

Alison: Yes, this is so. Yes, you are right. But the important thing is that I now felt delight. I was even joining in with the little ones; pushing the swings and the merry-go-round for them all. Wow, we were having fun. I was having fun. It is as though Little Alison was now part of this experience. I felt quite calm and collected when I later walked home.

Graham: So, how does it feel when you look back on this experience the other day?

Alison: Well, my thoughts are "How can I be treating the little child in me (any different) to these little children that deserve all the fun and laughter and happiness that they can possibly get?"

Graham: You are so right.

Alison: Yes. Why should I deny myself, and why did my mother deny this of me? She truly failed me. And now I can move on.

At the culmination of the 100th session designated for the study, Alison was reaping the rewards for her perseverance through the therapy process. She was consistently remaining in a much healthier state with the Child receiving loving attention and the DPM and coping modes remaining almost entirely suspended on the periphery. Her experience at the play park revealed not only the enormous growth in her HeAd, but a Child that felt safer and far more emotionally engaging and authentic. She was able to shed tears of excitement for the access she now had to the authentic and spontaneous Happy Child, but she was also willing to embrace the emotionally painful reality of a child that was both sad for the deprivation and abuse she experienced. This growth in the Child would not have been possible were it not for the determination in the HeAd to stand guardianship over a Child.

8.21. Summary

These extracts do not reflect a steady, linear growth in the HeAd mode. Early therapy saw my task to engage with Alison's Child through repeatedly modelling the many qualities of HeAd. Through limited reparenting and empathic confrontation, Alison experienced the care of a parent that was so tragically missing throughout her young life. Not only was I required to bring her to a fuller appreciation for the extent of neglect and abuse she experienced, but I was also tasked with helping her to feel safely entitled to express justifiable vulnerability, sadness, and anger residing in the Child. Muting the DPM from echoing her mother's messages forbidding her to express her emotion truths proved a very time-consuming and daunting task. I needed to remain very patient as the DPM frequently re-entered the frame, using a combination of therapeutic strategies and techniques to repeatedly demonstrate how

unjust and cruel her mother was; whether via explicit childhood memories of her mother's abuse, or the repeated echoes emanating from an internal DPM.

Within the first few sessions of ST it was already clear that the use of experiential techniques through chairwork and imagery rescripting already demonstrated to be very effective platforms in eliciting the emotion suppressed in the Child. Together with various CBT techniques, these exercises were frequently repeated, with consistent reward only emerging towards the end of the 100 sessions. It is well documented by contemporary trauma theorists such as Levine (2010, 2015) and Van der Kolk (2017) that trauma memory resides within the body as a physically felt sense. As I have grown with experience as a schema therapist, so have I come to increasingly appreciate the importance of bringing into awareness the bodily sensations associated with past trauma. It was with such access that Alison was able to most effectively resonate with her traumatic past and negotiate the unfolding conflict between modes that threatened the Child and the HeAd, whose task it was to protect and nurture the Child. In retrospect, I believe that if I had applied these valuable techniques more frequently, Alison might have resolved her past traumas more readily, thus, allowing the HeAd to cement its position of authority earlier in the therapy. My current and regular use of chairwork, imagery re-scripting and emotion-focused work is indicative of the value these elements of ST have provided me not only in my treatment of Alison, but also other patients in my practice. What I did already recognise early on in the treatment with Alison is the impact that such experiential techniques would have on my own emotional involvement in sessions. My intimate involvement in chairwork and guidance during imagery work heightened my empathy and compassion for Alison's Child. This made my role in the reparenting process (as the proxy HeAd) that much more powerful, meaningful and effective. While Chapter 9 focusses on eliciting the AnCh, the chapter also identifies the anger that I resonated with reflecting on the plight of Alison's Child. My own anger and the anger I assisted Alison's HeAd to express was no less important than the nurturing role that I and Alison's HeAd mode were required to develop in healing the Child. On many occasions it was evident that Alison was more willing and capable of expressing legitimate anger from her HeAd rather than directly from the AnCh who, for much of the therapy, remained forbidden by the DPM from expressing such emotion. It was this more endorsed anger from the HeAd that ultimately led to the AnCh feeling confident and fully entitled to express her anger and rage.

Another process that had to be repeatedly addressed was when Alison misconstrued the DPM and the AnOv coping mode as the HeAd. While self-assertion is an identified HeAd quality (Bernstein, 2019), there were occasions when either the DPM or the AnOv were bold and forcefully imposing on the Child; such assertion being mistakenly identified by Alison as coming from her HeAd. Sometimes it required strong provocation from my side during chairwork to bring Alison to the stark realisation that this forceful mode was not acting in the best interest of the Child, but actually compromising her safety. Such immediate insight mostly had the effect of immediately engaging Alison in HeAd to nurture and protect the Child. However, there were occasions when it was necessary for me to

assume the HeAd role to return the Child to safety. As the therapy advanced and Alison's HeAd strengthened, so I was less required to fulfil this role of coaching the HeAd mode or assuming the HeAd responsibilities.

Even early in the therapy, Alison's HeAd was remarkably capable of fulfilling the dual task of not only demonstrating empathy and compassion towards the VuCh, but also firmly scolding the modes that compromised the Child's safety. When Alison's parents were the source of such rebuke, this invariably evoked the gi-DPM for "dishonouring" her parents. Only through repeated chairwork and much psychoeducation did Alison eventually endorse this anger; first from the HeAd and eventually from the AnCh. The authority and confidence that the HeAd held relatively early in the therapy made such angry expression easier for this adult mode to express than a still very submissive Child. However, as the therapy advanced, so did the AnCh become increasingly confident and entitled to maintain her front stage footing, which was consistently endorsed in the latter sessions. It reflects the value of persistence and repetition, but also the added ingredient of emotion-focused work that heightened and sharpened the anger and rage.

Significant work was required to dismantle the strict and rigidly punitive Catholic code that Alison's mother instilled in her at an early age. This largely accounted for the guilt, shame, and defectiveness that Alison carried in the Child and defined the epicentre of her DPM that echoed her mother's criticism, obsession with penance, and her exhausting demands and expectations. While I chose to deftly tackle this brittle arena without appearing to threaten or disrespect the importance Alison held in her religious identity, it was imperative that the HeAd was not moulded on these rigid ideals, and that this archaic religious doctrine was eventually realised to be unacceptably cruel and the fabric of the DPM. Despite repeated efforts from the DPM interrupting the HeAd mode from encouraging the emergence of Alison's sexual identity and a broadening of intimacy in the marital relationship, it was a significant breakthrough when she finally engaged in a meaningful sexual relationship with her husband without the shaming voice of her mother interrupting her. While her Catholic beliefs were grossly distorted by her mother, her image of Christ was, thankfully, untainted. I used this image of an unconditionally loving, nurturing, and protective parental figure to instil an exemplary image of everything that defines the HeAd mode. While this concept required some time to gain traction, Alison eventually recognised the value of this image to remind her of the many qualities that her HeAd mode should aspire to in the care for her inner Child.

The therapy narrative of Alison demonstrated the need for the persistent repetition of exercises to eventually instil a strong and consistent presence of the HeAd at the culmination of the hundred sessions. Of significance was S47, revealing that Alison had spontaneously engaged in HeAd dialogue in her home environment, indicating that she was capable of engaging with this important mode without my assistance and outside of the therapy context. Alison's increasing use of mentalisation in the latter part of therapy ensured that she identified those modes that posed a threat to the Child before they were activated, thus, ensuring the HeAd sustained its ascendancy in protecting the Child without a mode conflict ensuing. What was evident in the therapy was how vital was the development of a strong and sturdy HeAd in order for the vulnerability and the anger of the neglect and abused

Child to safely emerge and find expression. While my role in reparenting the VuCh would require a strong HeAd mode as a collaborative adjunct to ensure Alison's pathway to autonomy, so my empathic confrontation would require of the HeAd a firm, protective, and appropriate limit-setting nature in order for Alison to safely negotiate a healthy and content entry into the outside world. Likewise, without me assisting in and encouraging the AnCh to confront the abuse she faced, little healing would be accomplished.

The extracts selected for this chapter illustrate and highlight significant aspects in the systematic construction and strengthening of the HeAd mode. The importance of this task and the building of a strong HeAd/Child dyad cannot be overstated. Through the therapy process, Alison managed to develop or refine many of the HeAd qualities described by Bernstein (2019) and Harris (2009) outlined in the introduction of the chapter. It is evident how Alison became increasingly self-aware and formed a clearer and healthier sense of personal identity as the therapy progressed. Her growing self-confidence was apparent in the way that assertion steadily replaced her previously subjugating and submissive demeanour. Alison also demonstrated more flexibility as the therapy progressed; being increasingly resilient in the manner in which she readily assumed the HeAd stance and forcefully confronted the DPM in order to validate, nurture, and protect the Child. While she had always treated others with immense empathy and compassion, these qualities became more self-directed as the HeAd engaged with the Child. Similarly, whereas Alison always exercised responsibility towards others (albeit much of the time through CoSu coping), she steadily assumed more responsibility in her self-care as therapy progressed. Finally, albeit a work in progress, Alison became more adept at receiving the love and kindness from others as we approached the final sessions. While it was an immense challenge for her to relinquish some of the strict and penitential qualities of the Catholic code that were instilled by her mother, we focused on building a spirituality that more reflected loving nurturance and protection – qualities synonymous with the HeAd mode and her perception of Christ as her quintessential HeAd. Even as we approached the 100th session, there was still evidence of DPM intrusion and a Child that was still susceptible to dysfunctional influence. However, what was also evident in the latter part of the therapy was how adept Alison's HeAd became at assuming ascendancy over those modes that threatened the well-being of the Child, and then engaging with the Child in a deeply nurturing manner. While this process needed to continue in subsequent therapy, it was clear how vital was this central task of therapy in developing the HeAd mode; not only in providing enough safety for the Child to emerge and be healed, but also to ensure that the Child would be defined by her creative imagination, playful happiness, and predominant contentedness.

CHAPTER 9: ENGAGING THE ANGRY CHILD.

What hindered Alison's access to the Angry Child, and by what processes did she ultimately gain access to this severely suppressed mode?

Many patients require extensive support from their therapist in exhausting the emotional expression emanating from the Angry Child (AnCh) mode (Arntz & Jacob, 2013). Incidents in everyday life, whether subtle or brutal, blatant or misconstrued, can be triggers that activate EMSs that point to abandonment, emotional deprivation, mistrust and abuse, or persistent subjugation; the scars of injustice and unfair treatment and the appraisal thereof (van Genderen, Rijkeboer, & Arntz, 2012; Young et al., 2003). Where this anger may be expressed in a manner that is enraged or tyrannical, impulsive, undisciplined, obstinate, or by way of defiance or rebellion, the task for therapists is to validate this Child's anger and assist the patient in developing new and constructively appropriate and authentic ways of expressing their anger towards the legitimate sources of unfair treatment. It is well established that many patients with EDs tend to inhibit their emotional expression, and that anger can be especially difficult for such patients to acknowledge, validate, and express (Pugh & Rae, 2019). This particular emotion is often accompanied by feelings of self-disgust and guilt as a result of parent mode activation (Fox & Harrison, 2008). Young (1990) reminds us how this can be obstructive in ST, given that healthy anger is required to facilitate EMS change.

Indeed, this was the case with Alison, where the goal was not so much to modulate or temper such expression but, rather, to uncover her deeply supressed anger and provide a safe environment within which she would be able to express it as an important component of her broader healing process. While the conceptualisation and dismantling of the AnOv coping mode is the central focus of this thesis and the diagnostic centrepiece in the therapy, remission of Alison's ED would not have been possible had it not been for the engagement of the enormity of difficult emotion, most notably the anger residing deeply within her Child. While the composite nature of the AnOv saw it sometimes serving as a mouthpiece for a Defiant Child, it more frequently served as a vehicle with which to suppress the Child's anger. Hence, the emotion residing in the AnCh would not have been accessible were it not for the explicit suspension of the AnOv and other modes. This demonstrated the very close and complex association between Alison's AN and the AnCh.

This chapter will illustrate the important unfolding process by which I supported Alison to access and engage with her anger. It will describe the therapeutic techniques that were used and the challenges that we both faced in achieving the development of Alison's healthy capacity to express anger – whether from the HeAd or directly from the AnCh. The first challenge lay with alerting Alison to and neutralizing the self-imposed anger emanating from the dysfunctional parent mode (DPM). Beyond this lay the challenge of breaking the mode dyad whereby the DPM forbade the Child from expressing anger. This is where the reflex activation of coping behaviour (most notably the CoSu) served as a secondary means of inhibiting the anger. Alison's mother lay at the source of the debilitating

onslaught emanating from the DPM, and it was the indoctrination of an extremely penitential Catholic code that was central to this process. It was within this severely strict, critical, and demanding domain that Alison inevitably developed some prominent EMSs (most notably, Emotional Inhibition, Self-Sacrifice, and Subjugation), thus, learning from an early age to suppress anger and any other spontaneous emotional expression in order to avoid being shamed or condemned. As the therapy evolved it was also revealed how Alison inhibited her anger for fear that it would become amplified and spiral out of control. Here is where a component of the AnOv served to maintain a sense of control.

While the majority of the 100 sessions that were analysed for the purpose of this research showed evidence of anger in some form, only select extracts from those sessions that most significantly highlighted the process by which anger was therapeutically addressed and encouraged into full and healthy expression are included in this chapter.

9.1. Session 1

While the AnCh was completely suppressed at the outset of therapy, Alison's only explicit expression of anger was intrapersonal, and targeting the Child. Where patients engage in such self-directed condemnation, Arntz and Jacob (2013) advise therapists that dialogue is needed to help the more relevant and legitimate source of anger to be made visible, thus validating the Child, and encouraging them to consciously experience and ultimately normalise the expression of such anger. This would require the DPM to be neutralised and, ultimately, banished. The DPM was evident in this, the very first therapy session that followed the 6-session ST assessment. It viciously chastised and shamed the VuCh when Alison realised that she had forgotten to document the circumstances surrounding her mother's death in her autobiographical assignment:

Extract 1 from Session 1:

Alison: Oh, how callous of me to have forgotten something of such importance as this. Oh, how could I have forgotten this? It really is unacceptable, you know. Oh, I am so disappointed in myself.

Graham: Are you telling me that because you have not immediately told me details about your mother's death that you have done something horribly wrong?

Alison: Oh yes, and I really do deserve to be punished for this. What daughter would forget to mention something as important as this? I mean, it's wicked. I'm really so unworthy. It's terrible. Despicable!

Graham: Okay, so, there is a part of you that feels that you should really be punished for not having spoken, well, written about your mother's death straight away?

Alison: Oh yes! And I think that I should; well, I will need to go to confession to be absolved of this.

Graham: You know, it's really interesting that you feel the way you do. We have been reflecting, again, on your mother's nature – her qualities – and I think it is true to say that your mother was far from the loving mother that you so dearly deserved and needed. You do see

this, Alison? (Alison nods to confirm) This is why I am not surprised that you have not yet written about your mother's death. You know, in many ways, I get the sense that your cruel mother IS still alive. She is still punishing and scolding you for everything and anything. Except now the voice echoes from, well, inside you. She does not have to be here in person. Can you see how this has happened?

Alison: Yes, I suppose so. It is true that she was emotionally cold and depriving. She really was, you know. She was vacant (pause); and she was so completely unaffectionate.

Graham: Right. So, instead of her being the loving mother that you needed – well, that every child needs – she was this strict authoritarian and someone that was rigidly controlling. You know, like I just said, in many ways by the things that you say here, it seems so clear that your cruel mother IS still alive. She's not really dead. And she is still punishing and scolding you for everything and anything. Does that make sense? And can you see that?

Alison: Yes, I suppose so. It's my voice, but it would be true to say that it sounds just like my mother's voice. It's just as she would have done.

Graham: Right, so when we look at your mode map here (there is a laminated copy of it on the table during sessions) do you see a mode that best reflects this voice?

Alison: Oh yes, it's this blue one here; this Punitive and Critical Parent.

Graham: Right! And it is totally unacceptable that the criticism and scolding of this little Child here (I point to the VuCh on the mode map) be allowed to happen. This is a mode that we are going to have to get out of your life. Right out, okay! Because it carries a viciously destructive anger; an abuse that is NOT okay. And this little child here does not deserve this kind of treatment. This anger towards the Child is NOT okay. If anything, it is the Child in you that has every right to feel extremely angry at your mother; not the other way around. Do you get that, Alison?

Alison: Yes, I do hear what you are saying.

The rawness and automaticity of the DPM imposing on the VuCh was immediately evident and expressed with ease. The slightest perception of fault in the VuCh activated this toxic mode dyad, where punishment or religious absolution was the only known option. In the absence of HeAd, I already assumed a protective parenting role in re-educated Alison (as I had done during the assessment phase) to the stark reality that her mother was extremely abusive. I was immediately challenging the illusory and idealised notion that she had built of her mother decades earlier as a coping strategy. While she cautiously confirmed the abusive quality of her mother and briefly elaborated on her mother's shortcomings, such insight was not enough to elicit internal protection. In light of her recognising this, I wanted to express my understanding as to why she might have omitted her mother's death in her autobiography. I was countering the internal condemnation at a metacognitive level. While I might have chosen to deepen Alison's connection with the emotional pain associated with her mother's abuse, I chose to provide insight to the internal threat that the DPM imposed on the VuCh as an introjection that closely echoed the abuse she faced at the hands of her mother. It was valuable that Alison understood the origins of this internal critic and appreciated that the toxicity of her mother's abuse provided the primary material for this internalised DPM. Alison's grasp of this concept demonstrated how the DPM was no less an abusive threat than was her mother, and that it would need to be banished. It was important in the session that I pointed out the distinction between the

unhealthy and unacceptable conflict emanating from the DPM, and the legitimacy of a healthy anger that would be required of the Child to fully express in an authentic manner.

In the next extract of the same session, Alison demonstrated surprising courage. With some prompting and preparation from me, she cautiously assumed the AnCh position and acknowledged the injustice that she faced at the hands of her parents. While she was already willing in this first therapy session to reprimand her mother and father for failing in their parental responsibilities, it was evident how cautious and blunted was her affect, and only momentarily sustained before being muted by the DPM:

Extract 2 from Session 1:

Graham: But, when we see all the dreadful things that your parents did, and their lack in providing you with the warmth and love that you needed, surely this little child here (I point to the space beside Alison) has reason to be upset?

Alison: Oh, you are right. It is not okay. Um, I guess that it is right to be cross and upset about this.

Graham: So, where this little child is sitting here between us, what do you think she would really like to be able to say to her parents? And, Alison, let this child say whatever she is feeling, okay. She has the right to say what she wants to.

Alison: (In a monotone voice) Well, it is not okay that you treated this little child the way that you did. You did wrong. It is wrong what you both did.

Graham: Okay. That's really good. Now let me see if you are willing to speak from this place here; the Child. And let's see if you can speak as though your parents are right here in the room with us having to hear you out.

Alison: I must speak AS this little child that I was from all those years ago?

Graham: Well, yes, this child sits in you today. She's always been here in you. So, yes, can you try and do that? Remember, when you speak from the Child, you are speaking from the child that went through all those experiences when you were young; experiences that still sit in a very raw way within you now; still today. Right up 'till now. This pain remains a part of you.

Alison: Hmmm, (A long pause follows as she deliberates) Well, you both failed me. It is simply not okay what you have done; what you are doing. It's absolutely not okay. (Another long pause as Alison looks increasingly unsettled) Oh no! This is not okay for me to be cross about these things. That's not okay. It is not okay for a child or anyone to be cross with their own parents. They should be honoured. My parents should be honoured. That is what is right."

As I persisted in educating Alison to the severe abuse imposed by her parents, I hoped to provoke legitimate anger from the Child. Although a significant challenge so early in the therapy, Alison's response to my invitation to occupy the AnCh was encouraging. While she initially spoke cautiously from the HeAd perspective (perhaps an easier perspective than speaking directly from the AnCh), she eventually responded positively to my prompt that the AnCh voice herself. Although very cautious a moment earlier, the AnCh now spoke with some conviction. However, this was unbearable as the swift and ferocious reflex of the guilt-inducing and scolding DPM muted the AnCh. As the session progressed and I attempted to revive the AnCh, the cruel facial expression and gesticulating

pointing finger of an animated DPM manifested to insist that "self-punishment would make (her) feel better" and that repentance would "wash away the problem". The prominence of the strict Catholic code instilled by her mother confirmed the source of this cruel DPM. I was beginning to appreciate the arduous process that lay ahead if I was going to succeed in dismantling this deeply entrenched dysfunctional belief system held in the DPM that forbade angry expression.

Immediately thereafter in the same session, Alison revealed another significant reason for her reluctance to express anger:

Extract 3 from Session 1:

Graham: Oh, I can see from what your little Child is saying is that there clearly is a very powerful voice that really makes you feel guilty and maybe ashamed for being angry at your parents? Is that the case?

Alison: Well, yes, it is certainly disrespectful for me to speak of my parents in such a way; to speak TO them like this is not honourable. It's dishonourable. And, yes, I do feel guilty for doing so. It's shameful.

Graham: I see. And, yes, I get that you are carrying these feelings, even though I don't think you should be. But, you know, I also wonder if there is another feeling behind this wariness to be angry with your mother and your father. You know, more than just the guilt you feel about being angry at them. Is there, perhaps, something else?

Alison: I am not quite sure what you mean?

Graham: Well, you have already told me how you feel unentitled to express anger at your parents – that it is disrespectful – and I think that that is something that we need to address; but I sensed in your (facial) expression a moment ago that you might be feeling something else that makes it difficult for you to be angry – to connect with that feeling – that emotion.

Alison: Um, well, I am scared to be out of control if I express this (anger). I am scared of the anger that I might feel; very scared.

Graham: I see. Okay, that is really interesting. I wondered about that. So, you not only feel unentitled to be angry with your parents, but you are also, well, very cautious and frightened to be angry with them because your anger might run away? Am I understanding correctly that you are scared that you will not be able to contain this feeling – your anger – if you allow it to be expressed outwardly?

Alison: Yes, exactly! I am scared that my anger might become too much. It might become so powerful and be out of control where I can't stop it. It might just be too big, this anger, and if I open that door it might just run out of control.

Graham: Ah, okay. You fear that if you tap into the anger sitting inside you and allow if to come out, that it will not be contained – that your anger will come out in an uncontained way – sluice gates that cannot be closed?

Alison: Exactly right. Yes, I am scared of that.

Graham: Well, what I think you need to consider, Alison, is that if you allow yourself to express your anger inside, you might see that it helps you to ultimately feel calmer and more resolved inside, rather than the way that you fear it spiralling out of control. You see, by holding your anger inside you, it builds up and up, and I think that this is where it gets very loud inside and wants to come bursting through. So, what I am saying is that by you holding the anger in rather than expressing it, it wants to burst through in a way that might feel out of control. But in

expressing the feeling, we can work with it and eventually bring you to a place of calm, because the truthful feeling of anger will be out there, and you will have felt heard. Does any of this make sense?

Alison: I hear you, Graham. But it doesn't take away my fear of things spiralling out of control.

Graham: Sure, I get what you are saying. But I am just wanting to introduce you to the possibility that you will feel more in control and calmer inside if you express your anger, rather than trying to hold it in, as you have probably done most of your life.

Only because I was attentive to her tone of voice and subtle changes in facial expression had I identified another very important factor that inhibited Alison's anger. While the primary challenge still appeared to be the defusing of the guilt-inducing DPM, Alison had identified another factor that inhibited her outwardly expressing her anger. Her fear of an uncontrollable unravelling of anger posed another important challenge. In the extract I had started educating her to the notion that I could facilitate a safe and containing environment within which Alison would be able to engage with the AnCh without the fear of losing control and feeling uncontained. Her inhibited attitude was not surprising, given that the eating disorder significantly reflected Alison's preoccupation with always needing to feel "in control".

9.2. Session 2

While anger was not the dominant theme in Session 2, the emotion-focused work and imagery re-scripting certainly deepened Alison's emotional appreciation to how abusive and neglectful were both her mother and her father's treatment of her. While recalling her father's chaotic alcoholic behaviour, she also identified how complicit was her mother in hiding her husband's behaviour from the public eye. Despite her repeated courage to occupy the AnCh chair, it was clear how difficult it was for her to sustain.

Extract from Session 2:

Graham: You know, listening to you describe what you went through with all of this – your father's serious drinking problem and all his really appalling behaviour while he was drunk – I get a sense of how incredibly difficult and unsafe your whole world was. You must have experienced so many really difficult emotions through all those years. Not so?

Alison: Oh, it was really awful; just awful all of the time. You are so right.

Graham: Can you say a little bit about these feelings you experienced?

Alison: Well, I felt scared. I really felt very alone and unsafe. Even my mother did nothing about it. She just pretended that my father was not there. Anything that he did, my mother just, well, literally at times looked the other away and pretended that the problem was not there. She ignored it.

Graham: So you had reason to feel really unsafe. Even your mother was complicit in allowing this to happen. She enabled it, didn't she? She helped your father stay in his ways; an unacceptable alcoholic and an embarrassment?

Alison: Yes, they were both wrong.

Graham: So, what other feelings does it bring up for you when you reflect on all this? You already say that it made you feel very scared and unsafe. Anything else?

Alison: Well, I felt very, very scared and very alone. I was always trying to do something to make things better; try and not have anyone being upset.

Graham: Ja, I completely get that. It must have been very scary and you were desperately trying to contain things yourself. Do I might be detecting something else in your face; sadness in your face right now?

Alison: Oh goodness yes, I feel very sad reflecting on this now. It's very sad (long pause).

Graham: Yes, I can see that. And I wonder if there are other feelings that go with this awful situation you are reflecting on?

Alison: I can't really think of any others right now.

Graham: Alison, I wonder if – when you reflect on the abuse of this chaotic home life – if you also feel any anger for the dreadful neglect and the negligence from both your parents'?

Alison: Oh yes! (pause) But my mother, she wouldn't tolerate such anger. That wasn't allowed, and it would never have been safe to show that. That was forbidden.

Graham: Yes, I really get that, Alison. It was unsafe to show your anger because your mother would punish that?

Alison: Yes. Absolutely.

Graham: And do you remember how last week we were talking about how this anger was forbidden by a voice that now sits in you; this strict and punitive parent mode?

Alison: Yes, I do remember that. And I do see how my mother's strict voice sits in my inner mode now.

Even though the session primarily focused on the fear and sadness that Alison experienced within her abusive home environment, I consistently pressed for the broader spectrum of emotion that she was feeling in this intolerable environment. While I correctly detected sadness in her facial expression after she expressed fear and loneliness in her home, I pushed for the acknowledgement of anger. It was understandable why she had not immediately volunteered this emotion given that she immediately revealed how intolerant was her mother of such a feeling. She also revealed the CoSu coping that she regularly adopted in order to avoid or dilute any form of conflict erupting in the home environment. Finally, it was important that I reminded her of the DPM introjection that continued to forbid anger. This is where the primary barriers needed to be dismantled. What was becoming clearer insight to Alison would need to be taken to an emotional level of appreciation for real change to manifest.

9.3. Session 3

Despite some initial caution, Alison was willing to, again, occupy the AnCh in chair work in this session. Although she appeared visibly hesitant, overwhelmed, and perturbed at my suggestion, she hesitantly occupied this chair to reprimand another part of herself, the AnOv, for imposing on the Child. Although she sometimes flipped into the

angry HeAd, which was typified by a more controlled and authoritative voice, the Child's voice was high-pitched and desperate. This very authentic scolding of the AnOv provided important emotional connectivity and a lucid and insightful realisation of its deceptive and abusive qualities; how this extremely contradictory coping mode hindered her personal development. The angry release was, again, very automatically and abruptly interrupted by the DPM's insistence that anger be muted.

Extract 1 from Session 3:

Graham: Okay. So, Alison, I would really like to see if you can sit in this place over here for the Child in you who is angry with this other part of you that starves you. Say what you are really feeling. Are you willing to do that?

Alison: Um, phew, this is not easy for me. Um, I suppose I can give it a try, but it does not feel right for me to do this.

Graham: Yes, I understand you. You know, you have always had a voice inside you telling you to never be angry; never say anything harsh to anyone or anything. But you were saying just now that you are really upset by what this anorexic part of you is doing to the heart of you; this little Child that is Alison. Right?

Alison: Yes, you are right. It does upset me what is happening.

Graham: Right, so what do you want to say to this Anorexic Overcontroller sitting here?

Alison: Well, I want you to move out of the way and as far away from this space as possible. And allow me to get better. Allow me freedom (pause) and stop interrupting what I am planning to do.

Graham: Planning to do?

Alison: (Spontaneously shifting into HeAd while sitting in the same chair) Well, I want this child that sits over here – this child part of me – to be able to have a better life without being controlled and hurt like this.

Graham: Ah, okay.

Alison: This anorexic voice just comes in. Just out of the blue you step in! I am so, so angry the way you interfere like this; stopping me – well, this little child here – from having a normal life. It is stopping this little child here from being a happy child.

Graham: Oh yes. I think that it is so good that you can express your anger towards the anorexia in this way, Alison. It's been long overdue. And, oh boy, is it legitimate that you express these feelings. Carry on, Alison.

Alison: (Shifting back into AnCh mode) You have no right, whatsoever, to step into my life. You are not needed and not wanted, and you are a useless part of my life. You must get away. I want to be rid of you.

Graham: (After an extended pause during which Alison was clearly reflecting on what was unfolding) Wow, so how does that leave you feeling, after saying that with such conviction?

Alison: Well, I don't like being subjected to angry feelings like this. You know, I am actually trembling right now. Actually trembling; look! (Alison extends her arms to show a visible trembling in her hands) I am not sure whether I am really allowed to be angry like that; am I?

Graham: Oh yes, you most certainly are, Alison. I'm trying to help you to see that you are very entitled to be angry with whoever or WHATEVER is being abusive to the Little Child in you; even this eating disorder, this anorexia. I think you learned through your upbringing that it was not okay to be angry, and so you had to stifle it. So we need to work towards you feeling safe and entitled to be angry where wrong was and is being done to you.

Alison was visibly shaken and highly threatened (triggered) by the heightened emotion that she was feeling, and clearly still holding to the notion that she was forbidden to be angry. However, it was extremely valuable that both the AnCh and the HeAd were able to condemn the abusive coping mode despite much initial caution to be angry. The very sudden DPM activation, again, demonstrated the automaticity with which any visible protest was prohibited. Perhaps because Alison's anger was directed towards an internal component (AnOv) rather than towards her mother, it made this forbidden emotion less guilt-inducing and more tolerable to express. Similarly, was my sense of the occasions in which she momentarily shifted from the AnCh to the angry HeAd that the latter was a more tolerable and permissible mode from which to express this difficult emotion. Anger emanating from an authority that was protecting the Child appeared more permissible than the same emotion emanating from the AnCh, who was still forbidden to express herself. While it was going to prove a significant task for the AnCh to express herself fully towards her abusive parents, these less threatening anger dyads were all serving to steadily familiarise her with this difficult and tabooed emotion. It was important that I utilised every opportunity to educate Alison to the fact that she was entitled to express anger. Inhibiting it was sourced in a core belief that needed to be dismantled.

In the next extract, the compassion that the HeAd expressed for the effect the eating disorder had on the Child provided valuable insight into how the restrictive nature of the eating disorder echoed the lifestyle restrictions imposed on her by her overly controlling mother for decades. Perhaps even more importantly, was the realisation of how the DPMs perpetuated this restrictive culture in her current life. My task was to join the dots and encourage Alison's anger to be re-routed from the AnOv to the more pertinent subjects; the voice of her mother that formed the main component of the DPM introjection:

Extract 2 from Session 3:

Graham: I can see that it is still really difficult for you to allow yourself to stay with your anger. Not so?

Alison: Well, I am STILL trembling. Look at my hands? (Alison, again, holds her arms out at full length) My body is quite distraught when I get angry like this. I am not used to this at all, Graham.

Graham: Oh, I can see that. And I think that you have been really brave and done so well getting angry with the AnOv as you did right now. So, really well done on that. Really well done. From what you are saying, it is quite clear that the AnOv has restricted you, really inhibited the little child in you from being able to have a normal life. And, you know something, that's not okay. But tell me Alison, is this the only place where you think you have been restricted in your life? Might you have felt this way elsewhere in your life?

Alison: (After a brief pause) Well, are you saying that this eating disorder part of me has been doing the same thing to me as my mother did? (I nod in agreement) Actually, I was thinking right now how I feel a very similar way about my mother. I just had that thought. I think that she was also very restricting. Is that what you are asking?

Graham: Ah, yes, now that is a very valuable connection, and exactly what I was thinking. You can see that your anorexia today has this tight, restrictive hold over you in much the same way as your mother controlled you and limited you for so many years?

Alison: Yes, I do think that is right. And, yes, the AnOv is just the way my mother was. That's an interesting thing we are both seeing right now.

Graham: Yes, it's a great connection, Alison. And tell me, do you think it stops there? As much as your mother was so overly controlling, strict, and restrictive; do you think there might be another place where you get treated so strictly, in such a way that stops you from being able to feel free and express yourself?

Alison: I am not really sure?

Graham: Well, what if we look at some of the other parts of YOU that really restrict the little child in you. Parts of you that say, "No, that's not okay! You can't do this and you can't do that?" Which mode in you, for instance, says "No, you are not allowed to be angry?"

Alison: Oh, okay, now I see what you are getting at. Yes, it's those bad parent modes; the critical, punitive, and the demanding adult parent modes in me. They are the same way. Am I right?

Graham: Absolutely. They are the voice of your mum that now sits inside you; a part of you doing the same things that your mother did when she was alive. So, can you see how your anorexia restricts you in the same way that your inner punitive parent mode does. And that parent mode is the voice inside you that restricts you in the same way that you mother did for all those years?

Alison: Yes, that really does make sense.

Affirming Alison's anger was an important element in the re-parenting process. Even the difficult physical sensation of her agitated state did not deter her from joining the dots to the sources of anger. While she had created a safe enough space to express anger towards the AnOv, so it was my task to consolidate this and help advance the anger towards her parents but not forget the destructive impact of the DPM. These were the more legitimate and pertinent sources of anger where a scolding and banishment would ultimately need to be performed. While, at this point in the therapy, I had conceptualised the voice of Alison's mother and the DPM as distinct entities, it is clearer to me now that these are, in fact, one in the same. The voice of Alison's (deceased) mother is the voice of the introjection that is the DPM.

Making these important connections was followed by an instance in which Alison's HeAd expressed anger towards her mother; a significant step in the campaign to fully access her anger. When I invited her to address her mother in chair work, she started out with an empathic reflection: "This little girl feels restricted. Even though she is so young, she should be allowed to choose which toys she wishes to play with, and not be told what to play with." The empathy from Alison's HeAd evolved into anger as she emphatically followed with the comment: "That's ridiculous, and as the healthy adult I won't allow it!" Where the previous extract demonstrated the disruptive

impact of the AnOv, the HeAd's confronting of Alison's mother had a stronger and more authentic emotional resonance to it. This was another bold step forward. However, it was short-lived with an immediate interruption on two already identified fronts. She "hated" this angry surge, explaining: "I am fearful and I want things to be calm and placid. I don't feel right being angry like this towards my own mother." Not only had the gi-DPM forbidden such anger, but the other reason that had already been identified in the first session emerged: "I am very hesitant to go with this angry feeling and not know how it will all turn out. What if it all goes out of control on me?" This was a reminder of the importance of providing Alison with a safe and sturdy platform upon which she would need to bravely open the sluice gates to a significant reservoir of anger. The challenge lay ahead to neutralise this fear and assist Alison to feel sufficiently and safely contained to fully express her anger.

9.4. Session 8

Chair work in this session reiterated how effectively this experiential technique served as a means of eliciting more consistent and authentic angry expression out of the shadow and into fuller exposure. With my prompting, chair work assisted Alison to speak more fluidly in the present tense, also eliciting a more powerfully relived and emotionally engaging experience. While Alison was still very reluctant to confront her parents, conflict at an intrapersonal level was more accessible. In this heated mode dialogue the HeAd was surprisingly capable of confronting and banishing the DPM for posing a threat to the VuCh. Although this was an important arena that needed to be entered, it served as an important gateway towards Alison ultimately being able to more fully confront her parents from the AnCh. The PuPa and DePa modes were already positioned in the couch opposite us, while the VuCh was seated between Alison (sitting in HeAd) and me. I challenged her to confront the DPMs represented by two red cushions positioned on the couch opposite her:

Extract from Session 8:

Graham: Okay, Alison, I want you to now connect directly to these two modes sitting RIGHT there (I point to the two cushions on the couch that now represent the DePa and the PuPa modes). Let those two cushions actually be them. I want you to gather your thoughts and feelings and start only when you are ready.

Alison: (After a short pause) Um, I want to say (pause) they have no right (I interrupt).

Graham: Wait, can you speak directly to them, Alison. See if you can speak to them as 'YOU have no right" (I point directly at the cushions). They are sitting right here. Here they are, sitting right here (I point, again, to the cushions).

Alison: Well, I want to say that you have no right to treat this little child right here in this way. It's horrible the things you say and the pressure you put her under. It's just not right! Oh, it's appalling! You do not listen to this little child and you do not listen to what she really needs. There's no place for you in her life. You cause nothing but harm. You are cruel! You are pressurizing and you need to stay away from this child at all times.

Graham: Yes, I can really hear the sincerity in your voice now. Wow, this is very good. Yes, I like the way you've said that, Alison. Do you want to carry on? Come, say more?

Alison: Well, I think I've said enough right now.

Graham: Okay, so tell me then; what do you think we need to do about these two (I point to the DePa and PuPa modes) sitting over here?

Alison: Well, we need to get them out of this child's life. They must be gone! Banished; like you said before.

Graham: So, what do you propose we do with them?

Alison: Well, they must go! Be off! (Alison gestures with her arms that they should be swept aside)

Graham: Absolutely. And I think that we need to do just that. I think that these two need to be kicked out of this office and kept away from this little child sitting over here. Why don't you go over there, take them off that couch and throw them out of the room?

Alison: What? You mean I should actually throw them out of your office? Out there (she points to my office door that leads to a waiting area)?

Graham: Absolutely!

Alison: (Without hesitating, Alison stands up, walks over to the cushions and throws them out of my office before returning to her seat) There. It's done!

Graham: Phew, so how does that feel for you?

Alison: Well, I feel quite overwhelmed right now. My heart is pounding right here (placing her fist over her chest).

Shocked at my suggestion but with little hesitation, Alison confidently engaged in the physical ritual of banishing the DPMs from my office. Her pounding heart was evidence of the visceral engagement in this process. It was important that I encouraged her to speak in the first person in order to fully embrace the sentiment of the HeAd, while my repeated encouragement and affirmation served to sustain the confrontation. While this banishing of the DPM would require much repetition, the ritual reflected a powerful conviction that Alison was not going to tolerate these threatening inner voices. I did not afford the DPMs an opportunity to retort because I did not want the HeAd's growing conviction to be interrupted. I had no doubt that these dysfunctional modes would offer a rebuttal at a later stage.

Chair work had created a very dramatic and emotionally charged stage upon which the unfolding process would need to continue. The valuable impact of the chair work was evident over the next few sessions as Alison demonstrated growing confidence in the HeAd confronting modes that attempted to threaten the well-being of the child. Alison was particularly responsive to me standing alongside the HeAd and modelling healthy confrontation. My support helped her echo, with increasing conviction, the important boundaries that were required to safeguard the VuCh.

9.5. Session 11

Where Alison grew increasingly familiar in confronting the DPMs from the HeAd with each session, this session saw the latter being able to emotionally engage with the Child at a much deeper and more authentic level than before. The rawness of the anger brought home the HeAd's deeper appreciation for the pain residing within the VuCh; something that was enhanced through emotion-focused work:

Extract from Session 11:

Graham: Yes, Alison, so you can see how this little child over here is left feeling?

Alison: (In HeAd) Yes, I certainly can. It really is unacceptable. It is really not alright.

Graham: Right. So, I want you to just, once more, say to these parent modes sitting over here what needs to happen. This little child's safety and needs are the priority, okay?

Alison: Okay. Well, I will not allow you to manipulate this little girl. I will protect her, and I will be a barrier against you. You cannot interfere with this little child any longer.

Graham: Right. I like that. Have you one closing remark for these two (DPMs)?

Alison: I have NO time for you!

Graham: That's really good, Alison. That was very direct. Very clear and direct. (Pause) Alison, what are you feeling inside right now; now that you have said this?

Alison: Well, it has to be said that I do feel very much better; more confident with what I have just said. I am starting to find it easier each time to stand up for this little child part of me sitting over here.

Graham: Ah, that's so good. It seems that practice makes it easier?

Alison: Oh yes. Yes, I feel that.

Graham: So, I'd like you to just focus inward for a moment. And I'd like you to listen to how it really feels inside for this part of you that is growing into a wonderful guardian for this little child over here. Can you do that?

Alison: Yes, I think so. (Pause).

Graham: How does it feel inside for this guardian; being the good mother figure for this little child? Can you feel this right now?

Alison: Yes. I actually feel a warm feeling inside me over here (Alison places a palm on her sternum area). You know, I feel very protective. I want to look after this dear little child here (pointing to the VuCh beside her). I want her to be safe from all harm. Hmm, does that make sense?

Graham: Oh yes, of course it does. I want to really encourage this caring mother part of you to continue feeling this warmth for the little child sitting over here. This is so good. A mother's warmth. Her loving care and protection from harm?

Alison: Yes, it does feel good. To be this little child's mother; she needs this. I so dearly want to be this little child's protector.

Graham: Right, so I'd really like you to turn to this little child over here and express how you feel towards her.

Alison: I so do really, really love you. You are such dear little child to me and I want to take care of all your needs. All of them. You deserve my loving care and you do not deserve any harmful treatment at all. You never did, you know.

Graham: That's wonderful, Alison. This little child sitting here has long been waiting for the loving care that she has always deserved.

This extract revealed an important unfolding process. Where the angry HeAd had grown in confidence in preceding sessions to confront the AnOv and the DPMs in a deeper and increasingly authentic manner, so was this same HeAd also developing more empathy and compassion for the VuCh as the level of abuse became more apparent. A more open and sustained channel of angry expression was thus opening up a channel of empathy from the HeAd for the abused VuCh. The character of the HeAd was becoming a more mature and rounded one, demonstrating a broader array of emotion in meeting the Child's needs for love and protection. Alison was also beginning to experience this empathy at a deeper bodily level.

9.6. Session 12

An unexpected and major breakthrough was achieved in the session the following week. Likely as a result of growing confidence in the HeAd's expression of anger in the preceding sessions, Alison was able to boldly express anger directly towards her treatment team. In the consultation with her dietician earlier that week she learned that her weight had increased. Even though it remained within the expected weight increments that she had contracted to, it triggered the AnCh, which was duly suppressed. Reflecting upon the situation later that day, it became clearer to her how she had, in a reflex manner, suppressed the anger through the CoSu coping mode during her dietician's consultation. This realisation prompted her to bravely share these feelings with me in her therapy session a few days later. This extract illustrates the importance of inviting and sustaining anger triggered in the Child, even though the context in which she was now angry was not justified. Harnessing this emotion was paramount, but once its source was better understood, the task becomes that of directing the anger towards its legitimate source:

Extract 1 from Session 12:

Alison: (Reading from her session bridging form) I am reluctant to tell my therapist that I feel betrayed by my support group, and I regret my disgusting increase in weight.

Graham: Okay, so you feel really angry for the team making you increase your weight?

Alison: Yes, but at the same time, look, I really am sorry for saying that this is how I feel. I know that I really don't have any right to be really saying this to you or the team (Pause).

Graham: Okay, hold on Alison. I am actually very comfortable that you are expressing how you honestly feel, and I get it; I understand why you feel angry when your weight increases. I think there are lots of feelings that you probably have when your weight is increasing to the place where the team is saying it needs to go. Um, is that not so?

Alison: Well, yes. Yes, but I know that it is not reasonable for me to be angry with all of you. After all, I know that it is something that I am meant to be doing under all of your guidance.

Graham: Sure. But the feeling; um, YOUR feeling is very real. And that's the important thing right now, Alison. Tell me, have you a sense of where you might have had this same feeling before? You know, where before you have felt this anger? This frustration? You know – in the past – maybe many years ago?

Alison: What do you mean? Have I felt angry before about my weight increase?

Graham: Oh, look, no, we know that gaining weight triggers feelings like anger in you. But I wonder if you have these thoughts or memories that go with this anger, whether you have had this feeling elsewhere in your life; maybe years ago? Maybe I am not explaining myself very well here. What I really want to understand is if this anger is something you have experienced before. Um, are you familiar with this angry feeling in having experienced it before? Maybe in a different situation?

Alison: Oh okay. Well, yes, I have often felt this feeling when I have needed to gain weight. I remember feeling this when I was at the ward in the state hospital.

Graham: Ah, okay. What are the thoughts that go with that anger? You're angry, but what is actually going on inside?

Alison: Well, I am thinking that it is unfair that I am not able to make my own decisions; that others decide everything for me. I am not in charge of making my own decisions or deciding what I want for myself.

Graham: Ah, okay, that's interesting. So, your anger connects with the sense of you not being able to decide what happens to you. Not being self-determined? Not being in charge of your own life?

Alison: That's right. I am not given the opportunity to decide on what I want to do.

Graham: So, tell me now, when have you had that emotional experience before; this notion of not getting to do what you want to do? And I am not talking necessarily only about situations where you have been expected to gain weight. Um, maybe other situations in your life where the little child within you was not allowed to decide things for herself. You know what I mean? (Alison nods) Maybe many years ago; before the eating disorder even started? Maybe many years before that when you were much younger?

Alison: Oh, okay, now I can see what you are getting at. Sure. Actually, this is how I felt all through my life; and throughout my childhood. This feeling of never being able to decide for myself and having everything decided for me. My mother was like that with me throughout my life, in fact. Yes, and it just was not okay! It's as though she did not trust me being able to decide anything for myself. She never helped me to feel confident in anything, always deciding for me what I must do. This does make me feel angry thinking about it now.

Graham: Well, okay, that completely makes sense, Alison. You have every reason to feel angry about the way you were denied choices and the chance to develop confidence in making your own choices. I remember you saying how your mother discouraged you from going into teaching or even getting your own drivers' licence. I suppose it was like that for even small decisions?

Alison: Oh yes! In fact, I remember a time when I was ten years old and my mother would choose a toy for me to play with in my room. I wasn't even allowed to choose my own toy! Isn't that crazy?

Graham: Yes. That's so ridiculous. I remember you telling me that before. How on earth were you going to learn how to make decisions or discover what you wanted when you have a mother who is so incredibly controlling like that?

Alison: Yes, you are right, Graham. It is quite ridiculous that she controlled me like that. Really suffocating!

Even though Alison quickly and insightfully recognised from a HeAd perspective that the Child's anger towards the team lacked legitimacy, I had made it my task to pursue the AnCh at every opportunity. Listening intuitively to the emotion being expressed, it was imperative that I discerned between angry coping that served the purpose of avoiding confrontation, and the initial and palpable anger emanating from the AnCh, even if the context lacked legitimacy. I wanted to engage with the latter and tasked myself with linking it to a legitimate source. Even though my emotion bridging was initially misunderstood by Alison and left her confused, we were eventually able to bring into sharp focus the raw anger associated with her denied autonomy. The risk had paid off. While she initially linked her anger for the team to an equally unjustified context of inpatient hospitalisation decades earlier, the link to the denied autonomy and self-determination at the hands of her mother was eventually realised. This was not only an important insight, but a very important link to the significant number of EMSs she developed in her childhood, namely: mistrust and abuse, feelings of defectiveness, social isolation, feelings of incompetence, a vulnerability to harm, an undeveloped self, and a failure to achieve.

Despite the valuable insight revealed in the above extract, renewed discussion about weight later in the same session reflected the automaticity with which Alison still directed anger at the team due to the pressure to gain weight. This illustrated the ease with which the still very prominent AnOv muddied the waters and brought the focus of Alison's anger back to anything that threatened it. Only upon reflecting on this transcript did I see that there was another source of anger at play. Despite the initial and legitimate anger and sadness relating to her stolen autonomy, I did not immediately recognize the presence of angry coping imbedded within the AnOv. Fortunately, I did not reinforce and encourage this coping anger, but it points to the importance of identifying between different sources of anger, and ensuring that there is never an encouraging or reinforcing of coping anger that is misconstrued as anger emanating from the Child.

Extract 2 from Session 12:

Graham: So, it's really relieving to see that you gained your 500g this week. (Pause) Right? Um, Alison, your increase this week; you still look uncomfortable?

Alison: Yes, it actually feels to be too much. I'm really not happy about this at all.

Graham: Okay, well, let's look again to see what's happening here right now. You know, as much as we saw just a moment ago how your anger was strongly connected to the past and about you not being allowed to be in charge of your own life; making your own decisions…

Alison: Yes, I do see that, but I am still having this same feeling here with what's going on right now.

Graham: Okay, say more. Explain to me?

Alison: Well, if I be true to how I feel inside right now, I am absolutely furious with you for having the audacity for doing just what you think is right for me, and not even listening to what I am saying. Our goal has not been the same. Your goal for me and my own goal for myself are two different things!

Graham: Yes, I really get that. I absolutely get that there's a voice in you that is really angry; furious about your weight needing to go up. Yes, I get that, and I think that it's really good, really healthy that you can express yourself so honestly in this way. You are speaking out about what you feel. And that is good.

Alison: (In a softer and sadder voice) Yes. That is right. I am. I feel betrayed by you and Elliene, and even Mike.

Graham: Okay. I know that you are angry, but am I also hearing sadness in your voice?

Alison: Yes, that is so. But, but, I want to let it out and get rid of it; that intense feeling of being overpowered by other people.

Graham: Ah, okay. What I do want you to consider, though, is that there is probably a bit of a conversation going on inside you right now. I hear one voice that is really angry that says "I don't want to be gaining weight!" Right?

Alison: Yes.

Graham: And there is also a sad child that feels overpowered. Might that be the case?

Alison: Yes, that is so. You are right.

Graham: And, don't get me wrong, I know that the child is angry for having to gain weight. But what we were talking about earlier (in the session) is how this feeling also sits much deeper and how it connects to the way in which your mother never gave you the freedom to make decisions for yourself. This is a very legit reason for you to feel angry. Right?

Alison: Absolutely so. It's infuriating how angry I feel about the way she never allowed me, in fact, never helped me to make decisions for myself.

Graham: Right. So, is it really possible that being angry about gaining 500 grams this past week is anger that sits in the child? Maybe there is another mode in you that's influencing things here?

Alison: I am not quite sure.

Graham: Well, I get that you feel angry about not being able to have your say. Right?

Alison: Yes.

Graham: So is it possible that as much as the angry child in you is cross about not getting her say, when we look at the weight you gained this week, it's an amount that the healthy part of you knows is important to make. The healthy adult in you knows the importance of getting to and staying at a normal weight level. Right?

Alison: Well, yes, of course the healthy part of me does know that this is what is supposed to happen. But that doesn't stop me feeling angry with my weight going up like this.

Graham: Yes, of course! I really get that, Alison. But tell me now, might there be another mode that is sitting here in the room with us right now – a mode that is influencing you to be angry about your weight going up – even though you know from a healthy place that your weight is meant to be going up steadily?

Alison: Well, I suppose it is that anorexic mode; the AnOv is the one that is really not happy about this weight gain.

Graham: Yes, I think so, Alison. I think that it is very valuable for you to be able to see here that your AnOv is here in the room with us. And what might it be saying to the little child?

Alison: Well, it says what it always says; that this weight gain is unacceptable and that no weight gain should be happening.

Graham: Okay. You know, I must say it again, but I think that it is very valuable that you are able to see that. But what I want to ask you is this: "Is it good for the little child part of you, the vulnerable child in you, to be underweight and facing harm?" You know, what I am saying is "How might the little child in you feel about being forced to stay underweight?"

Alison: OH! Well, no. It is not good for harm to come to this child. Of course not. It is not good for the child.

Graham: Right. So then, is it appropriate for you to be angry when there is a good and healthy reason for you to be restored to a healthy weight?

Alison: Yes, I see what you are saying. And, yes, you are right. I shouldn't really be getting angry about the weight increase this week.

Graham: Right, because this is all part of the agreed goals we have made together as a team; including you. The importance of following the meal plan and slowly gaining weight is about ensuring your recovery, not so?

Alison: Yes, I do see that clearly.

Graham: So, this anger you feel; might it be that the AnOv is sort of making things a bit murky here? This anger is coming from the AnOv to kind of intimidate the team into backing off? (Alison nods) But what about the anger you feel about not having your own say – not being self-determined and not having control over the full course of your life – something that was denied you for so many years?

Alison: Well, when you put it like that, it does make sense. Yes, I do feel angry for just not feeling that I have my own rightful say, right now.

Graham: Okay. Right. I think it's important that you keep this anger you feel for your mother, what happened for many, many years, and keep it separate to the anger you put on the team for having to follow the meal plan. There is the AnOv in there somewhere, playing a role. But, if we go to your mother, she never allowed you to take control of your own life; she always made decisions for you and she never allowed you to have YOUR say. It's very understandable that you feel angry about this.

Alison: Yes, it seems much clearer to me now. Yes, I can see now how it's the anorexic voice in me that gets angry about the weight – the weight increases – and it's not a good reason to be angry because I know that I need to gain weight to be outside of my anorexia. But when I get anxious, then a part of me gets angry. And I think this does connect to the anger of having never had my own say.

Graham: Right. So, there is another place where the anger in the child is there because the child in you feels she has NO say. As for the eating and weight gain, that's an important NEED of the child in you and not a correct reason to be angry. But I'm hearing you say that it touches a deep feeling that has always been there about not having your say. So, you have very good reason to be angry about all the years in which your mother denied you saying what you needed and wanted. Being silenced and having no say. Right?

Alison: Yes, it's very clear now. The healthy part of me is not angry with you and the team. And you all mean well. Yes, I get it. This is anger I have for my mother.

Graham: So, I want you to stay with this anger you feel for your mother taking so much away from you being able to voice your own needs. How does it feel inside when you reflect on this? And take a moment to reflect on this feeling inside you.

Alison: (Alison pauses to reflect) Well, It's unbearable. I want to let it out and get rid of it; you know, that intense feeling of being overpowered by other people.

Graham: Yes, I completely get this. I want you to stay with this anger you are feeling about what your mother has done and just stay with this. Just stay with this for a moment. (We sit in silence for 30 seconds) Where are you right now? What are you feeling?

Alison. I feel angry. Just angry!

Graham: Yes, I can see that by your (tightly clenched) fists. Can you say more?

Alison: I just feel such anger inside my body. Yes, my body is tight; like you say.

Graham: Can you say if there is anywhere else in your body that you are feeling this anger?

Alison: Well, I am tight in my chest (Alison puts her open hand flat to her sternum region).

Graham: Just stay with that. (Pause) You want to say something to your mother?

Alison: I want to say "Stop it. Just stop it! Stop it now!"

Graham: Okay, just stay with that feeling for a bit longer. (Long pause) You want to say some more how you are feeling?

Alison: No, I think I've said it all.

Graham: Okay, that's fine. Now, look, I'd like you to come and sit here in the Healthy Adult place for now. (Alison moves to the HeAd seating position beside me) I would like you to just reflect with me on this little child sitting right here, and see how that feels, while you protect this child here. What's coming through?

Alison: Well (pause), I want to push in the way and give this little child freedom.

Graham: Yes, say more.

Alison: She wants to be heard and listened to and given a place. She's not non-existent. She's somebody! Oh my, but my heart is actually bursting with anguish.

Graham: I can see that. I can see and hear how strongly you are feeling. You are very angry for what this little child has been through.

Alison: Yes. You know, I am stuck with this feeling of such anger for my mother, but I don't think that I am feeling that same feeling for you and the team now. Oh my; yes. Alright, I can see now how you are all actually very different, even though I started by being angry with you all. But it is my mother – you are right – my mother is the one that I am so, so furious with right now.

Graham: Yes, Alison. I think it is so good that you are seeing that the really proper way. The legitimate place for this anger is really your mother. This is where you really feel it?

Alison: Oh yes, so completely.

Graham: So, Alison, I want to know if you would be willing to sit here in the AnCh again and really own that anger that you are feeling right now. Would you be willing to do that?

Alison: Yes. I think that I can do that. But I still don't think that it is right for me to be angry with my mother. She should be respected at all times.

Graham: Alison, I know how tempted you are to go back to that rule of honouring your parents, but I think it's really important now that you allow this little child to be angry for what was done wrong to her. This is not about a disrespecting or a dishonouring of your parents. It's about it being wrong that you were so strictly over-controlled. And the angry child in YOU needs to be acknowledged for this. Right?

Alison: Okay, I do know that. It's just difficult after all these years.

Graham: I know, Alison. I do appreciate that. But for now, I want to take you back to where we were earlier; the little 10-year-old child denied the freedom to make some of her own decisions. Can we do that?

Alison: Yes, we can.

Graham: I want you to reconnect to this little child; this very angry little girl. Try connecting with this little girl as though you are all the way back many years in that same place again. Now. Let's see what is happening here? (Pause) Do you see how your parents both failing you?

Alison: Yes, I do. My parents never hear me. They just see me as an object, not a person.

Graham: I want you to listen to inside you. Don't hurry this, but I want you to listen to how the anger feels inside your body right now. Stay with being this little angry child. Can you try to feel that?

Alison: Oh yes, I surely can feel it. I am furious with the way that they – my mother especially – treats me. She is so strict, so controlling. Yes, I feel this anger in my body. I do.

Graham: And where in your body do you physically sense this anger? Where is it sitting inside you – inside your body?

Alison: I feel it in my chest and throat right now; like I want to scream. I want to scream.

Graham: What do you want to scream?

Alison: "How dare you! How dare you do that to me!"

This extract demonstrated the subtlety with which anger can shift between different sources, and the importance of me, as therapist, detecting these discreet mode sources and the flipping between them. Chapter 10 demonstrates the AnOv being conceptualised as a composite coping mode; a distinct and multifaceted mode that evolved out of pre-existing modes (DPMs and coping modes like the PeOv and ObOv), and serving a very specialised and complex role in Alison pursuing and maintaining an emaciated appearance for the individual. It was very clear to me from the outset that Alison's anger towards me and the team served to counter the treatment agenda of weight restoration. While I knew that she was expressing coping anger that was imbedded in the AnOv, I did not want to immediately neutralise this AnOv-based coping anger. Instead, I chose to pursue the legitimate source of anger in the Child that was associated with denied autonomy, but which had been very quickly diverted towards the team, making it illegitimate and no longer the anger of the Child. My task was to reconnect this anger with her parents, especially her mother. We succeeded in making this link, which helped me be in the position to educate Alison to the illegitimate source of her coping anger (in the AnOv) that she had directed towards the team.

Given that the only context in which Alison expressed coping anger in therapy was associated with the avoidance of weight gain, I conceptualise such coping anger as being imbedded within the AnOv, rather than an existing stand-alone angry coping that is temporarily recruited by the AnOv. Alison, herself, first identified and conceptualised the coping anger as a component of the AnOv. Even when Alison's sad VuCh reflected a "betrayal" by those expecting her to gain weight, this was an authentic feeling emanating from the VuCh, but an emotion associated with the betrayal of denied autonomy imposed by her parents many years previously. My task was to sustain and amplify the anger and sadness/betrayal experience in the Child and aimed at her parents. Alison's tight fists and powerful visceral bodily experiences were a clue to the intensity of anger in the Child, possibly better described as rage. While I had deliberately elaborated on the bodily felt sense of the anger in order to heighten the Child's experience, she did not tolerate this for long. Instead of persisting with an AnCh that was approaching the limits of her window of tolerance, I invited the HeAd to reflect with me on what the Child was feeling, knowing that Alison still felt it more tolerable expressing anger from the HeAd perspective than from that of the AnCh. The affect was not lost as indicated by her heart "bursting with anguish". As Alison was able to tolerate this, she instinctively returned to the AnCh with renewed courage. However, this immediately evoked the gi-DPM notion that anger directed at her parents was strictly forbidden. It was important that I, again, challenged this deeply imbedded and dysfunctional rule and convinced Alison that an appropriate expression of anger was neither disrespectful nor wrong, and that the AnCh needed to be heard and acknowledged for all the wrongs done to her in the past. This was an important concept that would need to be driven home repeatedly. I was re-engaging Alison with the 10-year-old childhood memory of abuse; heightening the somatic experience of the anger to maximise the connectivity to the Child. This had the effect of evoking a powerful outburst from the Child. The AnCh had found her voice, and little was required of me to assist her to condemn her mother for restricting her freedom, for instilling fear, and for neglecting to acknowledge her individuality.

With the confidence that Alison gleaned from confronting her mother from the AnCh a moment earlier in the session, she was able to progress later in the same session to challenging her father for his unacceptably drunken behaviour and lack of accountability towards the family. My main task was to interrupt her flipping into either the DPM or the CoSu; the former from invalidating her anger and the latter from attempting to subdue the discomfort associated with this difficult emotion. I managed to convince Alison to remain in the AnCh's chair, which was confidently demonstrated in her throwing the cushions that represented her parents across the room:

Extract 3 of Session 12:

Alison: You know, I still feel absolutely awful with this being angry with my parents.

Graham: Sure, I know that you feel this way Alison, but you know that this is the voice coming from an illegitimate place. This idea that you are not allowed to be angry at your parents, despite it being completely valid, is ridiculous. And the Child in you is only going to feel free when you can allow her to be angry for the rightful reasons that we have already identified. It's really important that we are on the same page here. Alison, do you get what I am saying?

Alison: Yes, I do. I know this in my head, but the feeling does keep coming through. It's an intrusion, is what you have always called it.

Graham: Sure, I get that. What you know in your head and what you feel don't come from the same place. Right? (Alison nods) So, Alison, can I ask you to speak from this place, the AnCh, and confront your parents both seated over there? I want you to know that I feel that you are totally justified to be very angry. In fact, I want you to know that I am sitting here right next to you to support you in whatever way you need. And I will help you to get yourself across to them exactly what you are feeling. You ready to do this?

Alison: Yes. Okay, I can do this. (Pause) Now, I want to tell you that I feel angry with both of you for never ever listening to me and always telling me what to do, and even what to say. And even being told to keep quiet when I had something worthwhile to say.

Graham: Good Alison. You are doing really well. You carry on now.

Alison: I'm absolutely furious that you've ignored me and that you have treated me like a "nothing"! You've given me no respect whatsoever. I feel unloved, insecure, scared. I'm absolutely terrified. Mother, you keep me in a tight compartment, giving me no space. And Dad, you are an encumbrance in my life. I can never feel relaxed because I have got it in the back of my head that you are going to come in and embarrass me or do something outrageous in your drunken state. You have betrayed me! Dad, I don't even talk to you because you cannot concentrate on what I am saying. You listen to me now and know that you have been a useless father and that you've let down your family. You've let me down! You've actually been a hopeless husband and father. I am appalled by you! You've been irresponsible and you've actually made me a terribly frightened person. I just can't relax. I never feel okay having fun because you might appear.

Graham: Wow, Alison, you look physically exhausted. And, well done on what you just said. That was fantastic. I am so proud of how you did that. (I face the two cushions representing Alison's parents and echo her sentiments) Do you hear? Little Alison here feels unloved, scared, and insecure. You terrified her. You give your daughter no space at all.

Alison: (In a gasping voice) But, Graham, no, my mother cared for me (indicating that she had flipped into an idealising overcompensatory coping).

Graham: Just wait a moment, Alison. Again, I think it's really important that you do not step away from your real feelings for what she did. I have no doubt that there were ways in which your mother did care for you, but what you are expressing now is the absurd control and restriction (she inflicted) in your life. The little ten-year-old in you feels unloved, restricted, suffocated, and ignored. Right? That's what I'm hearing you say here.

Alison: Yes, all those things are so real. They are so true! (Resuming the AnCh stance) Mom, I want to tell you that I feel that you have not been a good mother. You haven't been a nurturing mother. You've just been a disciplinarian telling me what to do and not loving me at the same time. I deserve more care and more love from you, and more sharing. We ARE poles apart!

Graham: Good, Alison. This is very important. Now, what do you think we need to do about your parents sitting over there?

Alison: Oh, like before, they must just be gone.

Graham: And how do you suggest that we do that? Here they are, sitting on the couch (represented by cushions).

Alison: Well, this has been a huge thing that I have been carrying. Or, is it really fair of me to …

Graham: Alison, keep your focus on what is required.

Alison: Gee, yes, you are right. It's such a burden on my shoulders to carry it around with me and not let it out (Without prompting, Alison's AnCh stood up, grabbed the two cushions and threw them to the far side of the room).

Graham: Yes, I like that.

Alison: All the anger is thrown at them and it's gone from me! I haven't got it anymore.

Alison's engagement with the AnCh in this session was the most significant and authentic to date, despite the initial interruptions from the gi-DePa, and a later intrusion from an overcompensatory coping in which she painted a contradictory idealised notion of her mother. I was more forceful than before in driving home to Alison the importance that the AnCh find her voice. Rather than directing attention to the modes that hindered the AnCh, I more deliberately pursued the AnCh. While Alison rationally appreciated that she was entitled to be angry ("I know this in my head"), this was not matched at an emotional level, given the persistent intrusive voices. Perhaps the reparenting process by way of my repeated reassurances that I would be actively present in the chair work to support the AnCh facilitated this boldest and most spontaneous expression from the AnCh to date. She was particularly vociferous in her first direct confrontation of her father. In addressing her parents, I reiterated the AnCh's sentiments in order for Alison to know that she was comprehensively heard. Her exhausted appearance confirmed the authenticity and magnitude of her most courageous engagement with the AnCh. It was not surprising that the AnCh's most powerful outburst was met with a coping to dilute the outspoken sentiment towards her failed mother. Rather than creating an absolute negative image of her mother, I did not dismiss that her mother cared, but reminded her that our current focus was to acknowledge her parents' shortcomings. This appeared to work, despite one further interruption, which I interrupted before identifying it as either a coping mode or the DPM. Her dispatching of the cushions that represented her parents concluded a productive piece of chair work. Our reflection on Alison's engagement with the AnCh revealed two valuable points. First, she expressed how it was not too late in her life to still unburden this deeply suppressed reservoir of anger when she said: "My anger is the same as it was when I was a little girl, and I have got the right… to get rid of it, even though it is so much later." Second, she realized after expressing her anger that she did not need to feel helplessly disconnected due to the lack of parental love. This is because she now had a husband (and son) who were providing the necessary (corrective) love that she always needed. Having been angry at her parents in this session enhanced her insight to how contrary to her parents was the way her husband was now consistently treating her in a loving and caring way. As in the previous session, in this one it was becoming more evident how increasing access to the AnCh facilitated exposure to the VuCh; the anger highlighting and acknowledging the abuse, neglect, and emotional deprivation was imposed on the VuCh. While, for the purpose of conceptualisation in ST, distinct child modes are recognised, it should not be forgotten that these different child states are all facets of a single child, and that there is a very close association between the VuCh and the AnCh.

9.7. Session 18

Where Alison read the therapeutic letter (see section 6.4.8.) that she brought with her as a homework task in this session, she continued to demonstrate ambivalence in expressing her anger. The interrupting influence of the gi-DPM resurfaced yet again to make it difficult for Alison to sustain her anger, and making it clear how important was the development of a robust and confident HeAd to hold the Child until the latter felt safer to express herself.

Extract from Session 18:

Graham: You know, something that really stands out for me from listening to you read the letter earlier is the way I heard two children there. I hear the angry child in you quite rightly expressing how furious you feel about the dreadful experiences you had to face with your mother's behaviour. (Pause) And then I also hear a very sad little girl who feels the dreadful impact of the life you had and the losses you experienced; not getting the love you needed. Not being allowed to be a happy child. Not being allowed to show any feelings that were uncomfortable for your mother. It's just dreadfully sad how cut-off and disconnected you needed to be. You see what I am saying?

Alison: Oh, I think that you are right. I think I was both angry and sad when I was young.

Graham: You know, your letter also shows me how this is the way that your mother always lived her life. You get that? (Alison nods) I think that the tone, the culture that your mother set for the home is what you inevitably got pulled into, and what became the norm. And here you are today, still facing the same forces inside you that compel you to live this – well, as you've said it – this penitential way of life.

Alison: (This sequence of mode flipping is analysed in the discussion immediately following this extract) Hmm, yes, I think you are right. My priest did say that my anger was righteous, but I also think that my mother had done her best. You know, for the grace of God, I have forgiven them. Yes, he did say that this anger was justified and righteous, but I also really think that all this anger is selfish. It's sinful. Yes, I think that it is selfish. It's just selfish, instead of me being understanding and showing that my parents did their best, and that I've expected more than what they had to offer.*

Graham: Are you telling me that you do not feel that you deserved more than what your parents provided? (Pause) Alison, just reflect on this for a minute – just for a little bit. And don't hurry your answer here.

Alison: (While her initial posture appeared to suggest that she was going to continue to defend her parents she, instead, became tight-fisted and taught in her facial expression) Oh goodness, Graham, my father's behaviour WAS quite unacceptable. His drinking was appalling. It was deplorable what this did to every member of our family. I'm furious about this. When I look at it, I see his behaviour was totally unacceptable; just dreadful. I really deserved better than this.

Graham: Ah, now I'm hearing your anger again. And rightfully so. And I wonder who this anger is coming from? Could it be coming straight from your child, or might it be the healthy parent part of you being angry here?

Alison: Well, it feels like I am angry FOR what was done to me – this little child here (pointing to the adjacent space on the couch) – when she was a child.

Graham: Ah, okay, so your grown-up HeAd is angry for what Little Alison was subjected to. Good. This is really good. I hope that you are okay to stay sitting where you are in HeAd and I want you to connect to little Alison right here next to you. (Alison nods in agreement) Okay, Alison, so I want you to talk to your little child right here. Can you do that?

Alison: (Speaking from her current position in HeAd to the Child beside her) Yes, I will. (Pause) Well, you have every right to be angry about the way your parents treated you. You know, your mother's most dreadful expectations; your mother who put on such high standards, making it impossible to reach them, and making you feel like a failure. She had no right to do that to you. They were impossible and were surely going to make you feel like a failure. It's just not right!

Graham: That's absolutely right Alison. I totally agree with you. It's really important that you help little Alison over here to see and know that the way she was treated by her mother was unacceptably agonising for her. Does that make sense?

Alison: Well, yes, it does. Um, I am still uncomfortable saying this. It's just not right …

Graham: Alison, can you see that this is that other parent mode coming through? Can you see this? Who is coming through now?

Alison: Yes, I suppose it is that critical and demanding parent.

Graham: Are we going to indulge that voice right now? (Pause) And do you really think it's fair that little Alison be denied what she needs to hear from your healthy voice?

Alison: No. I think you are right.

Graham: So, you can see the importance of us BOTH working on building up this healthy adult mode. It's important that your HeAd can support this child and that these modes that betray this child cannot be allowed to come through here. Alison, I will always be here to support this. Your HeAd is never alone because I am here to help build this important part of you that can protect the little Child.

Alison: Yes, I can see that. And you are absolutely right in what you are saying.

Graham: Okay, that's good. I'm pleased you see that. Now, is there anything else you want to say to your mother (who is) sitting right here?

Alison: No, I think that I have said it all.

Graham: Okay, that's alright. Maybe you want to say something to little Alison about her father's behaviour? You know, he, too, failed her?

Alison: Well, his behaviour WAS unacceptable! When he drank, oh, he was an embarrassment; an absolute embarrassment!

Graham: And how did this affect little Alison sitting right here?

Alison: Well, he was appalling. This poor child – little Alison over here – was subjected to such humiliation and discomfort. It just was not alright. No child should have been put through this sort of treatment. It just wasn't right, Graham.

Graham: And, again, you are absolutely right, Alison. So, what does little Alison here need from you? What does she need from a loving mother? From you, and me?

Alison: Well, she so needs to be protected and loved. She (Alison hesitates to turn to the child) – you need care and you need the attention. You need my attention and my care and love. (Turning to speak to me) Even this eating disorder is so bad for her. It really does need to go. Yes, this eating disorder, AnOv, is not a friend. It is a foe! It does nothing but take from this little child.

While Alison was steadily increasing familiarity in her engagement with her anger, it was not without a persistent resurgence of the gi-DPM; the source of which I pushed Alison to recognise as an introjection of her mother's strict Catholic attitude. The commentary from Alison in the preceding extract that is marked with an asterisk

demonstrated significant mode flipping, and is analysed here. Her opening remark acknowledging her priest's endorsement of her anger came from a healthy source, as can be viewed by her next remark that her parents had done "their best". However, when this was followed by her religiously loaded comment that she had "forgiven them", it felt less authentic to me and more emanating from overcompensatory coping to dilute or extinguish her anger towards her parents. What was important was that the Child was not invalidated by such comments. Even if her parents had done their best, they did not meet her basic needs for love, security and validation. This is an important element that therapy needed to accomplish. Expressing that her anger was "selfish" and "sinful" for expecting more from her parents than what they were able to provide reflected a mode flip into the DPM that completely undermined the Child's needs. This commentary from Alison demonstrates the intensity of mode flipping that she was still engaging in.

However, it required little persuasion from me for her to re-align with her anger, the DPM having to make way for a HeAd that was able to condemn both parents very effectively. Alison's preference to express anger from the HeAd rather than directly from the AnCh continued to reflect the former mode holding more authority and being more amenable to confronting Alison's parents. It was also becoming clearer how the HeAd held complementary roles of not only confronting her parents as a proxy for the Child, but also encouraging the AnCh to express herself directly at her parents for the abuse she experienced.

When, again, Alison's flipped into the DPM to condemn the anger being directed at her parents, she was quicker to identify this intrusive mode. I stressed the collaborative effort that was required to systematically strengthen the HeAd mode, it being important that Alison never felt alone in this struggle and that she knew that she had my consistent support and protection to bolster the HeAd. I did not push the HeAd to continue any longer than was tolerable for her, her ongoing commentary about each of her parents being brief but authentic. I also chose to steer the HeAd towards its nurturing role, given that she looked physically exhausted and that I did not want to push her beyond what she could tolerate. This decision appeared to be correct, given that she turned without my prompting to engage with the VuCh with deep authenticity, recognising the nurturing that the Child needed.

9.8. Session 47

Themes other than anger had dominated the therapy for the preceding few months leading up to this session. Even though, during these interim months, there was evidence of anger, and there was no notable change in the manner in which anger was being more readily accessed and processed. In this session, however, Alison once more faced anger with significant force. Again, it was following a deep and authentic engagement between the HeAd and the tearfully sad and frightened VuCh that the AnCh subsequently emerged to describe how, throughout her childhood and adolescence, she was compelled to suppress everything associated with normal and healthy development. It was through chair work dialogue between the HeAd and the VuCh that Alison was brought to a

stark realisation of how frequently terrified she felt throughout her childhood, and how she was compelled to marginalise the Child through the subjugation of emotion and self-sacrifice in order to dampen the conflict in the home environment. As she stepped closer to this realisation, it ignited the AnCh:

Extract from Session 47:

Alison: (Speaking from the HeAd to the VuCh seated alongside her) This dear little child should not be punished and deprived, and I do not want this little child to be frightened of punishment anymore.

Graham: This is so good to hear. And I can see that you are feeling very strong emotions right now. You were very tearful after our telephone conversation (earlier in the week) when you realised that I was not going to condemn or judge the way that you were struggling with the eating. And, of course, you know that I am completely invested in you eating in a good and healthy way at all times. You know that? (Alison nods) But I don't want this little child of yours over here to feel threatened that she will get into trouble. She needs encouragement and warm care. You know where those feelings of threat go back to, don't you?

Alison: Yes, of course. We have been talking about my mother all along, haven't we?

Graham: Yes. I think so. So, what do you want to say to her right now?

Alison: (Flipping into the VuCh being influenced by the unrealistic expectations of the DePa) Um, yes, of course. Yes, it's all very well, but I should have had the backbone to stand up for myself and faced my mother when I was seven years old.

Graham: Oh?

Alison: (Still in VuCh without needing to change chairs). Yes, I just did what was required. I just stood back and remained quiet; doing what I was told and behaving as expected.

Graham: Oh, okay, I see now what you are saying. But hold on here. Surely you should have never been expected to have to stand up for yourself at such a young age. In fact, I think it's really understandable that you were forced to develop ways of coping to survive this dreadful environment. Alison, you know, there is no way that you should have been expected to assert yourself as a young child of seven (years)? No way. You were just a young child. So, it must have been really, really difficult dealing with things at home; how things were at home when you were just a young girl. Can you remember what that was like? How it felt?

Alison: (Reflecting from the HeAd on childhood abuse) Oh, things really got heated at times. But, you know, what I most remember is the silent treatment. That was the most difficult, you know. I do remember feeling so guilty and so, so anxious in those situations. You know, the silence would go on for hours, oh, if not days. It was awful. JUST AWFUL! You know, as much as I was anxious all that time, it makes me actually feel quite angry when I think back on it now.

Graham: Oh, I get that. Yes, it must have been really, really awful. Very, very difficult; really awful to be left with such a sharp tension in the air. I really get it that it leaves you feeling this angry. Right? (Alison nods) I want you to really listen to how this anger feels inside you. What does it feel like to be in this situation where you are stuck in such tense silence; things so obviously tense all around you?

Alison: (Still reflecting from HeAd) Yes, I really had to bury my own feelings in a situation like that. I remember having to do everything to stop anyone from being angry. Really having to try and keep the tension down. I never really got to do my own thing, EVER! So, this is why I feel angry now.

Graham: Of course. I get that. And, yes, I think what you are saying is that you never really had a chance to be a child – a care-free child – a child that feels safe and loved. You know, it is not a child's job to keep a home environment safe and peaceful. That is your parents' job. Not for you as a little child. Not so?

Alison: Yes, you are right.

Graham: And the mode that you went into to keeping this peace. You know it?

Alison: Oh, that would be that compliant one, that compliant surrendering one.

Graham: Yes, quite right. Okay. So – as I look at it – so uncomfortable were things that you felt compelled to put your fears and anger aside and just focus on keeping the tension in the home to a minimum. Can you see how this is what you did to cope? Disconnecting from your own feelings? Ignoring them. Just keeping the peace. Trying to keep everything calm, but carrying such heavy feelings inside you at the same time. Right? (Alison nods) That must have been awfully difficult?

Alison: Well, yes, I think you are right. And, yes, I never did really feel safe. In fact, I felt that I had to constantly carry the responsibilities of my parents; for both of them. Thirty years ago I thought that I had to BE my mother. When she – my mother – passed away, you know, some of her clothing she wore, I thought I should wear. I didn't get (a)round to it, but it is what I thought I ought to do – to help keep my family connected – I had to control the family and not let them go out of line. I really felt that I had to be the one to keep things safe for everyone.

Graham: Sure. Phew, I really get that. It's just totally unfair. But I sense that it was not just when your mother died that you felt the need to take on such responsibilities. We need to go further back, don't we?

Alison: (Shifting from HeAd to AnCh, although not yet directly confronting her mother) Oh yes, you are right. Indeed so. You know, I really AM ANGRY. In fact, it's maddening that my mother gave me the responsibilities that she did when I was so young. I was never allowed to rebel. And then, on top of that, when I was growing up, she didn't allow me to become a young woman. She made me feel ashamed of growing up and developing! She made me feel quite unsightly. I had to hide myself! You know, it's as though she didn't want me to mature; to become a young woman in every way. I… I... I'm furious about that. It's absolutely SHOCKING! I cannot believe that I have not felt like this before.

Graham: You are absolutely right, Alison. I really get the sense of what anger you're connecting with. It's totally unacceptable that you were put in such a position. Ja, I really feel your anger right now; and rightfully so.

Alison: Oh no, that's not acceptable. You are right. Actually, that's WICKED! She had no right to do these things. The mixed messages. It is not right what she did to me when I was younger. So, so crippling. Oh, it makes me so very, very tired thinking about all this. I feel exhausted.

Graham: Yes, I can understand that you feel emotionally exhausted connecting with all of this?

Alison: Yes, I get really emotional thinking about this. I am not used to feeling these feelings so strongly. That's why I'm so exhausted.

Graham: Yes, I can see that. And that is so understandable.

Alison's expressed exhaustion at the end of this extract reflected the intensity with which she engaged with powerful emotion. While I had the option at this point to continue pursuing the AnCh, I considered her tolerance state and chose to rather draw her back to the VuCh; a Child who now felt immense sadness for what was denied

throughout her childhood and the interruption she faced in her pathway to womanhood. Early in the extract, Alison became increasingly aware of the threatening and dysfunctional home environment she was forced to tolerate as a child. While she was only briefly influenced by the DePa mode with an unrealistic expectation that she should have been asserting herself to her mother when so young, it soon became apparent the extent to which Alison was compelled to subjugate and sacrifice her own needs through CoSu coping and other forms of avoidant coping behaviour in order to dampen the tension at home as much as possible. Her insight was growing, and in recognising this, she became rightfully angry. The brief psychoeducation that I provided in pointing to how Alison's mother and father failed in their parental responsibilities helped Alison to more broadly recognise the extent of the abusive environment that she was place in. This evoked more anger, which she is now displaying with greater ease and spontaneity. She recognised how disempowered she was and how shameful she was made to feel where her mother stifled her sexual development. This directly implicated her mother in the development of body shame that manifested in her decades-long anorexic pursuit. This extract was the first notable instance in which Alison reflected on her anger without any attempt from the gi-DPM to mute the anger; and a significant shift. Again, this extract demonstrated how the depth of emotional access to the VuCh facilitated greater access to the AnCh and how these two different faces (modes) of the Child actually formed part of the same injured Child. The session helped me to more fully appreciate the extent to which Alison was forced to suppress her anger for decades, and how significant a reservoir of anger she had accumulated under the surface.

9.9. Session 51

In this session a month later, Alison had another opportunity to engage with the AnCh. Although weakened, the introjection of her mother's emotionally forbidding attitudes residing in the DPM resurfaced for the first time in a month, stubbornly attempting to threaten Alison's authentic outward expression of anger. Despite her still coping through an overcompensatory idealised notion of her mother (as she had often done early in the therapy), I was able to guide her towards greater clarity and authenticity. The following extract reflects Alison's anger escalating closer to rage as she voices her wish to punch her mother for the abuse she imposed on her during her childhood. This extract also brought renewed insight to the manner in which the AnOv served as a means of coping with anger as a forbidden emotion:

Extract 1 from Session 51:

Alison: You know, in all honesty I still have this sense that I should not be allowed to be angry with my mother.

Graham: Okay. But, Alison, do you know this to be a healthy voice? We've been here before a few times. Does this voice come from a healthy place?

Alison: When you say it like this, I know that this is an unhealthy voice. That healthy part of me (HeAd) knows that I should be in touch with this anger that I feel so much. You know, when I leave the sessions I am beside myself when I sit down at my desk (at home). And I so much regret not crying, because I am so angry. I have to take that little child home and absolutely reassure her that I'm looking after her (Alison

flips into an idealizing coping) and that she had parents that really cared about her. They did the best that they could under the circumstances. You know, my mother did a fine job with what was available to her. She didn't shirk her responsibilities, and took on her responsibilities very, very aptly for what she thought was the best for her children.

Graham: Hold on Alison, we have been here more than a few times before. Do you really think that your mother was a responsible parent? Yes, I do get that there is a healthy element in you that forgives her. And, you know, I'm not interested in just coming down on your mother with judgment, but let's just take a closer look at what is going on right now. As a little child, do you really think that you should have been expected to just blindly forgive your mother for her failings and move on without your inner child not feeling any of that pain? Can it REALLY be said that your mother performed the responsibilities expected of a good and loving parent?

Alison: Hmmm. (Pause)

Graham: I know that this is hard, Alison, but what is the little child in you feeling right now? What is she feeling DEEP inside right now?

Alison: (Alison engaging with AnCh) Well, yes, I suppose it has to be said that my mother was hopeless in letting me grow up. I hate to say this, but it is true. She just kept me as a CHILD and she made me feel that growing up was something unsightly, bodily. So, yes, it really does make me feel angry and sad thinking about it. But, you know, I also do think that she did try to do her best.

Graham: Hmmm. I think that it is really important for you to feel safe to say what your honestly feel inside, Alison. I want you to feel safe to say things that you really feel sit inside you, and not try and cover up what you are feeling and the full truth of what has happened. A parent is hardly ever all good or all bad, you know. So, I'd like you to try not go to that place where you paint a pretty picture that doesn't tell the full story, okay. Can it really be said that your mother – or your father, for that matter – were responsible in their roles as parents?

Alison: (Sitting very still in contemplation) Umm…

Graham: Look, I do hear that you have forgiven your parents for their shortcomings, but even though you have the compassion to forgive their many failings, the little child in you, Little Alison, still needs to be heard. She needs to still express how she feels for the ways that she was failed. Not so?

Alison: Yes, I do suppose you are right. It's sometimes difficult acknowledging this, but I know that that you are right in what you are saying. It does help hearing you say this. Yes, I know that it is right; that I have deserving reason to be angry.

Graham: Okay, good. I am relieved to hear you say that. It's really important that the healthy grown-up in you (HeAd) is able to permit this anger being expressed. It's so, so important that the little child in you knows that it is safe and important to express – and REALLY honestly – this anger for what happened. And that you REALLY feel it.

Alison: Yes, I do agree with you on that. I get what you are saying.

Graham: Okay, so then, I'd like to look at something you said a moment ago. Alison, I'd really like to know how it felt for you to have your mother undermining your physically developing into a young woman?

Alison: Oh, now that WAS terrible for me. She so shamed me. She, she really made me feel ashamed for turning into a woman. I mean, I felt SO ashamed of my body; my body as I became a woman. So ashamed.

Graham: I really get that you felt that way. It must have been awful. With all that shame that you were carrying, how did you deal with that? It really must have been awful.

Alison: Oh, absolutely, Graham. I mean, looking back on it with all that we have spoken about, being anorexic definitely became a way of hiding from the shame she put on me. Staying small was, well, safe. It feels as though that is what she wanted. What she expected of me. But I was not aware of this when it was happening. I wasn't knowingly trying to lose weight to hide what I was feeling in my body.

Graham: Oh, of course it wasn't a conscious thing. But ja, I think you are absolutely right Alison. It does appear that your anorexia served as a "protection" from the shame she put on you. (Alison nods) Becoming a woman must have felt so unsafe. So shaming. And she maintained such a strict hold on you. I think that you are absolutely right about the way that your anorexia became a protection, but you must have also spent many years before you became anorexic just feeling so uncomfortable in your own body? What about all those years before you actually became anorexic in your early twenties – even your teen years?

Alison: Oh, you are so right. There were many years that I just felt so, so uncomfortable in my body; this developing body.

Graham: I notice that you are clenching your fists now?

Alison: Oh, I suppose it's because I feel so uncomfortable thinking about this; actually, it's more about how I feel about what it was like during all those years.

Graham: Yes, I sense it in your body now. So what is your body saying right now?

Alison: Oh, it says that I am so, so angry for the way she held me back. She cramped my life. Oh, it was just awful; so bad, so bad what she did.

Graham: What does your body want to do?

Alison: Oh, I want to punch her, I suppose. She was wicked in the way she blocked me. JUST WICKED! Oh, this is so difficult, but I am so, so angry right now. She had no right, you know.

Graham: Do you want to say that to her?

Alison: Phew. (Waving a fist) You were wicked. Just wicked. You had no right, no right at all to hold me back. NO RIGHT!

Graham: That's good. I think that has needed to be said for a long time. Do you want to say more?

Alison: (Taking a deep breathe.) Well, she – YOU – led me to believe that the only right way of life is a penitential way. So now I can see that that fitted with me being in anorexia. Yes, so I ended up hiding, but that was also punishing myself; just as she would have it. Penitential. You know, although my mother wanted me to overcome the illness later on, my anorexia, I actually thought I was pleasing her in my diminishing state.

Graham: Just try to stay with what you are feeling inside right now.

Alison: Well, the strongest feeling is that I am ANGRY. I am SO, SO angry right now.

This extract reflected the persistent gi-DPM returning to hinder Alison's anger. Where, in a session a month earlier (S47), she had effectively sustained the AnCh without the DPM imposing itself, its recurrence here was very swiftly dealt with. This demonstrated the increasingly mature, insightful, and present HeAd. Rather than me forcefully challenging Alison's coping response of an idealised image of a good mother, I acknowledged her forgiveness of her, despite knowing that this could not be authentic forgiveness. For that to be the case, Alison would first

require resolution for the Enraged Child. For this reason, I continued to pursue and validate the Child for the many failings imposed on her by her parents. In this we succeeded; the shamed, sad and angry Child very quickly emerging. However, it did require persistent efforts on my side to drive home the importance of HeAd presence, and a just reason for the AnCh to express herself. Alison's acknowledgement of the value of my persistently driven message confirmed its importance. The more Alison resonated with the Shamed Child, the closer she would be able to step to a Child that was not just angry, but to feel enraged by the years of abuse that she experienced. Alison was also more clearly appreciating the coping role that her eating disorder was playing in hiding the emotional injury residing in the Child; a need to make the child invisible and devoid of shame. As had happened in S12, by my being attentive to Alison's physical state (clenched fists) I was more attuned to her raw emotion and able to encourage her anger into fuller expression. Her tight fists reflected something approaching rage, being that she was tempted to assault her "wicked mother".

While I had hoped that Alison would remain engaged with the Enraged Child without interruption, the intensity of Alison's anger appeared unsustainable and intolerable. The next extract from later in the same session demonstrates how the AnCh unfortunately continued to be hijacked by the coping in which an illusory and idealised notion of her mother invalidated the AnCh, forcing it into temporary silence. My task was to persist in creating a space for the Child to feel justifiably and safely angry. More so than a direct appeal to the AnCh, I turned to the HeAd in a hope that this more confidently authoritative mode would heighten Alison's appreciation and responsiveness to the Child's needs.

Extract 2 from Session 51:

Alison: I am still not really alright being angry with my parents. It's really unnecessary. And I do think that they were just doing their best.

Graham: Well, Alison, we have been here a few times before. I still get the sense that it seems safer for you to not hold them accountable for the way in which they treated you. But, as I have said before, I think it is so important that Little Alison be validated for what she experienced. Her life was hellish; and you have spoken about such circumstances so many times before. And rightfully so. Little Alison needs it to be heard that her NEEDS were NOT met.

Alison: Yes. But it is still so difficult to go there.

Graham: I get that this is very difficult for you, Alison, but I want you to know that I am right here to support this healthy grown-up part of you (I point to the HeAd chair) in really validating the feelings that little Alison over here is experiencing. She is so, so justified to be outraged at the way your parents treated her through all those years. You remember the things that happened? Maybe you can sit here in the HeAd chair and recall the dreadful things that Little Alison experienced over all those years?

Alison: (Immediately positioning herself in the HeAd chair) Well, yes, I can see it from this place quite a bit more easily. (Hesitating before turning to the Child) It's not fair what you were put through in your childhood. It's frustrating. It makes me angry, really angry (She suddenly pauses, her face filled with sorrow) I'm on the verge of crying and I am not going to do it. I'm just not going to cry these angry feelings. I am not going to be weak and I am going to be in control. No, no. I am not going to cry. I don't even want to hear my voice, and I don't want this

therapy. I am attending a funeral straight after this (appointment) and I need to be composed. Tears – these tears – should only be for the grieving.

Graham: Hmmm, it's interesting that you say that, because I think that these tears of yours are maybe not just of anger, but also for a grieving little girl; Little Alison over here. It is this little girl between us here who lost her entire childhood and her entire adolescence. Not so?

Alison: Well, I'd rather talk about food and weight at this time.

Graham: Phew! I didn't see that coming. Um, it would appear that this would be a way of steering away from these powerful feelings that you are experiencing right now. Not so?

Alison: Well… (Long pause)

Graham: (With provocative intent) Look, Alison, do you want to go and sit in that chair over there (I point to the seating space associated with the DPMs) and tell this child that there is no place for these tears?

Alison: (With a knowing smile) No. No, Graham. Oh no, I am not going to do that because it is absolutely cruel to tell this little child not to cry. I will not be cruel.

Graham: Okay, this is a relief to hear. I'm pleased you realise this. So, I take it that you are prepared to stay seated where you are (in HeAd) and connect with Little Alison right here. Can you do that?

Alison: Yes.

While on previous occasions Alison understood and repeatedly endorsed anger towards her parents, it had certainly not gained consistent traction. Insight was not proving enough to create a sustained pathway for the AnCh, because she was still locked in an emotional bind where expressing anger still felt illegitimate and unsafe. It seemed that the only route to a sustained AnCh was repeated experiences of an environment that felt safe and justified, and brought healing. I more vehemently and persistently reiterated the importance of the AnCh being validated for the needs that she was substantially denied. As this was still not easily held in the AnCh I, again, turned to the HeAd. While Alison confirmed that this was more tolerable, there was immediate resistance as the Child was powerfully triggered. Although she was determined to not shed "tears of anger", it was very apparent that my prompting to reflect on the abuse also revealed the facial expression of a very sad and abused VuCh. Again, it was evident how the many different faces of the Child fell on the spotlight almost simultaneously. The resistance, this time, was not only associated with guilt for a forbidden emotion, but also for her fear that this amplified anger that was approaching rage would run out of control and that she would not be able to contain it. By provocatively inviting Alison to occupy the DPM chair and condemn the Child's tears, it had the intended effect of eliciting an immediate and strong HeAd response that justified the Child's distress. She knew that it would be cruel to suppress it. This opened the pathway for the HeAd to very compassionately engage with the VuCh sitting beside her.

Yet, later in the same session when the depth of the Child's vulnerability was re-established and sustained, it eventually elicited rage from the Child towards her parents. The automaticity with which the forces inhibiting the anger persisted spelt the challenge that still lay ahead in dislodging them.

Extract 3 from Session 51:

Alison: But, you know, I still feel that I should not be blaming my parents for how they were. It's not fair that I be angry like this.

Graham: Wow, Alison. I was really touched by the way that you just connected in such a loving way with Little Alison here, but when you then get angry with your parents – oh, and rightfully so – it seems that this is not acceptable; not allowed. Alison, we really need to kick this destructive parent mode out of the way, because it is really important that you can connect with Little Alison here and help her to see why she is in so much pain, and why SHE is also so angry at the miserable job her parents did, as parents. Can we do that?

Alison: Well, yes. When you say it like that, I know that you are actually right.

Graham: So, sitting here (in HeAd), what do you want to say to Little Alison to validate what she was put through for such a long time?

Alison: (Facing me) Well, this child here was completely deprived of an identity.

Graham: It's better if you speak to Little Alison directly.

Alison: (Now facing the Child) YOU were completely deprived of an identity. You were silenced all the time and kept quiet. And you were never allowed to go out and play with the other kids. All alone, all the time. (Briefly turning to speak to me) And she really felt unloved by both her parents. (Re-engaging with the Child) Your mother showed you no affection at all, and your father, well, he was just an embarrassing drunkard. (You) always had to be quiet to not make him angry and upset. You just felt so unneeded. And if you showed any sign of anger you were sent to your room to be alone and told which toys to play with. Just imagine all that rage being shut up in you. That's dreadful. It's very unhealthy to have all that rage in you, and if you show it – any sign of anger – you are sent to your room to stay there until it is time to come out. (Turning to me again) If she did not play with a certain toy for a long time, it was a waste. Never allowed to choose what to play with.

Graham: It's just terrible, Alison. Horrible. So lost, so alone; so lonely. I really get a sense of how unloved this little child has felt. And it's dreadful that she was controlled in such a way – not given the chance to make decisions for herself – not allowed to show her feelings at all. This must have been so infuriating. Are you getting a stronger sense of how angry little Alison must be feeling here?

Alison: Yes, but you know something, I am still hearing that voice that says to be quiet about this. I don't want to speak with such anger now. I'm still not comfortable about this. I know what you have said in the past about me allowing the anger and it's been for good purpose. But…

Graham: Ah, there is that someone else in the room telling you that this is not okay? Yes? (Alison nods) Alison, now which mode do you know that always seems to step in here and interrupts this very important process? Who is it?

Alison: Oh, it's those parent modes again. Oh boy! Yes, it is those parent modes that say that it is wrong for me to be angry. Yes, they sit right there saying this to me (as she points to the seating area normally reserved for the DPMs). That's not right, is it?

Graham: Damn right! So, okay, I get that these parent voices are making it difficult for you to speak your mind. Um, maybe you would like me to step in here and be the healthy voice that protects this poor little child from those bad voices?

Alison: No, no, I don't need you to do that. I know that I need to look after my child here. I know that I can do this. I must do this.

Graham: Okay, that's good, Alison. That's okay. It's good if you can do this, and I'm right here to help you. You don't need to do this alone. You know, that's why I am here – to help you. So, you go ahead and say what needs to be said. But I want you to just pause for a moment and reflect; reflect, again, on the plight of this little child. What is she feeling? And how has she been affected by all this terrible treatment from her mother and father?

Alison: (Alison pauses before demonstrating insight to numerous unmet needs of the Child and their associated EMSs) This child is sad and lonely and frightened, and she is unheard, a non-identity. She's a non-entity. She feels like garbage, a nuisance, and in the way! (Turning to me) You know, she really does feel a nuisance and in the way of her parents. That's what this child was for my mother and father. (Turning back to the VuCh) Oh, you feel such a nuisance and so in the way of your parents. But it is very important to be able to feel that you are somebody. You were always pressurised to be perfect. Oh boy, you were not even encouraged to go into teaching as you wanted. There was nothing you were shown to be able to do on your own. And you had to remain so silent with your father being drunk all the time. Just imagine all that rage being shut up in you. That's dreadful. It's very unhealthy to have all that rage in you, and if you show it – any sign of anger – you are sent to your room to stay there until it is time to come out. Gee, this makes me so angry FOR you.

Graham: Yes, I can hear so much pain for what Little Alison experiences. I can feel that emotion right now. And I also see now that you are angry about the pain this little child part of you has experienced. Okay, can you carry on, Alison?

Alison: (After a pause) Yes. Well, I really feel for what you have been through. Oh, it is so unbearable what has been done to you; such an innocent little child who meant no harm. (Pause) Oh, Graham, I don't like this.

Graham: Tell me, what is happening right now?

Alison: (As she approached the edge of her window of tolerance) I, I'm just feeling so sad. (Pause) And at the same time also so, so angry; both sad and also so very, very angry. I really don't like doing this because it makes me too close to tears. I don't want to cry for this anger and this sadness. I don't like feeling this anger. It's not right. It's just not right. It's just not safe to do this.

Graham: (I gently try to expand this window) Alison, again, I have to say this; I know that this is difficult to stay with these feelings. But do you see that these feelings are very real and it's very understandable why they are here? What the little child in you has been subjected to is absolutely awful. Just awful. And I know that it is difficult to stay with these feelings, but it is so important that little Alison here know it to be safe to feel these feelings; this anger and this sadness. Your tears are an important acknowledgement of the pain that Little Alison has been through. It's an important truth. And it is so valuable if you allow yourself to feel the upset of what Little Alison experienced for so long. Can you just feel that; stay with that? Can you just stay with these feelings so that Little Alison can heal? She needs to feel heard.

Alison: Oh Graham, yes, I know that I struggle so much to allow these feelings to stay here with me; to come through. But I do know that these feelings are true. And, yes, I do think that the little child in me – Little Alison here – has good reason to be angry. Angry for what both my parents did; oh, and did not do for me.

Graham: Yes, Alison. This is so important to stay with. Oh yes! This anger IS very real and it is so, so important that it is acknowledged here; that it is recognised here and now. The little child in you needs to know that this anger, and all these uncomfortable feelings are very real, very appropriate, and need to be expressed to, well, make it real what pain you experienced for so long. That it be known what happened. You know, it is so wrong that Little Alison feels that she needs to hide all this anger; to mask it when it is so very justified.

Alison: Yes, this anger is still so real. And I have not yet rid myself of it (I interpreted this to mean that she has not yet fully expressed and, hence, not resolved the anger that has been suppressed for decades). Yes, it is right that I feel this way. I know, I know, I know.

Graham: Absolutely. And I think you need to say that again.

Alison: Yes; I am absolutely right to be feeling this anger. Absolutely right. Well, when I look at the little child sitting in this seat here, I completely understand her anger and sadness.

Graham: Can you talk right to her here, Alison?

Alison: Okay, I can do that. (After pausing to prepare herself) Yes, I understand your anger and your sadness. And I understand your fear and terror and everything that has made you such a scared little child. And I can see why you are such a lonely little child having to look after yourself with no protection; no support. Yes, without a parent; both parents not being there to protect you.

Graham: That is so good, Alison. Is there anything else that the little (child in) you needs to hear?

Alison: I want you to know that no matter what your mother and father said about you was not a reflection of you. You were not at fault. You were not at fault. You were not at fault. You were an innocent little child growing up and trying to do the right thing, but being bullied and pressurised by a mother and a father. (Facing her mother) You couldn't hug that little child. (Turing to the VuCh) You couldn't go to your mother and hug her. It was not allowed. That is what it was – not allowed. It was a bad thing. (Alison pauses as her body becomes more rigid) They made you feel that you were weak and that you were not in control. You shouldn't need all these hugs. Your mother just didn't believe in it.

Graham: Alison, what are you feeling for this little child right here?

Alison: (With her voice quivering) Oh, I feel it. It is so painful. It's unbearable. It's just so unfair to do that to an innocent little child that meant no harm to anybody, and didn't mean to be in the way of anybody. (Emotionally overwhelmed, Alison pauses as she finds the pain intolerable) Graham. I'm not doing this. I am not doing this therapy. It makes me feel very fragile and near to tears, and I am not going to cry.

Graham: Just try and stay with this for now, Alison. Where are these tears coming from?

Alison: They are from the little child in me. But, as I see it, she should have cried years ago. I think it's too late now. This all happened years ago.

Graham: Hey, just wait a moment, Alison. I want you to try and resist running away from this and just stay with what you are feeling right now. The child in you IS feeling RIGHT NOW. Remember Alison, what I have said to you many times before: this little child is a part of YOU and she is still alive inside you. And she needs to hear that what happened so many years ago is not okay. She still needs to hear this all these years later. Little Alison has been waiting a long time to hear this. Just stay with it, okay, and tell me what's happening?

Alison: Well, to be truthful, this is still a child that does not feel worthy of any good things that come her way. But I do think that this child wholeheartedly deserves love.

Graham: And where is that love now?

Alison: Well, you know something Graham, I think that I have held back for so many years from receiving the beautiful love that Mike HAS provided me all these years. He has loved me all these years. Unconditionally so.

Graham: Yes, I think that you are so right, Alison. Mike has loved you deeply all these years. This is something that your parents were not capable of giving you. But you have always deserved this love.

Besides my applauding and affirming the manner in which the HeAd had compassionately engaged with the VuCh, when this elicited anger, there was still a powerful and abrupt interruption from the DPM. This was turning into a

notable battle of attrition; as frequently as the forces that muted the anger stepped in, it was my task to repeatedly intervene to encourage and validate Alison's anger, whether coming from the Child or the HeAd. More than before, I confronted the gi-DPM very directly and forcefully. I facilitated the strongest possible emotional connection between the HeAd and the Child in order to break the impasse. For the reason already outlined, I still held the view that eliciting anger from the HeAd was going to prove easier than from the AnCh. Where Alison continued to demonstrate an affinity for chair work, the angry HeAd expressed herself with increasing confidence and familiarity, almost reaching an enraged state. Despite Alison's insight to the validity of her anger and the damaging presence of the DPM that inhibit it, it was still proving a very difficult task to create a safe passage for angry expression. When I offered to assume the HeAd stance on her behalf, she immediately declined, realizing that she should assume that role herself. This more robust HeAd was operating on two levels. After first showing compassion towards the abused Child, the HeAd was renewed in her anger towards Alison's parents for the harm that they had inflicted on their daughter. Where such vulnerability brought Alison to tears, it felt intolerable to her and was immediately hindered. This was due to her fears that such powerful emotion would become uncontrollable. However, my persistence in maintaining Alison's emotional engagement in this process paid off. Despite renewed coping behaviour to avoid the strong emotions, she persisted in validating the Child. Throughout this time, Alison remained in HeAd without venturing across to occupy the Child's chair. However, the HeAd still maintained a deep emotional connection with the Child, empathically holding the pain by proxy, and validating the Child's needs.

9.10. Session 53

An extract from the session a fortnight later demonstrated how, through emotion-focused work, Alison was able to more clearly and vividly realise the nature of her anger and more clearly recognise and articulate the two sources of her reluctance to express it. As had happened in the session a fortnight earlier (S51), Alison, again, acknowledged the role that her eating disorder coping mode played in inhibiting her anger. This time there was an opportunity to drive this realisation home from a bodily and experiential level:

Extract from Session 53:

Graham: Can you feel that anger now, Alison? Can you connect with that anger somewhere in your body now?

Alison: Um, yes. It is that same feeling that I described to you before (some weeks earlier). This anger is sitting right here; it is sitting here right in the pit of my stomach. Right here (Alison points to the solar plexus region).

Graham: Can you describe this feeling some more? Do your best to describe it to me. You know, how it feels physically; or even what it might look like, if it has an image?

Alison: Well, it feels like a hot, heavy feeling. Like a heat; a fire. Very hot. Um, very red.

Graham: Ah, okay, well that's really good. Can you say more? Do carry on.

Alison: Well, it is like a furnace, Graham. This hot anger inside me – it sometimes wants to come out – and it will make me need to be very angry, actually am enraged, in what I have to say. A part of me actually wants to let it out. It would be very, very real. And then there is another side that says to keep it in. It shouldn't be expressed. It is not right and it would blow out of control; like a veld (grasslands) fire.

Graham: Okay; very good Alison. It's very useful what you are describing. I can imagine you really want to let this anger out. It seems so real. So genuine, yes? (Alison nods) And I do think that this fire of anger really does need to be expressed for all the harm that has been inflicted on you for so long. It's as though you have been waiting for a very long time – for years to express the fullness of this anger. You know, it is so, so justified. So real. So understandable.

Alison: (With a wary facial expression) But, I am also so frightened to express this anger, even though it does rage inside me.

Graham: Yes, I do see your hesitation very much. I get that you are tempted to try and stop that anger from coming out. As you stay with that image, well, that bodily sense of the anger as a fire raging inside your belly, how is it when something else inside you is trying to stifle, trying to cover that angry expression? What does that look like or feel like?

Alison: (After a long pause) Hmm, now that is interesting. Actually, I think you are so very right. I do have a very real image of what is maybe happening in that place in my stomach (again, pointing to the solar plexus). You know, it feels – well, it seems as though I need to throw this big blanket – a big soaking wet blanket over that ball of fire; smother the fire and stop it from burning. Smothering these flames so that they do not rage. Keep it under control is what is going on inside.

Graham: Okay, so there is another aspect inside you that is telling you that it is unsafe for you to express that anger, however true it is. You seem very hesitant, right, um, maybe cautious to express that anger because it might never stop. It might spread across the land burning everything in its way; in its path. Would that be accurate?

Alison: Yes! Yes, that is EXACTLY it! I am very scared to let that anger out and let it go out of control. But, you know, like we spoke about before – some part of me says that I am also not allowed to express the anger – those bad parent modes inside me keep saying this.

Graham: Yes, I get that. So, on the one hand there is this need to stifle the anger because it might run wild; it might run out of control like a veld fire. And then you are talking about another force that stifles these flames; that you are not allowed to express anger or you will be sent to your room. This is the demanding and punishing parent voice inside you, right?

Alison: Yes, it is exactly that. I am worried about the anger running out of control. But, yes, there is also that parent (mode) that says (Alison raises her finger to point in front of her) "No, you may not express that towards your parents. It's wrong. That's bad!"

Graham: Ah, okay. Shall we stay with this other voice that won't allow you to be angry? (Alison nods in agreement) So, do you have an image – a picture – of that voice that demands you to not be angry; a voice that says "No, not allowed"? Maybe it's a memory?

Alison: Oh, it's a figure that waves its finger at me saying (she gestures in the same manner as earlier) "No, it is wrong for you to be showing those bad feelings."

Graham: Hmm, I think that we might be talking about someone we have spoken about quite a bit already.

Alison: Oh well, it's got the voice of my mother, of course. But I know that it's now that voice inside me. I am saying this.

Graham: Yes, of course. I think you are absolutely right. I think it all started with your mother, and now you have taken that voice of your mother's to inside you. It's your destructive parent mode, right?

Alison: Yes, that is quite right. Absolutely.

Graham: It sounds very intimidating. It's an absolutely not okay thing to get angry, right?

Alison: Yes, that is how it is. Yet, deep inside I know that it is ridiculous – wrong – that I not be allowed to express my anger. I know that I should be allowed to express my feelings freely.

Graham: Right, I think that you are really getting that now. I think I'm hearing a very healthy part of you telling Little Alison: "Hey, you are really entitled to express your feelings openly and freely. It is wrong that all these strong feelings have had to remain hidden deep inside there for so, so long." Is that right, Alison?

Alison: Yes, I can hear that healthy voice inside me. Yes, I think you are right; that is my Healthy Adult voice, and she's absolutely right.

Graham: So, Alison, can you repeat this again; say, again, from your healthy (adult) voice to Little Alison, who is sitting right beside you here, your reassurance that she need not feel unsafe or forbidden from expressing herself in any way that rings true to her.

Alison: Yes, I can certainly do that. (Pause) So, little child, I want you to know that whatever you are feeling inside – however strong the feeling, and however painful the feeling (Alison briefly looks to me for a reassuring nod) – whether you are sad or angry, frightened or worried, you can say it out loud. You tell me or anyone what you are feeling because your mother and father were wrong. They were terribly wrong teaching you – "NO" – telling you to be quiet. That was wrong, wrong, WRONG! I want you to feel safe saying anything; just anything, because you are entitled to express yourself. Yes, entitled to it. Yes, that's it.

Graham: Wow, that was fantastic, Alison. I don't think it could have been said better. And I think you are going to need to repeat this message to Little Alison many, many times over to help it sink in. Alison, I really feel good about this. I'm excited inside when I hear you speak like this. And I'm really proud of your efforts. You seem to be really getting it now.

Alison: Yes, it does ring true inside. That's quite new.

Graham: Yes, and absolutely brilliant. So, remember, keep inviting Little Alison to express herself for whatever she needs to say. Those feelings need to come out. If you are angry, then just put it out. It takes practice to really feel right and for your feelings to start coming out naturally.

Alison: Yes, I'm really starting to see that. I can see that I really need to just keep doing this; make this more familiar, and just put it out. And, yes, to know that I am entitled to be angry – outwardly – whenever I feel that way. It's actually sinking in.

Graham: And tell me, Alison, is there anything that you think needs to be told to that (dysfunctional) parent mode that is your mother's voice that is sitting over there (I point to the position always reserved for the DPM)? I'd really like you to say something directly to her.

Alison: Oh yes. I want to tell you that Little Alison here is ABSOLUTELY entitled to be angry when she feels that way. Oh, and I am angry; me, this healthy adult here. YOU have NO right telling her to be quiet! NO right at all! You just stay out of the way for good now. You get out! I'm telling you this right now!

Graham: That's really excellent Alison. You said it perfectly. And I want you to know that this is exactly what needs to be said to this parent mode each and every time that it tries to cut Little Alison's feelings off. Will you do that? You can say this, and Little Alison is also entitled to say it. She is allowed to be angry for the feelings that have been blocked away for so long. Right?

Alison: Yes, I am going to try my very, very best to do that. I'm angry with this critical parent right now. And I am rightfully holding to this feeling.

Graham: Brilliant. (Pause) Right, so we have identified this parent mode that makes you feel guilty for being angry, and you need to keep defying it and keep practicing putting this anger out. And I hear you saying this from your HeAd – and that is great – but I also hear you saying now that Little Alison, herself, should be allowed to be angry. Angry Alison, the Child, is also allowed to be angry about her feelings having been cut off for so long. Right?

Alison: Yes, I fully get that.

Graham: Okay, good. But now, there is that other thing that makes you hesitate to be angry. You say that if you connect with your anger, then you fear that you will not be able to stop it and it will run out of control. That veld fire is a strong image, you know, because when that happens, there is panic in trying to put it out and it has a force of its own in burning everything in its path. Right?

Alison: That is exactly what it is. Yes, that is my fear. You are quite right. Yes, I AM terrified of that.

Graham: Ja, I get that Alison. But I do think that the way in which you have stifled your anger for so many years has done nothing to extinguish those flames; that anger. I think that they have been still burning strong and still want to find expression because they are so real and also because it's so legitimate. At one level there is that parent mode saying: "No, you are not allowed to be angry; it's forbidden." And then the child in you is scared that if you express yourself, that anger will run out of control. So, you push the feelings down. They stay trapped inside you.

Alison: Yes, you are so right, now that you explain it like that. You are quite right. The anger has stayed inside there and never really gone away. It's kept burning.

Graham: Of course. And, you know, I think that if you continue to allow me to help the child in you to feel safe re-connecting with that anger, then Little Alison will really feel heard. "Yes, I have a right to feel this way." And I think that as long as we persist in giving the child in you an opportunity to keep expressing her anger, then a think you'll get to a place where you will feel acknowledged; you will feel validated knowing that you have a rightful reason for being angry. If we can safely allow the anger out, I think a time will come when you will feel safe inside you and that the anger will have been released and heard.

Alison: Yes, you are absolutely right.

Graham: When it is all put out, Little Alison will feel heard. And expressing that anger is an important step in bringing about a new calm inside – a sense of resolve. You know, I'm thinking that maybe all that starvation in your anorexia was, in some way, also a way in which your body was attempting to deal with that anger; maybe to stifle the fuel that feeds those flames. It's just a thought that comes to mind. I don't know if you want to comment?

Alison: Hmmm, that is quite an interesting thought. And, yes, we have spoken about how my anorexia has blocked my feelings. Yes, that is quite an interesting thing. It does actually completely make sense that it was a way to keep my anger inside – YES, to stop me from expressing it. Or, maybe to even be aware of it. Yes, that really makes sense to me now, the more I think about it.

Graham: So, Alison, it looks like this really resonates with you; this notion that your eating disorder, your starvation, might have served the purpose of, well, suffocating your emotions, your anger and even other feelings that were difficult to feel?

Alison: Yes, it really, really makes sense. Yes, definitely so. I think it's that idea of being in control – well – feeling in control. If I control my eating, then I am in control of those feelings as well.

Graham: So, here we have the idea that your anorexia served to bring you into a place where you felt in control. And you described earlier the notion of a blanket – I think you mentioned a drenched blanket – suffocating that red-hot fire that is your Child's legit anger. So, we have anorexia cutting you off from your anger and then we have this image of a wet blanket smothering the anger. Are these two different things?

Alison: Well, it certainly makes sense to me that my starvation did the job of keeping me disconnected from my anger, and all other feelings, for that matter. In my starvation state, I was just blunted and disconnected from everything. My world was just a tiny space where I did little else except stay at home and clean all day and not eat; eat as little as I could. I think that my anorexia just closed down all focus on anything and any feelings other than cleaning and not eating; cleaning all day and not eating. Just staying in control and feeling in control.

Graham: Ah, so I think I hear you describing anorexia and your starvation as "a thing" – a system that just made your world really small and kept you focused on just a few specific things in life – keeping things tidy and keeping your weight down by eating very little. That way, you felt in control?

Alison: Right. Yes, that is right. It shrunk my world down to a place where I felt in control of a couple of things in my life and that I felt nothing else. I felt in control. Yes, I suppose I was in control of housework and I was in control of my eating and my weight.

Graham: Right. So, your world in anorexia was a small world where your focus on a few areas in your life created the feeling that you were in control of your life in this little bubble.

Alison: Yes, that is exactly it.

Graham: And then there is that image of a big wet blanket that smothered your anger; a blanket dampened the feeling?

Alison: Yes, that blanket thing is where I would say to myself: "No, just don't feel this feeling. Just stifle it out. It is just not there. No anger. No nothing." I think that that is less about the feeling in control like my anorexia did, but more about just blanking a feeling out; you know, if I don't think about it or acknowledge it, it will just disappear. I would disconnect from it. "No, the anger is just not here. Don't fuel it, just block it away and it will be gone."

Graham: Okay, so I think you are talking about two different ways in which your anger would be sort of detoured, right? The anorexic world served to just make your world a small place where you focus on only being in control of your housekeeping and your eating. There was nothing else really featuring in your life, right?

Alison: Absolutely.

Graham: And then this drenched blanket. It sounds to me like this big wet blanket serves as a coping in which you just become emotionally detached. Do you remember that Detached Protector mode we spoke about before – a mode that just shuts you down to just not feel – a mode that just disconnects you?

Alison: Oh yes, that was one of the green modes (Alison is recalling the green rectangle on her mode map labelled the DePr).

Graham: Wow, that's quite right. That's quite something that you remember that.

Alison: Yes, I look at my map quite often. It really helps me to see these different sides of me at play.

Graham: Very impressive. It's really excellent that you do this, Alison.

This extract demonstrated the significant value of addressing Alison's emotional state from another vantage point; that of consciously identifying anger and the forces that inhibit it through bodily sensation and imagery. It took the

exploration from a metacognitive to an emotionally based level. The visceral images of her anger as a red-hot furnace that could run riot like a veld fire was a vivid expression of her rage; its intensity and its capacity to destroy. The fire image is more associated with rage than anger.

The image of her mother's disparaging face and wagging finger painted a vivid image of the DPM that forbade anger. This was the most prominent factor that inhibited Alison from engaging with her anger. However, the image of a fire burning uncontrollably across the grasslands provided another intense description of the other force that inhibited Alison's anger or rage; that of it spiralling out of control. Such uncontrolled anger or rage is associated with a very early and primitive experience in which the concern is that such powerful emotion can destroy the parents or themselves. Imagery took the process even further, bringing Alison's understanding to an even richer level. While the drenched blanket image clearly represented something of a DePr coping to inhibit her anger, Alison resonated with my suggestion that the AnOv served a more overcompensatory role in restricting her life experiences and creating a limited world in which she created the illusion of control. Such illustrations inevitably assisted in Alison's growing insight that anger should not be inhibited, but find expression in order for the Child to feel acknowledged and find resolve.

9.11. Session 54

While in the previous session the HeAd engaged with the AnCh at a deeply compassionate manner, in this session a week later, the anger was expressed significantly in chair work. It is likely that this was facilitated by the preceding few sessions frequently demonstrating the legitimacy of the anger whereby the HeAd demonstrated an increasingly confident ability to hold the Child's pain. While the AnCh reflected a Child who had engaged even more deeply with the severe neglect and abuse that she had faced, she was now escalating it to an enraged level. This powerful emotion was now touching on the need to take revenge or destroy her abusers. Immediately prior to this extract (as was evident in S12 many months earlier), the anger was being defiantly channelled towards the treatment team, whereby the motive of the AnOv was being vehemently protected. This time, however, Alison was better equipped and more willing for me to assist her in bridging this anger towards her abusive parents. In this extract her alcoholic father was the focus of her legitimate anger. Although, at first, she was reluctant to confront him, I succeeded in persuading her to eventually address him from the AnCh chair while I repeatedly supported her. However, it was not without interruption:

Extract from Session 54:

Graham: Okay, Alison, so we have seen now that this anger you are feeling for us is not legit. It's a touch of the AnCh for a fleeting moment – you get triggered – but I think it very quickly turns into that coping anger and, boy, is it clearly protecting the AnOv; the agenda of your AnOv. Not so?

Alison: Yes, that is true. I can see that clearly now. You are right – completely right. I am so, so, sorry.

Graham: No, that's okay. Look, I just want to focus now on what I think is happening. So, we see that the anger, like before – you know, that time quite a few months ago when you were angry with us (the team) – is actually really about not being seen and not being acknowledged as having your own voice? (Alison nods in agreement) This is actually real anger. It is legit anger of yours that goes back a long way. Right? (Alison nods, again) So, once this anger is being directed onto the team that's helping you to get better, it's no longer legit, right? No longer legitimate. It's now a coping anger that serves to protect the AnOv. Do you see it as I do?

Alison: (Alison pauses to reflect on my comment) Yes, this really does, really make sense now. Now I really see what you are getting at.

Graham: So then, who do you know who should really be sitting right here in front of us – being told what they have done is not okay - never giving you a voice, never actually listening to your needs?

Alison: Well, just as before, it is my parents who were like this.

Graham: Absolutely. So, do we not need to have them sitting here with us? Don't they need to know that they did so much wrong for so many years? (Alison nods) I'd really like you to sit right here in your AnCh and say what you need to; to them.

Alison: (Speaking from the AnCh chair) Oh yes, I have to absolutely reprimand them. I'm speechless, actually. Oh, and I don't know how to explain the anger I feel towards them right now.

Graham: Well, don't hurry. Just slow down and reflect on this. I'd like you to really say whatever you want to. You deserve to have them sitting here and listening to what you have to say about the way YOU have been feeling so invisible and muted for so long. And, Alison, I want you to speak AS little Alison. You are angry, and I want you to own it now.

Alison: Well, I'm not sure if I even have to speak to my father. You know, he was non-existent and he's not even worth talking about.

Graham: Ah, well, let's see if this is really the case. What I would actually like to do is seat him right here (opposite the AnCh position). Now, Alison, I want you to really speak your mind to him. And I am here to support you, so I want you to say exactly what you want to your father. Are you okay to try and do this? Come, let's see if you have actually got something to say to him.

Alison: I can talk to him; sure. (Long pause as she gathers her thoughts) Well, you were a selfish father.

Graham: Alison, sorry to interrupt. But I'd like you to talk to him as Angry Little Alison and see your father right here opposite you. I want you to BE little Alison right here-and-now, and give him lip for what he deserves. Can you connect with angry Alison, this little child inside?

Alison: Yes, I will try. (Pause) You ARE a selfish father, a selfish husband, and you are an unpredictable encumbrance; a hindrance in every one of our lives! (Alison begins to get tearful and is visibly uncomfortable with this).

Graham: Don't mind the tears. You are doing really well, and I really want you to continue. Remember, I am here to support you. You say exactly what you want to; what you need to. And you need okay.

Alison: You were shocking! Every day of my life I was scared to see what condition you were going to be in the night, and I had to keep my friends away from you. I couldn't enjoy playing. I was too conscious of saving my friends from any embarrassment coming from your behaviour. You were an appalling embarrassment and you were a shocking father! You must get the HELL out of here! You have no right to be near me. Even after your death you still plague me because I have such dreadful memories of you. I have no respect and no regard for you, whatsoever! (A long pause before she flips modes to speak with a softer voice) Oh, I'm not a worthy daughter.

Graham: Hold on, this (last) comment is not coming from angry Little Alison, is it? You had EVERY right to just say what you did to him. In fact, you did really well right now. So, let me help you here for a moment, little Alison. (I speak to her father seated opposite us) You have NO

right to treat your child, well, all your children in this way. It is absolutely UNACCEPTABLE! It's highly abusive. You leave these children constantly terrified. And I insist that you hear what you are doing. And you need to acknowledge your appalling behaviour. Alison, do you want to come in here? Are you ready to join me and speak to your father again?

Alison: Yes, I am. (Pause) You are a piece of RUBBISH! I am going to rid you once and for all – banish you – absolutely get you OUT of my life!

Graham: Thank you. I am relieved that you can stay with that. What you said right now is more honest; more real. It feels more real when you express yourself like this.

Alison: Well, yes, I suppose that is more how I really do feel inside. That is true, to be really honest.

Graham: Okay, so I want us to stay with this anger and I would like you to continue pointing out how he's failed you. Will you do that?

Alison: Yes, I will. I think that I am more ready, again, to stay with these feelings.

Graham: Alright, so let's see you pick up on from where you were just a moment ago. You were saying that he has to get out of your life, right?

Alison: (Grabbing the cushion on the couch opposite her with one hand and punching it with the other hand) Now, look here: I will not, will not, will not tolerate you anymore. You are unacceptable. Just unacceptable! This is enough. Unacceptable! (Unprompted, Alison stood up, opened the door to my waiting area and threw the cushion out of the therapy room before returning to her seat in an exhausted state. There she sat in a still and quiet state, reflecting on what had just happened).

Graham: (After the long pause) It's good that you are just staying with this. Let's just sit here quietly together for a while.

Alison's posture and facial expression were enough for me to be convinced that she had expressed herself authentically and that she was sitting with a sense of peace and resolve. Where Alison now had a better conceptual understanding of the coping anger residing in the AnOv, she was better equipped to occupy the AnCh chair and confront her father. There was only a brief distraction in which she flipped into the Defective Child not feeling worthy to express her anger. With my active involvement in the chair work, Alison's EnCh expressed herself with deep and sincere force. With the confidence Alison gained in the chair work to confront and banish her father, Alison was equipped later in the same session to confront her mother in a similar manner. While she initially spoke to her mother with the despair of a child, she switched to the HeAd in condemning her mother for having failed to meet any of her basic needs, including her controlling Alison and her siblings like "puppets on a string". The cushion representing her mother was also thrown out of my office in a similar manner; another successful ritualistic banishment of the source of her DPM. The extract in which she confronted her mother is not included here due to it being similar to the way in which she confronted her father.

Despite Alison's initial avoidant coping by considering her "non-existent" father unworthy and unnecessary to confront, it was immediately apparent how deep the anger really ran. In reparenting her, I repeatedly encouraged the AnCh to speak in the present tense in order to heighten the intensity of emotion. I even occupied the HeAd

stance myself in order to scold her father once I had halted a DPM intrusion that deemed the Child "unworthy". All this assisted Alison to engage with the AnCh with a rich and significant force not seen before.

9.12. Session 59

An extract early in the session five weeks later demonstrated that Alison was still not consistently making the distinction between healthy and unhealthy expressions of anger. While my encouraging Alison to safely express anger from a healthy source (AnCh or the angry HeAd) was a central theme in her treatment, it was important that she was able to more readily identify coping anger that was unhealthy, inauthentic, and self-defeating. Like all coping mode behaviour, this anger only served to inhibit access to the authentic Child, and it was imperative that Alison distinguish between these two sources of anger.

Extract 1 from Session 59:

Alison: Oh, I am just mad at you all telling me how much I need to eat all the time. I just don't want to do this; always following your rules. I feel like I always have to do what you all tell me to do. And this makes me mad; really angry.

Graham: Well, I hear you, Alison. But wait a moment here. You've expressed anger towards the team a few times before, and I'm reminding you that we came to the realization that this anger you put onto the team last time was not really correctly meant for the team, but towards someone who has played a major and destructive role in your life; someone for whom your anger is really legit. Do you get what I am saying?

Alison: (Pause) Yes, I do remember. I am angry with all of you here, but I know that it was actually with my mother that I was really angry before – umm, the last time.

Graham: Might it be that this is a similar situation here, now?

Alison: Well, yes, I know this to be the case. So, yes, you are right. I am not really angry with all of you. I need to be responsible for my eating going right and my weight being correct. That's what my HeAd is saying, right? (I nod) So, yes, I know that my HeAd is saying this. I think I was just pushing you all away a moment ago.

Graham: Okay (Pause). And, yes, you are absolutely right here. Do you remember we had this situation a few weeks ago (S54)? And, again, really early in the therapy (S12) when you were angry with the team. So, your HeAd – and it's good that you are going there – she knows that this anger for the team is not right. Your HeAd is saying: "Nah, it's not right that the team is getting it in the neck for helping the little child to be healthy and well." Right?

Alison: Yes, that is so true.

Graham: So, what was maybe going on in the background when you were being angry at us (the team) a moment ago? What do you really sense was the motive; the real reason why you were being angry? You said something about pushing us away a second ago?

Alison: Well, I just want you to all back off from stopping me having to eat ALL this food. It's scary and it makes me uncomfortable. Nothing must stop me from being able to eat my way, I guess. Stay away from that part of me that wants to eat less.

Graham: Ah, okay. So, might it fit that this anger you express here is anger that protects the AnOv; allows the AnOv to remain in charge of things? Kind of keeps it an untouchable? Well, what I am saying is, could it maybe be that this anger is anger from a coping place? (Alison

nods in agreement) You see, to me it feels a bit like a few weeks ago where this anger towards me and the team is more of an intimidation – a sort of bully and attack to have us back off from your AnOv being in the forefront – the foreground. Think of it as a kind of intimidating coping mode that protects your AnOv. This angry coping behaviour is being, well, a bit like a bodyguard. Let me tell you how I see it. I see this anger as protecting the AnOv and helping it remain in charge. And then the Child does not feel uncomfortable things. She's kind of offline; disconnected. So, anybody that comes close to the AnOv to challenge it, well, then this bullying and attacking coping intimidates them and does everything to scare them off. Do you see what I am getting at? Do you, perhaps, see it this way as well?

Alison: Hmmm, okay, I see what you are saying. (Pause) Yes, I think I know what you are saying here. Yes, I remember some weeks ago we were dealing with something very much like this. Yes, it was a time that I was being angry at you and the team about my food intake. So, yes, I think that you are right here. My AnOv wants to stay in charge – in place – and this anger, I think you are saying, really is an unhealthy anger that keeps the child in me under the control of the AnOv. And my anger – this anger – is keeping you all away from my AnOv. Is that right? Am I seeing it right?

Graham: Yes, that's how I see it, Alison. Absolutely. That's how I am seeing it as well. Do you? (Alison nods in agreement) Remember, sometimes anger is not actually from the little Child, but a coping that serves to, well, cope or deal with things that the Child can't or doesn't feel safe enough to face or deal with. We've spoken before about angry ways of coping. Maybe you remember?

Alison: Yes, I do now. And, yes, that makes sense. So this is bad anger – this coping anger – anger as a coping mode. I remember reading about that mode in those notes you gave me right in the beginning (of the ST). But I don't think this one has ever been on my mode map, has it?

Graham: Ja, you are right. It's never been a stand-out mode for you, and I don't think it made the cut to get onto your own map when we first made it. But I think we can see some evidence of it here. So, what is important now is that we notice the difference between anger coming from the AnCh in you – because this is important and needs to be expressed and put out there – and this other type of anger that is more of a coping mode; a hindrance to Little Alison. The healthy anger from your AnCh mode is anger to deal with what is a threat to Little Alison's well-being. Even your HeAd gets angry, and this is good; an important anger. It's legit. It's like a protective parent making sure her child is safe from harm. No one mess with my girl, you know. But coping anger is a different story. It's not good. It is not protecting the Child. It is stopping the Child from being connected with; from feeling. It's keeping the AnOv in a strong position. Do you get that? Do you see it this way?

Alison: Okay, yes. That makes complete sense to me now. Wow, I really do see that now. Yes, I can see why it is important to see the difference between these two.

Graham: Great Alison. This anger coming from your AnCh and from your HeAd is really so important to express. It acknowledges all the wrongs that have been done to you and says: "No! No more!" But this angry coping is not an acknowledgement to the child. It's actually quite the opposite in the way that it is anger that pushes people away from the AnOv remaining in charge. And it's this AnOv that actually prevents Little Alison from being truly safe and being allowed to feel her feelings.

Alison: Yes, I really see that now.

In a similar scenario almost a year earlier (S12), Alison's anger towards the team was important to recognise as initially emanating from the AnCh. However, it was vital that this anger, triggered by the necessary authority held by the treatment team, was steered towards its legitimate source – a mother who denied her daughter autonomy and freedom of expression from an early age. While, in the session a year earlier, my emphasis was to preserve the

authenticity of the initially triggered anger in the Child and direct it to its legitimate source; this time the emphasis turned to identifying and understanding the coping anger in the AnOv that quickly replaced the very brief triggering of authentic anger in the Child. Alison's immediate and lucid insight to this coping anger was indicative of her growing maturity.

I also had to consider how to conceptualise Alison's coping anger. As there was no evidence of anger as a coping mode outside of the coping anger associated with the AnOv, I conceptualised this angry coping not as a stand-alone coping mode that sometimes flanked the AnOv, but rather as a coping anger that defined one component of the composite and specialised AnOv coping mode. The sole purpose of this angry coping component of the AnOv was to intimidate anyone that threatened the AnOv's dominant status.

While there was significant value in identifying the coping anger earlier in the session, this next extract from later in the same session demonstrates where I progressed beyond the metacognitive work to help Alison engage with the authentic anger in the Child associated with stolen autonomy. It was important that Alison not only had insight to the anger triggered by the firm boundaries set by the team, but that this was emotionally bridged to an AnCh denied visibility and autonomy when she was a young child. While coping anger associated with the AnOv was front stage, it was important that I brought the AnCh that was backstage into the spotlight to address the legitimate source of anger.

Extract 2 from Session 59:

Graham: Alison, I'm not sure whether you remember very well that session about a year ago; some time towards the end of last year when you were angry at the team for insisting that you follow your meal plan. Do you remember how angry you felt towards the team for saying that you needed to keep following your meal plan? Do you remember that session well?

Alison: Oh yes, I do remember it quite well. But for the life of me, I cannot remember exactly when it was. Was it a whole year ago?

Graham: Ja, about a year ago, but that is not so important. That time I remember your anger being really about being sick and tired about having to follow your meal plan. We didn't really focus then on how this anger turns into a coping anger like we did a moment ago, but you were really angry for us TELLING YOU what to do. It was about you being told what to do that made you SO angry. It was real anger, even if not directed rightfully towards the team. You just wanted to have some say in what you did. You remember that? Ja, it was a long time ago.

Alison: Yes, I remember. And, you know something – to be really honest – I still often have that voice that says "I don't always want to be told what to do. Where do I get my say?" Yes, that is STILL very much a feeling I get.

Graham: Well, we were looking at the angry coping mode a moment ago, but I think it's also important that we look at that angry voice of a child before any coping is happening – the voice of a little child that is angry for not being heard – being invisible. Are we not talking about the legit anger that sits in the Child before it then gets all muddled up into a coping anger to protect the eating disorder? This is real anger that goes way back, not so?

Alison: Oh yes. Well, yes, now that you put it like that, I am actually with that earlier anger right now. I know that it is not right in this place because my HeAd tells me so that I should not be angry about being helped to get better, but I still feel that anger in the Child part of me, to be honest.

Graham: Okay, but don't get me wrong. It's great that you can recognise that anger. Yes, you are right that it is not appropriate in this context where your anger goes towards the team to protect your AnOv. But I just want you to just stay with this earlier anger for now – this anger where you feel that you are not getting your say and not being heard. Can you do that? (Alison nods) Can you describe it some more?

Alison: Well, yes. (Pause) She's rebellious and she wants to get the hell out of this situation because it's been going on for too long now. She needs to break away. She can't be pushed around and bullied anymore.

Graham: Okay. So Alison, it is really, really important that this child – shall we call it your angry rebellious Child – that she has a voice. She needs to be heard, and she has a right to be heard. Not so?

Alison: Yes, exactly.

Graham: In fact, it is very, very important that she DOES have a voice and that she IS heard. Now, what if we have your mother sitting right here opposite you over here (I point to the space next to me on my couch)? And you connect with this rebellious child right here? This is because you have every right to be very, very, very upset with her. And I'll sit right there next to you (I move to the couch opposite me where Alison is seated and sit beside her). Right, I will stay right here while you confront her, okay? Can you do that?

Alison: (Alison nods and pauses to gather her thoughts) Well, It's DESPICABLE! I'm furious because you don't let me make a single decision for myself; even the most elementary ones that can do no harm to me. You know, even the clothes that I wore or the friends that I kept had to be chosen by her.

Graham: Okay. That's good. Remember, I want you to try and stay with the Little Alison in the here-and-now. Be angry Alison; the Child. I'd like you to stay with the feelings as though your mother is sitting right here and you are still Little Alison. Visualise her sitting here opposite you.

Alison: Okay. My mother is right here. Sorry, the clothes that I wear; these were not the clothes that I chose! These were the clothes that YOU chose for me.

Graham: Stay in the now.

Alison: I think that I should be allowed to choose my own clothes. I'm capable of that, am I not? And you know, even the friends that I have to come play; YOU choose who can come. Not me. I'm not allowed to make that decision. I'm sick and tired of listening to you, and I won't listen to you anymore, and that's the END OF IT!

Graham: Wow, Alison. That is absolutely it! And you are so right in what you are saying. It's appalling that you are not given the opportunity to choose for yourself. Are you able to carry on? You have more to say?

Alison: You need to get a life of your own and stop pushing us (she's referring to her two brothers) around! Stop bullying us!

Graham: Okay, I'm really hearing you now. And this is good. You are infuriated by how much your mother, right here, is denying you from making any decisions for yourself. Right? She never lets you choose your own clothes or even your own friends to visit you. That is horribly controlling, and it completely denies you from making or learning how to make your own choices. It's so undermining. You feel so bullied. You feel SO bullied. You have more to say?

Alison: Yes, Mom, take charge of your own life! And don't you dare put what you think is best and right for me onto me! Allow me to decide for myself. I can make my own decisions.

Graham: How does that feel?

Alison: Yes, it feels good to say that. I have needed to say this for a long time. Really good.

Graham: I couldn't agree with you more, Alison. And I think that you need to be able to see what part of you, which part of you inside still stops you from having this freedom; from knowing what the child wants and needs. Do you see from where inside you this is happening?

Alison: Oh yes, I do. I can see that it is the parent mode, the demanding one. That's the mode I think it is.

Graham: Absolutely. These are the demands by which your mother expected you to live your life in a very specific way. So, you do see how this part of your mother now echoes inside you; demands that you place on yourself about how things should be done. Very controlling!

Alison: Yes, I see that. And, you know, I don't have to be a perfect example of a well-behaved, good, little child. I must even be allowed to be naughty, because that is natural for a child.

Graham: Absolutely. Carry on. Say more, Alison.

Alison: You can't restrict me in everything that I do. I'm rebellious! That's what I am! I'm rebellious and that's why I am so, so angry with you! I have every right to be so, so angry with you!

It was palpable to me how present was the AnCh in the room, passionately confronting her mother who she saw sitting opposite her. This was facilitated by my keeping the Child in the present and directly confronting her mother during chair work. The extract demonstrated how Alison's growing insight to her mother's true qualities facilitated a willingness and confidence to give the AnCh her voice. Upon reflection, it was likely an unnecessary move for me to shift attention towards identifying the DePa mode that threatened the anger. She was already so powerfully engaged with her anger and this distraction had the effect of dampening the intensity of her emotional engagement. Whereas Alison was submissive in her childhood years, she now recognised how justifiable was the voice of the Child that had been suppressed for so many decades. It was decades earlier that the "Rebellious Child" should have pursued the autonomy she deserved and needed. However, she did not have the healthy resources available to her to do that then.

Whilst Alison's sustained anger was encouraging, the next extract demonstrated the transition between the AnCh and the tearfully sad VuCh, thus demonstrating the close proximity of these two child modes. My task was to broaden the window of tolerance for her to feel the intensity of emotion that she was so automatically avoiding before. It was notable how courageously Alison sustained the intensity of such difficult emotions, despite the temptation to detach from it:

Extract 3 from Session 59:

Alison: Oh goodness, this is so sore inside now. It's really painful this sadness that I am feeling. I want to just go home right now.

Graham: Alison, I completely get that this is difficult to stay with. Of course you feel such sadness. You are connecting with the way your mother treated you. And that is so understandable. You know, this is the little child in you that is deeply sad, and she needs to know that what she experienced was just terrible. (Pause) And Little Alison here needs to be able to hear that it was not okay what your mother did. It was NOT okay. And I know that it is really difficult for you to feel that pain right now, but this is what Little Alison is feeling. And it needs to be heard and things need to be made right.

Alison: It's just that it is sometimes quite unbearable. It is just so sore. One moment I am so angry and then I just feel this overwhelming sadness for what I went through. That is what little Alison went through. When I am angry, I really feel the pain I went through. And then this makes me so, so sad. Does this make sense?

Graham: Absolutely Alison. I think that this anger in you gets you so much more in touch with the hurt you've experienced, and that you still experience. And I think this brings the very vulnerable side of you – this little Child – right back into focus. I think that your very real anger reflects all the abuse you have been through, and this means that Little Alison, this sad little Child in you, comes back more sharply into focus. Does that make sense? (Alison nods) She realises what she's experienced; what she's been through. And I think that this vulnerable, little child needs so much support to feel safe again; and to feel loved. Does that make sense to you?

Alison: Yes, I do really get that. I know that Little Alison needs all this, and I do know that she deserves this. But what I went through when I was young was deplorable. It was just appalling, Graham.

Graham: Oh, yes, it certainly was. Absolutely! Your mother really restricted you. You were given no breathing space to be yourself. Right?

Alison: Yes, she stole away so much of my life. She (Alison spontaneously re-engages directly with her mother), well, YOU really cramped me. I hated that. I really did.

Graham: I'd like you to stay with this and say more to her.

Alison: (Pause) Well, if you get in my way again, I am going to throw you out of the house and I will do the right things for everybody!

Graham: Right, so what does Little Alison, and maybe her brothers, need right now?

Alison: (The AnCh Insightfully challenging the enmeshed relationship) Well, I need you to get it in your head that I am not an extension of you. I am somebody absolutely separate from you. I am NOT you. I am my OWN person!

Graham: So, Alison, do you think that your mother would have ever really got these messages?

Alison: I don't think you can get through to a person like that. No, I don't think she got it, Graham.

Graham: Well, I think that you might be right there. And I think you realise that this meant that you were always going to need to take charge of your own life because your mother was never going to really change. So, what does your mother need to hear?

Alison: Well, she needs to hear this. (Alison turns to her mother as she begins to be tearful) Get out of my space! Get far away! You are NO good. You're useless, and you are a burden in my life! Oh, but Graham, I don't like feeling like this; these tears of anger and sadness. I don't like this.

Graham: I understand Alison. But I do think that you've needed this opportunity for such a long time; for so many years. In fact, Little Alison has needed to say this for ages; for a very, very long time. And as I said just a moment ago, I think you really need to be able to say this now, even though your mother is no longer here today in person. It's more a case that you carry these aspects of her in you now as a parent mode. Right? (Alison nods) You are entitled – well, more than entitled – to say this. Do you know that we have spoken about this quite a bit before – how you need to allow yourself to be angry? And sad. This is what is needed for you to eventually find peace within you for Little Alison.

Alison: Yes, I think that I do more clearly see this now. Yes, I do feel entitled to be angry like this. And I do think that I am able to carry on being angry. And nothing should stop this feeling I have. Yet, this voice keeps coming in that says that I should step back; not be so angry, you know? But, yes, I do see that it is healthy and right for me to be with the anger in me; to let it come out.

Graham: I am very relieved to hear you say that. And, yes, that interfering voice sitting over there (I point to the DePa position) needs to keep out of this. We need to keep actively defying it from interfering over here. And it needs to get out of your life. Completely! So, Alison, are you ready to say more?

Alison: Yes, I am. I really am. (Alison pauses to gather her thoughts) She was cruel, so cruel! You know, she denied me all that love and affection. I was starved! (After a pause, she followed my cue and turned to face her mother) I never experienced a loving hug from you. I was starved of all that love and affection that was my due. (Long pause) You were never approachable. You ruined my childhood! You didn't let me grow up like a normal, healthy little girl. And when I reached my teenage years you made me feel that I was a disappointment. You, you didn't even encourage me to go into teaching. You did nothing to build my confidence in my wish to teach. Actually, I think it was YOU who lacked the confidence. And then you placed that on me. It's just not fair. It's just shocking that you did that. No, no, no. It's not alright! You didn't have the confidence to make your own career path and because of that, you just thought the same for me. That is a violation. Significantly so. And it's just NOT okay!

Graham: Phew, I can really see by your clenched fists how you feel. Do you want to say what's happening right now?

Alison: Oh, I'm actually quite exhausted right now. But I feel better for having said this. I think that it makes me feel calmer. I do feel much calmer now for that. But, you know, I can feel what she has done to me. I feel such a sadness in me now. So much was taken from me by her; so much. I did not have a childhood, you know. But, one moment I'm angry, actually furious, and then I'm just very, very sad. But that is honestly where I am now. It is sore, but this is quite where I am right now.

Graham: Yes, I completely get that, Alison. I think that you are seeing now how when you allow your real anger out – this rightful anger – that it allows the sad little child in you to also come through and really feel deeply all the loss and pain that you experienced for so many years. And, you know, as difficult as it is to feel that pain, it is important that not only I realise this, but that a part of you does (I point to the HeAd chair), and that Little Alison, here, feels heard; that she is no longer alone in that pain. Right? And this is where the healing happens.

This extract demonstrated the close association between the sad VuCh and the AnCh, and how evident it was how the one child mode was facilitating and deepening access to the other. While my acknowledging and facilitating access to these child modes remained vitally important therapeutic tasks, it was becoming clearer to both of us how closely connected were these two faces of the Child. Alison was able to articulate early in the extract how "unbearable" was the intensity of her emotion. This is where the quality of the therapeutic alliance is paramount in facilitating new healing experiences when there is such heightened emotion. Fosha's (2003) Accelerated Experiential Dynamic Therapy (AEDP) well exemplifies the engendering of new experiences for the patient through feeling thoroughly understood, and both recognising and expressing emotional truths that were previously never

acknowledged. Also a hallmark of ST, the AEDP model also seeks to facilitate corrective emotional experiences in order for the patient to feel adequately safe to allow core elements of the self (the Child) that were previously shielded by defences (coping modes and/or the DPM) to come into focus to be processed and integrated into a fuller emotional repertoire. This fostering of new emotional experiences in which Alison was able to engage with deep painful emotion across the Child spectrum is a central feature shared in both AEDP and ST.

It was valuable that Alison recognised the unlikelihood that her mother would have ever acknowledged her failings, and that she was now developing a healthy internal component of her personality that appreciated the deplorable nature of the abuse. Her insight to the enmeshed nature of their relationship evoked particular anger. It was becoming clearer to her that her HeAd held an important task of validating the Child. This was also the first instance in which Alison recognised and blocked the DPM's intrusive attempt without my involvement being required. This was an important breakthrough. It was also important insight on Alison's side in taking a significant step towards building autonomy and protecting the needs of the Child. Similarly was it a valuable insight for Alison to recognise that it was her mother who likely lacked the confidence to pursue a fuller life for herself, and that she projected this onto her daughter. Alison's exhaustion at the end of the extract reflected an authenticity with which she sustainably embraced powerful emotion and experienced a sense of resolve through this process.

9.13. Session 60

Despite the significant progress Alison made a week earlier (S59), including the renewed insight (originally articulated a year earlier in S12) and acknowledgement of the coping anger imbedded within the AnOv being directed towards the team, this did not stop her, again, being drawn into the same coping anger scenario. Her complaints about having to comply with the prescribed meal plan made it necessary to recapitulate the steps we had taken before.

Extract from Session 60:

Graham: Alison, tell me, is there any justifiable – any good reason to withdraw the necessary food from this little child? What I am saying is, which mode do you think Little Alison, the Child, would more benefit from listening to?

Alison: Hmmm, so who will she benefit from more? I think you are asking me whether I should be listening to the HeAd or listening to the (anorexic) overcontroller?

Graham: Yip, that's what I am asking. So, which one of these two do you think is going to take better care of Little Alison?

Alison: Well, I do know that the HeAd is the correct answer, and the answer you want to hear. But I have to say that when I was young I felt very rebellious, but I never got the chance to be that. It was certainly not safe for me to be at all rebellious in all those years.

Graham: Ah, okay, I get that. As a child you certainly did not feel safe to express yourself truthfully and really say what you needed. Right? (Alison nods) And it seems to me that Elliene's (the dietician) comment earlier this week really brought to life this rebellious (child) voice in you that was kept quiet for so many years? And now this child wants to voice herself, right? She's upset.

Alison: That is absolutely right.

Graham: And you are right. You have really needed to voice your needs for a very long time now. In fact, it has been the case for almost your entire life.

Alison: Yes.

Graham: And this voice is very important. It's needed to be found for a long time. But the problem is that here we are now with this rebellious voice making her needs known, but they sound to be very much that of the Anorexic Overcontroller? It's really saying that you should not be eating all the food on the meal plan. Can you see how this is a very dangerous direction for your anger – this rebellious voice – to be going?

Alison: Yes, I can see that now, now that you put it out this way.

Graham: Okay, I think it's really good that you can see that this rebellious voice of Little Alison needs to be kept away from swinging in any way towards supporting anorexic behaviour and thoughts. But that does not mean that there isn't an important and healthy place for this angry voice. I'm saying that we need to make sure that there is a healthy place for this angry voice. A chance to really voice needs that were not met; this child who was never heard. Can we give that child a voice?

Alison: Yes, I suppose so. Yes, I think it is important.

Graham: Okay, so here is the place for her to sit. Can you come sit over here?

Alison: Yes.

Graham: (After Alison occupied the AnCh chair) So, I'd like you to choose someone to be sitting in this chair here (as I point to the empty space on the sofa opposite her).

Alison: Well, I think I want to choose Elliene. You know, she has a one-track mind.

Graham: Oh, okay. Well, let's go with this then. So, what would you like to say to her right now?

Alison: All you see is the need for me – I'm a 66-year-old woman – to eat and become heavier than I already am. You are, well, oblivious to my need to be comfortable in my body. You are ignoring my feelings, you are!

Graham: Okay then, so you really don't feel heard. Your feelings are completely ignored about where YOU are?

Alison: Yes. Absolutely! Oh, it's so frustrating, Graham. I have always been so quiet about these things. Always staying quiet and not dare to say what I am really feeling. I mean, I just continue to always follow what others say. And this makes me so, so angry inside.

Graham: Yes, I really get that. You – this very angry child – you know what you want, but you don't really feel safe to say it. I have to say that I do not think that we are just talking about what Elliene makes you feel, but you have for so many years not been safe to say what you really want and what you really need. It makes you angry, but you dare not say or do anything. (Pause) But now you are more ready to show this anger?

Alison: (Expressing herself from a very amplified angry and defiant toddler) Yes, I want to just say it as it is in me. I am angry and I want to just do what I want to do! If I don't want to eat all of this, then I will not eat all of this food. I want to do what I want to do. Right?

Graham: Well, yes, I get it. I don't think it's that simple, though. You know, the good thing is that you are finally saying what you feel. And that is very good. And this is what I have been encouraging you to do; voice your needs and say it as it is. But, as much as I want you to be able to assert your needs and voice what you need, do you really think that this defiance, this rebellion about Elliene's meal plan, is the right place for your anger to be going? I mean, you have certainly come some way in voicing your opinion and being angry. And that is good, but is this rebellion of the meal plan a wise place to be bringing this? Is this a healthy place for your anger? We've been here a few times.

Alison: (Pausing and reflecting from the HeAd perspective) As you are talking now, I do think it is becoming clearer to me what you are saying. This child in me wants to be able to really, really finally say what she wants. But, yes, you are right. I know that Elliene and all of you are only caring for the little child in me when you ask me to follow the meal plan. I know this to be the healthy (adult) thing to say. But it's just that I want to finally be heard for what I am really feeling inside.

Graham: Yes, of course, it's good that you can do this. I think it is also very important that you can see the importance of being this little child who is allowed to be angry. You can rebel. You are allowed to say "no" and express what you want that is good for you. I think that you are starting to see the importance of being heard, right? (Alison nods) But I also think it is important that the protest is for what you want and need that is GOOD for Little Alison; not what is harmful. Can you see this?

Alison: Yes. Absolutely. But, you know, I still hear this voice inside me saying that I don't need to follow my meal plan fully this week. You know, I have this new voice where I can say how I really feel, and I want to be able to say what I want. It's time for me to say what I want.

Graham: Alison, I really do hear your strong desire to be heard; don't get me wrong. You have taken the submissive stance all your life and always gone into the CoSu way of coping, which is not good. However, as much as I am strongly encouraging you to voice your truth and voice your feelings, it's really important that you are not mistakenly asserting the needs of your AnOv, as I see you blatantly doing here. It's a real pity that we have run out of time today, because there is something really important and unfinished in this. You know, what I really want you to consider is that your anger, this rebellious voice, as you call it, is so important to be heard. But it is one thing for you to be angry about the ways in which your healthy needs were not met all throughout your childhood and beyond, and then you being angry with the likes of Elliene, who you have repeatedly acknowledged is here to really help the little child in you be well. You anger in this context is not good. It's dangerous. This is your AnOv wearing a mask of supposed healthy assertion and saying, right, I have a voice, and this is my need. It's as though there is a contamination of your anger here. Your healthy anger belongs to a child who has reason to be furious about all the harm that has been done to her; abuse imposed on her for so long. Does that make sense?

Alison: Yes, I'm listening very clearly to what you are saying. And it all makes sense in my head. And, yet, there is still this voice in me that wants to say how I am feeling and this is what I want. No more pretending and no more just doing what others want me to do.

Graham: Sure, Alison, I really get that. I wish we could actually carry on talking about this now, but maybe we can speak on the phone later on, as I am really concerned about you having this healthy thing called anger, but using it in a direction that is not coming from your justifiably angry child or your angry HeAd. It's not healthy anger if the effect is bringing harm to the Little Child. And here you are using anger to push your AnOv into a powerful position. Your AnOv is carrying the anger here. And that's called something else. That's self-defeating and an abuse being imposed on Little Alison. I do get the sense that it just feels to be a great relief to finally feel safe saying what upsets you; you know, being honest and open about what you are thinking and feeling. But it is important – so important – that this new assertion is for the protection of Little Alison, not being used for the opposite, where this anger is pushing the anorexic into a strong position. Can we talk some more about that later?

Alison: Yes, and thank you for that. I know that you really care. I do appreciate you wanting to speak to me more because I know you care. And I think you are right. My anger just feels so novel to be putting out there. But I do see that there is good and bad that can be done with it.

With the hour drawing to a close, I felt concern so deeply into the therapy process at having not yet fully driven home to Alison a clear distinction between healthily directed anger and this misdirected drive to assert herself via a significantly contaminated AnOv influence. Rightfully, we had worked tirelessly to "let this angry genie out of the bottle", and it was imperative that I ensured that this newfound anger be consistently harnessed to meet the needs of the child and not be misdirected in a way that perpetuated abuse towards the Child. It was significant progress that Alison's anger was no longer being automatically extinguished by the subjugation of emotion and self-sacrifice schemas underlying her CoSu coping. As important as it was that the anger was now used to meet the needs of the Child, we needed to be careful that it was not being contaminated and used to enhance self-defeating objectives. Even though Alison was repeatedly cognisant of my concerns about this misdirected anger, it was valuable that the Rebellious Child that had been suppressed for decades was finally emerging and being articulated. For a brief moment, Alison's authentic anger was triggered due to the feeling that she was denied autonomy and self-determination. However, as had happened in a few previous sessions (S12, S59, S60), the initial triggering of the AnCh was quickly pushed backstage to make space for the angry coping (incorporated in the AnOv) to step forward into the spotlight. While Alison was making progress in expressing authentic and healthy anger emanating from the AnCh or angry HeAd, she was still not easily making the distinction between this and clear evidence of coping anger.

9.14. Session 62

While Alison's opening remarks in this session demonstrated a cautiously confrontative approach rather than her previously submissive stance associated with the CoSu, she steadily became angrier with increasing confidence. However, such anger, when expressed, was still a coping mode imbedded within the AnOv. As immense as the progress was that she was no longer automatically avoiding her anger through CoSu coping behaviour, the challenge remained to help Alison to still fully appreciate the distinction between the coping anger imbedded within the AnOv and the authentic anger emanating from the AnCh. While I had failed a fortnight earlier to drive home the important distinction between these two sources of anger, a similar scenario here provided a renewed opportunity to address this.

In this first extract early in the session, it was clear how Alison sustained her connection with the coping anger, yet was simultaneously relieved that she was no longer submitting to the CoSu. My task was to engage with the anger in the hope that I would be able to draw across to an authentic anger residing within the Child.

Extract 1 from Session 62:

Alison: Oh Graham, I am not sure about all this. I have to say that I am quite upset.

Graham: Oh, okay Alison. Well, please tell me more what you are upset about?

Alison: Well, to be honest here – to be absolutely honest – I have to say that I regret every kilo I have put on. And so, I feel that my support group is against me. This is true. And this is exactly what I feel.

Graham: Okay, I don't think I understand fully what you are saying, but I am certainly interested to hear anything you have to say that is upsetting you. Carry on. Help me understand why you feel that we are all against you?

Alison: Well, I am very unhappy with my body. I have always felt this way. And I have to say that with this new weight I am particularly upset with the way that I look; with my appearance. And in being totally honest and open with you – and I should have said this to Elliene (the dietician) earlier this week – that I do not think that I am going to ever change my view on the way that I feel about my appearance. And I do not want to continue following this meal plan. I refuse! I mean, I think that I am only doing this to satisfy everyone. I am only doing this to meet all of YOUR needs. Everyone's needs; all of you. Even Mike and Eric. I am angry about this; very angry, indeed.

Graham: I see. (Pause)

Alison: You know, I gained another 400 grams this week and I know that I did not even eat every little thing on the plan this week. Still, my weight went up another 400 grams. I cannot trust this meal plan at all!

Graham: Well, I can see that this is making you very unhappy. You are angry. Look, I see that your weight is still very safely in the set range, but I don't really want us to focus on that right now. Alison, I get that you are feeling angry and there is nothing wrong with you expressing this. Actually, you know that I have been really encouraging you to express anything that makes you angry. So that part is good. But with your weight still sitting really comfortably inside the goal range that we have always all agreed on, I wonder what it is that is making you so angry and upset right now? Your weight is stable – very stable – and staying comfortably within the limits we have agreed on. You know, I remember us being in this exact place a couple of weeks ago (S60). What I am really saying is that I wonder if this is about something else? Alison, just reflect for a moment and see if there is something else that is upsetting you so much at the moment. Try and look at this beyond being a weight issue. I'd like to see if you can just sit still with this for a moment and listen to the feelings inside you? (Long pause) Maybe you have a sense of these feelings somewhere in your body? If you could just close your eyes for a moment and just take a moment to listen to this inner feeling.

Alison: (After a brief pause, Alison impressively acknowledged the value and motive of her AnOv coping) You know Graham – I really just want to be an anorexic walking skeleton – getting attention for this.

Graham: Ah, now this IS really interesting, Alison. It seems that it sits comfortably with you that Little Alison, here, needs attention? She needs to be seen? Or, she has needs? And they are not being seen?

Alison: (Pause) Oh. Now I really am annoyed with myself. I know that what I am saying now just comes straight from that anorexic place; that Anorexic Overcontroller.

Graham: Well, yes, you are absolutely right, Alison. But I really don't want us to focus on that straight away; not just yet. We can come to that in a little while. I think that there is something else going on here that is really important. You say how you want, how you need, more attention. I think that this is an important issue.

Alison: Well, that is all very well. But I have to say that I am still determined to exclude my snacks from the plan. I only want to lose one kilogram. That's what I want to do right now. And so I think that it is absolutely alright for me to continue keeping those snacks off my plan – my meal plan. That's what I want to do! Look, this is what I am angry about.

My attempt to access the underlying process in which Alison was denied autonomy and remained invisible throughout her life remained a significant challenge. Despite my attempts to decontaminate her of the influence of the AnOv and pursue the authentic underlying process at play, the fear associated with weight was still too heavy. This myopia ensured that the AnOv continued to be safeguarded by its coping anger component and remain a dominant force in her life.

The next extract from the same session reflected the ease with which Alison neutralised her CoSu coping. I commended her on this, but more directly confronted and assisted her in dismantling the coping anger. Alison's progress was being compromised whereby one form of coping was merely being replaced another. As such, the authenticity in the Child was still being denied.

Extract 2 from Session 62:

Graham: Yes, but I think that this anger that you are expressing here is not healthy anger. I see this as a coping anger. What do you see?

Alison: Well, I just really want to decide for myself what I want. There is this anger voice in me that says for all of you to just back off. Just back off and let me decide for myself what I want to do. What do I want! That is what feels important to me.

Graham: Okay Alison. I mean, yes, I totally get what you are saying. And I have to say that it is really refreshing – really good to hear you express so honestly what you want – what you feel you need. When you speak with such honesty, then I get to hear what YOU need; what YOU want. I think that there are a few things going on here right now, but, okay, let's for now just focus on what you need or want. We can deal with the merits of this later. Okay?

Alison: Okay. What I want to say is that – well, you see – I have always needed to be in that compliant mode; the CoSu. And I am not onto that anymore. I am so tired from always doing what others expect of me. This has been the story of my life. I'm fed up with that now. Just fed up.

Graham: Sure. Of course, we have visited this place a number of times. In fact, we were here only a couple of weeks ago. You are aware of where this all comes from; where it all started many, many years ago when you were a young child? Right?

Alison: Yes, of course. Oh boy (said with a sigh). I've only known myself to always do what my mother wanted; just to keep her happy. It's all I knew to do. And as for my father, I never really said what I was feeling inside. I just did whatever was going to keep his drunken behaviour hidden from everybody. Always trying to keep things happy for everyone else. Never really saying what I really thought. So yes, that part of me that does things to keep others happy is so normal, and not okay anymore. It is just not alright anymore! No more!

Graham: Sure, Alison. I think it is very good that you are not hiding in the CoSu mode anymore. But, as I see things right now, you are caught in a bit of a fix here. Do you do what I and the team want you to do, or do you insist on doing what feels right to you? Is that the issue here?

Alison: Exactly, Graham. I have always got to meet your expectations, and I hate that now. I just hate that I am forced to do what you and all the others tell me to do. I'm angry at one level that I am not allowed to do what I want to do. And, yes, I do also hear another voice in me that says "But you have given me all the tremendous amount of support and help." I can also hear that voice. I have learned that much.

Graham: Okay, so you seem to actually have a better idea of what is going on here. I think you are seeing another angle here. You are absolutely right to be angry that your life has been filled with pushing down your own needs and simply meeting everyone else's expectations.

From your mum and dad, still right up until today, you feel so obliged to do what others tell you to do; follow the meal plan, eat like this. Make sure you complete the full meal plan each day. Get to this weight here. And so on. That makes you angry, right?

Alison: I feel terrible saying this but, yes, it does. And, yet, I am also aware that when you all want me to follow the meal plan, you are only meaning well for me.

Graham: Sure, and I think that there are a few modes in the room right now. Right? But which mode sitting in this area (I point to the designated seating place for the VuCh) do you think we are totally committed to looking after; to nurturing, loving and caring for? You get what I am saying?

Alison: Yes, I do. I know that it is little Alison sitting right here that you are all helping; that WE are helping. I do know that. Yes, my own HeAd is also doing its bit, I hope.

Graham: Right. So you can see that this loving parent in you – this Healthy Adult – is who we are trying to help you make stronger in order for you to be able to take care of this little child sitting right here?

Alison: I do get that. I see that it is important that the little child right here is not betrayed, and (not) remain too thin. But at the same time, what I am asking for is to let go the snacks and just take care of losing that one kilogram. That's all I am asking.

Graham: Now, tell me Alison, which mode in this room is actually saying that? Which mode is turning this discussion back to manipulating the weight in Little Alison? After all, you are actually still so squarely in the goal weight range, so who would be trying to jeopardise that?

Alison: Oh, I suppose it has to be that mode (pointing to the seating space reserved for the AnOv). Yes, I know that this thinking is wrong, but I cannot be quiet about that voice (pointing to the AnOv) still being so loud and getting in the way here.

Graham: Look, Alison, I get it. I do think it is a very good thing that you have realised now that going into CoSu is not a healthy thing, and that you need to be expressing your true feelings. But what I really think is important is to make sure that you are not swapping one coping mode for another. This anger that you have for the team that wants you to stick with you eating on your meal plan and working toward your recovery from anorexia; do you think that this is a healthy and legitimate anger that you are expressing?

Alison: Well, as I was saying, I do know from my healthy (adult) side that I should not be angry at any of you, and that my anger is more about the frustration of not being allowed to make decisions for myself. But I know that it is not right in this situation to be angry with you all. It's just that this is the feeling inside me which I am finally starting to put out instead of just keeping quiet.

Graham: Okay, Alison. Now that is GREAT that you are saying this. Because I really do think it is brilliant that you are no longer hiding in that CoSu coping and just being quiet to avoid a conflict situation or just making sure everyone around you is happy. Stopping this CoSu coping is fantastic progress. I really mean that. However, as much as I don't want you going into CoSu, I think that instead of doing that, your anger and feelings that you then put out need to come from a genuinely healthy place. What I am saying is that when you now connect with your anger, it is really important that this anger you express is genuine and legit – anger from the Child in you – and not another coping, where your anger with us as a team is actually a coping anger. Do you see what I am saying?

Alison: Yes, I can see exactly what you are saying here. Yes, it does feel such a relief to feel safe not doing the compliant (surrenderer) coping thing. I am feeling that now. But I do see that where I am angry with all of you is not fair; not a fair anger. Yes, I am angry for the purpose of you staying off my back; not forcing me to follow the meal plan 100%. Alright, I get that my being angry here is not a rightful anger; not a healthy anger. It is shouting from my anorexia to back off. Phew, the pressure gets so high.

Graham: Okay, that is fantastic that you can see this. So, Alison, you seem to be able to now see that your anger that pushes us from wanting you to keep following your meal plan is a coping anger; a sort of bully in you that says "Hey, back off from me deciding how I am going to eat". And that's your AnOv staying in charge of how you eat, right?

Alison: Yes, I get it. That's right. So, this is coping anger, not my angry Child?

Graham: Spot on, Alison. I see this anger that you are putting to the team as a bully and attack type of coping, where you are actually intimidating the team into backing off from the AnOv carrying on its business of keeping the meal plan too low; keeping Little Alison in a place where undereating is a way of staying calm and in control. Are you able to see that this anger – this coping anger – is very different to the anger that legitimately belongs to a child who has rightful reason to be angry; a child that was never given a voice?

Alison: (Showing exceptional insight to the backstage and legitimate defiant AnCh while the coping anger in the AnOv holds the spotlight) Yes, I think I get it. Um, while I've not a rightful reason to be angry with the team that is trying to help Little Alison, I do have a very rightful reason for being angry with my mother for never giving me a chance to have my own voice and have my say. Is that right?

Graham: Yes, absolutely. You really seem to have it. This team is helping Little Alison, and the anger coming at the team is a coping anger that is actually protecting the AnOv, or a coping anger that is maybe coming from inside the AnOv mode protecting its influence on Little Alison. Maybe your AnOv has a coping anger department, so to speak. And we know that the AnOv is not good for the little child, right?

Alison: Yes, of course.

Graham: So, Alison, can you now see the difference between anger coming from the Child in you who has every reason to be angry with your parents for keeping you silent and leaving you feeling invisible? (Alison nods in agreement) This is legitimate angry in your Child; the AnCh who has every reason to be angry. But then this anger at the team is something different. This is a coping anger that protects the AnOv. It's not protecting Little Alison. This is unhealthy anger – coping anger. But anger that reflects harm done to the Child in you is rightful and healthy anger; this is genuine anger from the AnCh mode.

Alison: Ah, okay, I really see the difference now. Yes, of course. All coping is ultimately going to do harm to the little child in me. This coping anger is not good, just like the CoSu coping mode is not good. I get it.

Graham: Okay, this is very good that you see this.

Alison was consolidating her neutralising of the CoSu coping mode, but it was important that she now understood that her exchanging one mode of coping (CoSu) for another (angry coping in the AnOv) was equally disarming of the Child. Also vitally important was her ability to differentiate between the authentic and defiant anger residing in the AnCh and a coping anger that was essentially serving the purpose of preserving the agenda of the AnOv. Without having articulated it to her, it was clear that the team's limit setting with regards to the meal plan had repeatedly triggered Alison's Defiant Child that was momentarily resonating with the autonomy denied her and the invisibility that she had experienced under her parents for decades. In the context of the team's (healthy) limit setting, however, this anger (or defiance) was not legitimate, but operated as coping anger embedded within the AnOv. It demonstrates the speed with which modes can flip, and points to the importance of the therapist reading the context very carefully and being astute to the sometimes very complex unfolding mode sequences.

Later in the same session, Alison's ambivalence to express anger about parental abuse was more fully tested. The challenge remained to push past the intransigent gi-DPM that inhibited legitimate anger associated with decades of abuse and neglect. The fine line between the Child's anger and sadness, again, revealed how one powerful emotion triggered in the Child facilitated access to another powerful emotion in a different child mode. This points to the notion of primary and secondary emotions, and how each of these emotions were interchangeably primary to the other; anger sometimes evoking an underlying sadness and sadness sometimes reflecting suppressed anger.

Extract 3 from Session 62:

Alison: Well, yes, I can see that, well, how my under-eating is not really any different than what my mother (pause) and my father did in neglecting me. Yes, I see that connection clearly now. Oh, and I do so want to be angry, but I can hear that voice of her forbidding me to express it. It's not righteous. It's just not right, Graham.

Graham: Hmmm, it seems that voice of a very demanding parent with all those "musts" have appeared on the scene again?

Alison: Well, saying that, you know that I visited my priest in confession earlier this week – I think it was Monday, in fact – and actually, he said it again that I have every reason to be angry with my parents for the way that they treated me. He actually said that I had every right to be angry with them, and that I should bring that here to my sessions with you, he said. But I don't know. I mean, surely it is just not right to be angry with the deceased? Surely not? And you know, really, I think that I have every reason to take care of little Alison over here, but it would not be right for this child to be angry with her parents, especially considering the respect one should have for the dead.

Graham: Look Alison, I think I understand this loud voice inside you that echoes your mother – this is the voice that forbids you to be angry with her, well, angry at both your parents – actually to be angry with anyone. And even though your priest – and I totally agree with him – rightfully encourages you to be true to your anger, it still seems that this voice of your mother, this guilt-making parent voice that sits within you, insists that you do not express that anger. Surely that would be morally wrong, right? I mean, the kinds of experiences you were exposed to as a child were truly awful; horribly abusive. And being angry about that is surely justified. I think that's an understatement.

Alison: Well, yes.

Graham: If we look at what you were put through throughout your childhood, it is just shocking. Absolutely shocking! The control of your mother, the absence of your father, the pressure you always felt. Yes? Right?

Alison: Well, yes, it was constantly difficult. You are right. I was always under pressure to perform in certain ways. Always frightened. My mother was always telling me and expecting me to do things in certain ways. She often scolded me for no rightful reason. Walking in the road, she would tell me to do this, and to do that. When we bumped into acquaintances, she would push me into her shadow like I needed to be hidden. Not seen AND not heard!

Graham: These are all the terrible things that happened to you when you were young. I think that it is very right for you to be angry about all of this. If this does not deserve anger, what does? Ja?

Alison: Well, yes, I think you are right. I do have every reason to be – to feel – angry. I just automatically feel guilty, feeling angry. I think I am now seeing it more clearly that this was another bad lesson that my mother taught me. A child should be allowed to be angry. At least express it. Yes, I have to say that this is starting to make much more sense now. There were so many, many things that my mother and father did wrong; so many things that were appalling at home.

Graham: Yes, the many incidents and the entire atmosphere that you faced at home must have been so painful, so cruel at times. It must surely have been a perpetually terrible and frightening world. Tell me, when you reflect on it, is there one particular incident that stands out? One instance that comes to mind?

Alison: (Long pause). Well, yes. Well, the one that comes to mind is when, oh, I was quite young, I walked one evening, when it was rather late, into my parents' bedroom. And there was my father – he was drunk as usual – actually he was completely inebriated; so drunk that he was not aware that he was urinating on the floor. He was standing up as though over the toilet, his arm stretched out against the wall, but he didn't know where he was. Oh, it was a dreadful experience. In fact, especially so because my mother saw what was happening and I could tell from her look that there should be nothing said about this. And you know, Graham, he was such an embarrassment to me that I felt too uncomfortable to even have my friends over, because he was always messing on the bathroom floor; all the time. I couldn't have friends at the house because it was just so, so embarrassing!

Graham: It is appalling, Alison. Not only is it appalling that your father got so drunk and did the things that he did, but equally that your mother expected you to accept such behaviour and keep quiet about it. Keep it secret. Shameful family secrets, right?

Alison. Yes, it was all such a difficult thing. So, so wrong from both of them.

Graham: Okay, so you are still sitting in your healthy adult place right now. What do YOU have to say about this? Just speak for the little child sitting here. And, of course, I am happy to step in whenever you need. But I think you've got this.

Alison: Well, I am so angry. So, so angry for this little child. She was …(pause)

Graham: Carry on.

Alison: Oh yes, of course. Um, this, this was such a deplorable environment for this innocent little child here. How, how, how can you expose her to THIS! How could you have allowed this? You should have protected your children from this behaviour. Your husband should never have been allowed to behave like this. It's DEPLORABLE. IT'S ASTONISHING! And you controlled everything else, you did. Look at how you controlled this child with an iron rod, yet you allowed this deplorable behaviour to continue!

Graham: And we know how Little Alison had to deal with that when she was young.

Alison: Yes, that is where I did my semi-disappearing. I just wanted to be invisible to get away from the awful things that happened; from everything.

Graham: Yes, I can understand that you wished to be invisible to just try and protect yourself from everything at home. It's how you coped; how you survived in a horrible environment that was never really going to change for the better, right? So you hid; you made yourself inconspicuous?

Alison: Yes. And I remember what you said to me some time ago; how this invisible hiding away that I did kind of found its form in the eating disorder later in my life. The less of me there was to see, the better.

Graham: Yes, I think you are absolutely right. Yes, how anorexia became another protection; another way of coping with difficulties around you and all the unresolved pain and feelings sitting inside you?

Alison: Yes, my AnOv did become a sort of invisible protection. Again, I feel myself being both sad and angry as I see this. One moment I am feeling so sad about this, and then this anger just wants to come through; like how dare I be treated that way through ALL those years. It's just SHOCKING! Absolutely shocking.

Graham: Ja, absolutely, Alison. And it is good that you can see how you coped by becoming invisible, by disappearing to protect you from such deplorable things that were happening. But right now, I just want you to stay with this anger. It's very right that we stay with this anger and deal with the scene you have just described. I'd like to see what little Alison has to say about this situation with your father that you just described. And the way your mother just covers it all up.

Alison: (Reflecting from the HeAd) You know, it was more important for my mother to maintain good appearances in public. Behaving like that was not okay, because I was not allowed to be myself.

Graham: Absolutely. That was so not alright.

Alison: (The AnCh is channelled through the HeAd before she reflects on her fear of losing control in her EnCh) That should never have been allowed. That was depriving the little child of the help that she needed. Oh, it makes me SO ANGRY! This really does. Oh, I really shouldn't be feeling this strongly though. It's not right. I shouldn't be so angry as it is going to boil so out of control.

Graham: You're uncomfortable about allowing yourself to fully connect with this anger?

Alison: Well, I certainly don't want it to get too much more. I don't want to be out of control with this.

Graham: Well, do you think it is right then that you ask the Child sitting over here to rather just hide away; to disappear? Or does someone need to take her parents to task?

Alison: (Flipping into AnCh while seated in the same chair) Oh no! That wouldn't be right. I am so, so angry. I was silenced all that time and it is unacceptable. I mean, I need to feel heard and recognised. That's what I need. You never once asked me whether I like this or like that. "That is the way it has now got to be", is how she would have it.

Graham: You are SO right, Alison. I want you to really connect with that. Allow the little Child in you to say it as it should be said. You've every right to be very angry. VERY angry.

Alison: Absolutely, yes. You really let me down. You really did! You were like a bully.

Graham: That's it. "Mum, you really ARE a bully." Really put everything into it now.

Alison: Well, you were a bully. You really failed me! Yes, that's what you did. You failed me! What you did to me and my brothers is completely different to how I was with Eric (Alison's son). And it is completely unacceptable that you allowed our father to carry on the way he did with his drunken behaviour. That, too, was completely unacceptable. And you allowed it! YOU tolerated it. In fact, you tried to keep it hidden. You just swept it away. He was so drunk most of the time and his behaviour was a total embarrassment. It was wrong. And you did nothing except hide it; sweep it under the rug. He wasn't even a father. All the time he was either a drunken embarrassment – falling about and making a mess everywhere – or he was not there. He just simply wasn't there. What a thing, Graham! And mum, you made it okay for him to carry on with all his vices while we were in the background having to let it all pass by and pretend it was all not happening. That was living a lie! My life was a pretence. That's what it was! A pretence, and nobody did anything about it!

Graham: Yes, Alison, you are so right.

Alison: You know, Graham, I was unsafe throughout my childhood. I was never safe. No one helped to make it safe at any time. And rather than encouraging me to do the things that I wanted to do with my life, she stopped them. She stopped me from dreaming. I DO feel infuriated about this now! I do.

Graham: (Pause) And how does it feel expressing this anger now?

Alison: Well, I think I have to admit that I do feel very alright in saying this. If I be absolutely honest, I have every right to be angry; very angry, indeed. Yes, it is right that I be angry. What both my mother and father did was deplorable. It was wrong, and I feel quite worthy to say that. Yes! I don't want to carry on being silent about this anymore. That's nonsense.

Graham: That's good. I like that you can trust to let these feelings out.

Alison: Yes. And, you know, I actually feel calmer – more at peace – having said all of this now. It doesn't really go completely out of control. When I have said this, it just seems to naturally quieten down inside after a while.

Graham: Ah, so you can see that your anger will not boil out of control. In fact, the more you give yourself permission to express these feelings, the less it feels all boiling up inside and you feel more relieved having released it?

Alison: Yes. That is true. That is how it is.

Here was a significant opportunity to push past both the guilt and fear that inhibited Alison from expressing anger. Despite my repeated encouraging for Alison to engage with her anger (including her priest's endorsement), she was still wary to defy the enormity of an internal voice that forbade her to hold her parents accountable for their abuse. I directly challenged Alison's skewed moral notion of her parents' immunity to confrontation by reiterating the enormity of the abuse they imposed on her that needed to be addressed. She responded positively to this, sighting the frequent pressure she faced, the denied autonomy, and the shadow she occupied that filled her with shame. This helped Alison to adopt the HeAd perspective, recognising that the DPM perspective on anger was another introjection of her mother's attitudes.

While Alison held this healthy insight, the extract demonstrates how I drew her closer to an experiential level by encouraging her to identify a specific childhood experience that evoked this flood of emotion. Switched between the Child and the HeAd stance, Alison reflecting on her father's alcoholic behaviour and her mother's complicity in his appalling alcoholic behaviour. Because she had previously tolerated anger more readily from the HeAd than from the AnCh, I first appealed to the HeAd with the hope that I would be able to eventually encourage her to engage from the AnCh. This worked very effectively, with the HeAd very vociferously confronting her mother before the Child entered the arena. It was here that Alison, again, recognised the analogous nature of her eating disorder to the abuse imposed by her parents having restricted her life. Where this evoked both sadness and anger in the Child, I urged her to stay with the anger. It was here that her other threat to sustained anger was brought into focus; that of it "boiling out of control". My provocative comment that we consider shutting the Child down had the desired effect of immediately evoking a powerful eruption directly from the AnCh. In the most vociferous expression yet displayed by the AnCh, Alison required minimal support from me in being furious with her mother's many failings as a parent. Not only was there a total absence of modes interrupting her angry outpouring, but she acknowledged feeling calmer, more peaceful, and quieter inside. Rather than anticipating her anger spiralling uncontrollably, Alison experienced a cathartic release as a result of opening the sluice gates to the AnCh.

While Alison was making good progress, demonstrating increasing insight and courage to express her anger more forcibly, she was still susceptible to flip back into coping behaviour. As healthy as she was in sustainably expressing her anger about decades of abuse, this last extract from the same session shows that when such anger provided access to the sad VuCh, she succumbed, despite her earlier insight, to AnOv coping to restore a sense of "control" or containment of her feelings. This time, however, the anorexic preoccupation was brief and very effectively diverted through emotion-focused work that identified the hidden emotion residing behind it:

Extract 4 from Session 62:

Graham: Alison, please tell me what you are doing now? You are not comfortable to stay in this chair and feel these feelings in Little Alison?

Alison: No, it is all a bit too much Graham. Actually, my thoughts are that my body is not right, right now. I feel that my stomach is too distended. That is what actually needs to change right now. It's all very well …

Graham: Okay, I know that you feel it necessary to always look at what it is about you that needs to be changed, but I do think that you are edging away from something very important where you are having strong feelings about your parents' behaviour. (Pause) And yes, I get it that you suddenly want to turn to something physical; something to be critical about; something to change, but I don't think what is happening now is actually just about your stomach. Um, I'd really like you to just try and stay with the feelings you are experiencing now, right now. Okay? For instance, is this distended feeling in your stomach saying something? Is there a feeling connected to it? (Pause) Just try to stay connected to this feeling in your stomach and see if something emerges.

Alison: (After a long pause) Okay. Yes, I know in my head that this is not about my stomach; well, not just my stomach.

Graham: Alison, try to get out of your head for now. What is this FEELING when you just sit back and listen to it? See it? Maybe just close your eyes and see if an image comes through?

Alison: (In extended silence with her eyes closed) Ah, okay. Well, there is this pressing feeling in me, like something strong wanting to come out.

Graham: Say more. That's good, but say more. Feel it.

Alison: Something hot. It is a heat.

Graham: Okay, stay with that. Do you see more; sense more?

Alison: Actually, it is that anger ball in me. That ball of fire. You remember that ball of fire I saw some time back (an image that emerged two months earlier in S53). That is what is pressing at me now. Oh, my goodness, this is so strange that this has come up, again. This feeling pressing in my stomach is my anger. It's actually my anger. YES!

Graham: This is good. I want you to just stay with this anger feeling. What is happening with it right now?

Alison: (Alison pauses before opening her eyes to turn to where her mother was positioned) This ball, these flames of fire, they want to come out (Alison gestures with her hands to her mouth) and I want to scream at you (her mother). That is what I want to do right now. I am infuriated with you, mother! Just infuriated!

Graham: Okay, so keep letting it out.

Alison: Oh, can I really do this? (I nod in agreement) I want to say to you – mother – that in every single way, you FAILED me! You failed all of us. It is true, in every possible way you failed me! You are just a big pretence! You are distant; A FAKE! I hate what you did to me and my brothers. It is unacceptable; TOTALLY UNACCEPTABLE! I am furious, Graham!

Graham: Oh yes you are, and for good reason. And you are completely right. So, here she is, sitting here (I'm pointing to the seating position designated to her mother). And what are we going to do about it? What needs to happen right now?

Alison: Oh, it seems so obvious. She needs to leave. I don't want to say much more to you. It's already been said. YOU must leave NOW! Oh, we did this before with, with, with the pillow – well, a cushion – and here she is, again. Ridiculous! Graham, she needs to be GONE. It's RIDICULOUS! It's ENOUGH NOW!

Graham: Well, we've booted her out a few times before, haven't we? But as long as we keep at it and keep banishing her from this place, she will surely become more silenced and weaker each time. So, Alison, what do you think we need to do to keep you mother silenced for good?

Alison: Well, maybe that means I need to throw her out again.

Graham: And how.

This extract demonstrated the potency of emotion-focused work, and the manner in which Alison's visceral experience of anger as a ball of fire was brought into full expression. For an emotion that Alison was very reluctant to express, the distention in her stomach suggests the role that anorexia served to inhibit an emotion that she feared would spiral out of control. The modes that had frequently inhibited the AnCh appeared to now be weakened and easier to neutralise. By once again throwing the cushion that represented her mother out of the therapy room, Alison was ritualistically reminded of the importance of banishing her mother (the strongest representation of the DPM) from having access and influence over her Child. It was clear how this ritualistic banishment of the DPM needed to be repeated until it was integrated at an emotional level.

9.15. Session 72

This session, more than two months later, demonstrated Alison's growing familiarity and confidence in sustaining her anger. Despite her being consciously aware of the DPM threats in the background, the HeAd had matured to a level that denied this interrupting voice from gaining foreground access. This threat was swiftly dealt with in chair work, during which a significant confrontation unfolded. When Alison recalled another instance of her mother failing to hold her husband accountable for his drunken behaviour, she demonstrated how adept she had become at marginalising the DPM, thus providing a safer forum for an uninterrupted AnCh to voice herself:

Extract from Session 72:

Graham: Oh boy, it seems that this is what happened repeatedly at home. Here you are sitting at the dinner table with both of them, and your father is, once again, clearly blatantly drunk during dinner time.

Alison: Oh, it just makes me furious. It's SO INFURIATING that he was allowed to carry on being like that. I didn't have my brothers to help because they had long left home for good. And my mother would just ignore it. My father would be so blatantly drunk; slurring and knocking

things over. He couldn't even hold a conversation. His food would be falling onto the floor beside him and he didn't even know it. I would look at my mother and she would be just looking ahead, ignoring it as though nothing was happening. And he stank; he stank of alcohol! It was mostly quiet, except for my father bumbling on about something. But we couldn't even understand what he was saying. HE probably didn't know what he was trying to say!

Graham: Listening to this, it is quite unbelievable that you were expected to tolerate all of this. Not only was he unacceptably drunk – his behaviour TOTALLY unacceptable – but your mother did nothing to stop this from happening, repeatedly. Right? This sounds so like the situation you described some time back when your father was drunk and weeing on the bedroom floor (described in S62). Not so?

Alison: Yes. I have so many recollections of this happening. Graham, it happened countless times. It was quite normal at home, happening over and over again. And my mother did nothing to stop it. Just nothing but looking ahead; saying nothing and doing nothing. Such a pretence.

Graham: Ja, it really is appalling. It was completely unacceptable that this EVER happened! And, yet, it happened repeatedly; over and over and over again. Do you have a vivid image, a vivid recollection of this situation? What was that like?

Alison: Yes, just awful. I remember feeling so angry, but not feeling safe to say anything. Dare I say something, I would have been shot down so quickly. Even now, there is a small part of me that I can hear saying that it doesn't feel absolutely okay to be angry about that. Well, I know that I am angry, but then there is this other voice saying "Just be quiet. Just be still and say nothing. You don't want things to get even worse, do you? Right."

Graham: Yes, I can understand that. It sounds like that need to be quiet was a way of coping; just be quiet and things won't get worse. I'm betting you know – all too well – this mode in you that keeps the child quiet so that things don't get more troublesome; you know, more out of hand?

Alison: Ah, yes, I think here we are talking about that surrender mode. That COMPLIANT surrendering; surrenderer.

Graham: Yes. Quite Right. But, of course, we can look back on such incidents now and say, "Hey, this situation is just absolutely not okay." Right? (Alison nods in agreement) Yet, you weren't in a position to confront it. You were just too young. Not able to interrupt what was happening without getting a "klap" (Afrikaans slang words for a smack or slap). It just wasn't safe, right?

Alison: Well, yes, I think you are right. And I think that I do feel safer putting my anger out here now. And yet, there is still that other voice on the side saying that I should not be angry at my parents. It's disrespectful and all.

Graham: Ah, now that's the other voice sitting over there (as I point to the seating area in the office typically designated for the DPMs). So, what is THAT mode sitting over there saying to you now?

Alison: Oh, it says to honour your parents, you cannot be angry at them. You must respect them.

Graham: And how are you experiencing that command now, from that parent mode?

Alison: Well, I still hear that voice, but, you know, I am starting to see that this is ridiculous. I think that I am taking your discussion, our many discussions, to heart. I CAN have respect for my parents, but that does not mean that I have to accept all their dreadful behaviour; all that behaviour that was so, so deplorable. SO unacceptable! You just don't subject a child to this kind of behaviour. And that I should not have to accept. That should not be respected.

Graham: Right.

Alison: So, yes, I do find the behaviour of both my parents absolutely unacceptable in this instance. Unacceptable! THAT should not be respected. Absolutely not. Graham, I think I truly get that now.

Graham: Okay, yes. I like it. You get that this anger needs to be afforded Little Alison. Expressing this anger really does tell us about the terrible things that you went through when you were young; things that you should have never been exposed to. But it is very important that Little Alison can see that this behaviour is unacceptable from your parents and that you have every right to express yourself. In fact, it's a very important task; a responsibility that this anger is voiced.

Alison: Yes, I see that so much more clearly now.

The extract demonstrated Alison's growing insight and clarity to the permissibility of her anger towards her parents. It was significant progress that the HeAd was now able to identify the distant allure of the DPM forbidding her from reprimanding her scolding her parents, but keep this dysfunctional mode at arm's length and discredit its legitimacy. Immediately prior to this, as she had done in previous sessions, Alison confirmed the futility of CoSu coping behaviour whereby she had repeatedly subjugated her emotion for the sake of maintaining the inauthentic veneer of peace in her childhood household. The HeAd was now demonstrating a significant maturity in its guardianship over the AnCh.

Over the following few months, anger was not a consistent or significant theme in therapy. However, when it did come into focus, Alison continued to embrace it and spoke confidently from the AnCh. Extracts of these circumstances have not been included here as they do not demonstrate anything unique beyond what has already been illustrated.

9.16. Session 93

Chair work in this session typified the traction that Alison was sustaining in expressing authentic anger towards her parents without it being distracted by the gi-DPM or any coping mode messages:

Extract from Session 93:

Graham: Ah, so here, again, is how controlling your mother was; always telling you what to do at home. She never encouraged you to be adventurous or explore and discover things for yourself. And she never afforded you the chance to decide things for yourself.

Alison: (From the VuCh chair) Yes. That is absolutely right. She would tell me to read this book and then she would leave the room, leaving me all alone there. SHE chose the book that I had to read and would then just leave the room. She never asked me about the book. She wasn't interested at all. It was as though it was better that I was just out of sight.

Graham: I want you to stay with this image of you sitting all alone in your room, reading a book chosen for you, and recollect what that feels like. What is Little Alison feeling in this situation? (Pause) Can you see her here – you sitting all alone in the room? What do you see? And what do you feel?

Alison: (Pausing as the AnCh begins to emerge in the same seating position) Yes, I definitely can see this happening. Hmm, I was about eight or nine years old and sitting against the wall beside the window. Graham, I felt so lonely. I sometimes saw the neighbours my own age

playing outside. I could hear their laughter – see their togetherness – all having fun. And I wished that I could be there. But, yes, my mother would have said that I would have become dirty there; my shoes, my clothes. So I was CONVENIENTLY kept in my room. HER convenience, her convenience!

Graham: So, what is Little Alison feeling in this space? Be Little Alison in this situation you're describing. What are all the feelings that you have?

Alison: Oh, oh, oh. There's a lot of what I am feeling. For one, I was lonely.

Graham: Keep it in the now.

Alison: Yes, so lonely. I AM so lonely in this place. So lonely all the time. And, you know, I am also so angry; so angry that I am so unfairly left alone in situations like this. These are the two feelings, and they are both so strong.

Graham: Which is the stronger feeling right now?

Alison: My anger at the situation is actually the stronger right now. I do feel SO angry.

Graham: Okay, well, let's for now just stay with that feeling. Let's stay with your anger. You are sitting in your vulnerable (child) chair right now, so I want you to come and sit here where Angry Little Alison sits. Can you just shift to here now (Alison relocates to the AnCh chair). Okay, so I want you to just stay with the anger you feel in this place. Here you are sitting alone in your room; left alone while maybe other young children are outside playing and having fun. Your mother has left you in here reading a book that SHE has chosen for you. She's left you alone and you are expected to be okay with this. So, what are you feeling at this moment?

Alison: Oh goodness, yes, I am ANGRY. I am irritated and frustrated, but mostly just very, very angry. How can my mother keep doing this to me? It is so thoughtless! Just pushing me out of the way. This is not okay. JUST NOT OKAY! Oh, I am actually infuriated inside. Just INFURIATED! And I was not allowed to complain either. Had to always do what I was told. Do this, do that.

Graham: Yes, it makes complete sense that you feel this way. And I understand this completely. You are such a rightfully infuriated young girl. There is so much wrong with the way you are being treated here. So much.

Alison: Yes. Absolutely. And you know something, Graham? This other voice that usually tells me to not be angry is just not going to come in here now. I am not going to allow myself to be quiet about this. I DO have every right to be feeling this way, and about so much. I think that I am finally getting to understand that I am allowed to feel this way. Yes, the healthy part of me (HeAd) knows that this is right. It's not okay the way I was treated.

Graham: You are absolutely right, and I am very relieved that you are allowing yourself to feel this.

Alison: Phew, but it is so exhausting putting all of this out. And, yet, it feels right. I actually feel lighter for it. It is a relief putting this all out. Definitely.

Graham: Yes, I can actually see a calmness in your face now. It's surely been such a strain holding onto all those feelings for so many years? Not feeling safe to say how you are really feeling. I hope that you are going to continue to be true to your feelings and express yourself completely in how you are feeling. Will you allow me to support you in that?

Alison: Yes, I know that this is what I need to be doing.

This extract demonstrated, again, the value that experiential technique was providing Alison in helping her recapture the full experience of a childhood filled with sadness and anger. In this instance, with anger at the fore, the HeAd (without my prompting) consciously denied the DPM from muting the Child. Alison's continued lightness and relief at having expressed decades of suppressed anger reflects the persistence and bravery of many months of work to reach this point of fully appreciating the importance, permissibility, and safety of expressing this emotion. Again, the close proximity and mutual accessibility of the AnCh and the sad VuCh was evident, demonstrating the layering of emotion residing within the abused and neglected Child. As was often the case, I did not immediately transfer Alison from one seating position to another in the exact moment that she shifted across Child's modes for fear that either of us could be distracted from the subtle phenomenology of her shift between these two interrelated Childe states.

9.17. Session 100

Some months later, during what was the final and one hundredth session that capped the research study period, Alison was reflecting significant advances in the HeAd. This, in turn, enabled the more frequent emergence of an increasingly prominent authentic and contented HaCh. While out on her daily walk on the promenade close to her home, she stopped for the first time at a playground which was filled with young children. There, she sat on a bench watching and listening to the laughter of toddlers and young children at play, even engaging with them occasionally. She was filled with a myriad of emotions as she reflected on the enormity of abuse, emotional deprivation, and isolation that she experienced for decades. This filled her, again, with both sadness and anger. Being far more capable of engaging with and tolerating these feelings, Alison revealed how she had become increasingly aware of how the little Child within her deserved the same opportunity for authenticity, joy, and spontaneity as any other child.

Extract from Session 100

Graham: So, what were these feelings that you were filled with while sitting there on that bench?

Alison: Oh, it filled me with so many feelings. Just looking at all those children playing in the park area, so playful and so happy. They all looked so, so happy – so different to my experiences when I was their age – when I was young.

Graham: Absolutely. Yes, such a contrast. Yes, I can only imagine how different were your experiences as a child. So, what does it fill you with when you reflect on this now?

Alison: Well, it fills me with those same familiar feelings I have felt so much; such sadness and also such anger. I had no right to be denied what those children were experiencing the other day. And, you know something, I now know that I have such a rightful reason to feel these feelings; both this anger and sadness. But, I actually feel more of a calmness inside me now. I don't really feel the need to be angry with them any longer. I think I have said it all, and I think I've expressed all the anger that there is to say. I suppose that I am now filled more with sadness for what I was denied; what I missed out on for all those years. My parents didn't seem to have a clue, did they?

Graham: I think you are right, Alison. I think they were truly clueless about how to be good parents. Would you agree that their own injuries – their many emotional injuries – is what made them incapable of seeing that what they were doing was so wrong? (Alison nods) Do you think they were aware of the damage they were doing all those years?

Alison: Oh, I think you are so right. I do not think they even knew how much wrong they were doing. They were just clueless.

Graham: Absolutely.

Alison: Anyway, you know something Graham, as much as they didn't have a clue as to what they were doing, I can now see how right you have been all along saying that I needed to be angry about the ways that they mistreated the little child in me, and all the wrongs that they did. So, it all seems so much clearer to me now that I have allowed my anger; getting it all out. And now that I have put it all out, I definitely feel more at peace inside. I really do.

Graham: Right, so you can truly see the importance of how the little child in you has needed these feelings to be validated, and even though your parents might have never really known how much they failed you – oh, and your brothers – you are justifiably angry because your needs were simply not met and you were neglected; horribly.

Alison: Yes, you are so, so right.

Graham: So, what are the feeling that you are filled with now? What still sits inside there?

Alison: Oh, well, I don't really feel the anger anymore so much. But I think my heart is still filled with sadness for everything that I missed out on. I think seeing those children all playing – with such joy on their faces – that reminds me of so much that I missed out on. I never had that kind of happiness. I was always anxious waiting for the next thing to happen.

Graham: Yes, that little Child in YOU needs and deserves to have all those playful experiences now. What is so good, Alison, is that you have a very loving husband, and Eric is a very loving son. And you have all the opportunity to now live a life filled with joy and happiness, provided those dark voices in you, like that PuPa and the AnOv, don't get in the way of the little child part of you that is starting to come to life; really blossoming..

While therapy proceeded beyond the one hundred therapy sessions that comprised the research study, this extract from the 100th therapy session reflected the typical growth and maturity that Alison had achieved in not only recognizing the enormity of parental abuse she faced, but also the importance of having acknowledged and expressed her anger and sadness in order to bring her to fuller resolution. There was no evidence of a mode that threatened the Child from engaging in a fully emotional way. It was, again, evident how now that the secondary emotion of the AnCh had been expressed, the primary emotion of sadness in the VuCh was able to move into prominence; a process of grieving becoming the important focus. It was valuable that I reminded her of the loving family she now had; something in strong contrast to the childhood environment she was trapped in. Equally important was it that she appreciated that the self-defeating modes that threatened the Child were the only remaining and significant threats in her now, otherwise, world. Absolute liberation for the Child would only be possible once these modes were thoroughly dismantled or banished. This extract was one of many that exemplified what was becoming a consistent picture of Alison's now consolidated and increasingly secure HeAd/HaCh dyad.

9.18. Summary

At the outset of therapy, Alison's first permissible expression of anger was of self-condemnation rooted in the PuPa mode, but now a Child turning on herself. However, it was not long before the AnCh emerged. Even in the first session, Alison was willing to adopt the AnCh position, but the formidable impact of the religiously influenced gi-DPM forbidding such emotional expression towards her parents resulted in an almost immediate and reflexive muting of the AnCh. Despite the muting impact of the DPM remaining prominent, Alison was still able to access anger more regularly, albeit more confidently from the HeAd perspective, given that this parent mode held a more authoritative and confident disposition than the AnCh. The AnCh was more susceptible to feeling that anger was impermissible due to the guilt-inducing nature of the DPM, or too risky to express for fear of it spiralling out of control. The influence of the DPM forbidding condemnation of her parents also made Alison's earlier expressions of anger more permissible at an intrapersonal level, whether expressed towards the AnOv coping mode or the introject of her mother that was the DPM. With repeated banishment of the DPMs (sourced in her parents and a strict Catholic code), however, Alison's HeAd was eventually able to express anger towards the source of these parent mode introjections; her extremely abusive mother and father.

As the HeAd steadily grew in confidence expressing this previously forbidden emotion, so it created a safer platform for the AnCh to eventually enter the arena to condemn her parents for decades of abuse. A marked breakthrough was achieved when Alison's AnCh was able to confront me and my colleagues, albeit within the context of contaminated influence of the eating disorder. Despite the context, the bravery of this outward expression of anger was a significant breakthrough. Not only was it normalising this immensely inhibited emotion, but Alison was now provided with an environment that felt safe enough to express her anger. It took some sessions before Alison was able to fully appreciate that the anger associated with the AnOv was not authentic anger emanating from the AnCh, but coping anger embedded in the composite AnOv that served to threaten anyone that challenged the eating disorder's dominant status. This was a very important process, given that the initial anger triggered by the team members' position of authority echoed the autonomy denied her by her mother throughout her youth. But, once this anger was associated with the AnOv and no longer serving the legitimate needs and rights of the Child, it was serving as a coping anger. It was vitally important that this was not encouraged in the therapy but, to the contrary, identified as compromising the Child no differently to the manner in which the preceding CoSu compromised the needs of the Child.

While imagery rescripting was providing an effective experiential tool in therapy, it was chair work that provided a potent arena to promote angry expression, often culminating in the AnCh admonishing her parents for the abuse they committed. Arntz and Jacob's (2013) point to the efficacy of chair work as a technique that serves to draw the Child into appropriate angry expression. Not only did this experiential tool allow me to facilitate and spontaneously participate in chair dialogues, but the specifically designated physical spaces for each mode provided Alison with

the clarity to distinguish between modes. In this way, Alison was able to better appreciate the unfolding of complex mode sequences and identify the significant modes involved in the expression or inhibition of anger. With me often sitting beside her in support, the HeAd was a vital and steadily developing component that fought to endorse anger and also reassure the AnCh that such anger would not unravel uncontrollably to create chaos.

Another important development in the emergence of the AnCh was the revelation of how closely associated were the AnCh and another face of the Child; the VuCh. This dyad demonstrated the manner by which closer engagement with the one child mode facilitated a closer engagement with the other. Not only did this engagement with the AnCh facilitate in the VuCh a deeper appreciation for the abuse she faced, but so was the converse true that a deeper connection with the VuCh evoked stronger anger in the Child. It demonstrated how anger and sadness each served as primary and secondary emotions to the other, and how inseparable are Alison's two prominent child modes. As convenient as it is in ST conceptualisation to have distinct modes to identify the different faces of the Child, we should never forget their close association; the many faces of the Child.

Through the complex sequences whereby Alison flipped between modes, even one of the many roles of the AnOv was revealed to be an inhibiter of anger. This was revealed thorough emotion focused work in which vivid images of her anger and its inhibiting components assisted both of us to more clearly understand the complex and subtle processes at work. Such imagery work served as a very valuable medium in identifying Alison's anger and its inhibiting forces, and broadened our understanding of this important element in the therapy. It was through such experiential work that even an EnCh emerged.

It was only in the latter part of the one hundred sessions that the AnCh was able to express authentic and well-directed anger without undue interference from the DPMs or coping behaviour. While Alison did access anger very early in the therapy, it was only with the painstaking dual process of building the HeAd and repeatedly interrupting the DPMs and coping behaviour that she was eventually able to sustain expression from the AnCh towards her parents. Even her fear that the anger could spiral out of control was eventually dismissed as she came to realise that her authentic expression of anger inevitably dissipated to a state of calm, once released.

Even beyond the one hundred sessions, ongoing therapy indicated the need to deepen this necessary and difficult process of normalising and exhausting the Child's anger; an important component in building an authentic HaCh mode and consolidating its engagement with a sturdy and protective HeAd.

CHAPTER 10: IDENTIFYING AND DISMANTLING THE ANOREXIC OVERCONTROLLER

Is there a place on the schema mode map for an eating disorder-specific coping mode; the Anorexic Overcontroller?

The vast majority of therapists will have experienced their patients talking spontaneously of an “anorexic voice”. Some authors have made specific reference to the AN as a separate and external force, be it a “friend or foe”, their “guardian” (Serpell, Treasure, Teasdale & Sullivan, 1999) or the “anorexic minx” (Treasure, 1997). However, some researchers have discouraged the externalisation of anorexic features (Wright & Hacking, 2012) with concerns of a reduced willingness to engage in treatment, apprehension at being required to overpower an external entity, the denial of emotional experiences being attributed to an “other”, or a reluctance to engage with a construct developed by the therapist rather than by themselves (Pugh, 2016; Vitousek, 2005). However, there exists broad empirical evidence to suggest that such concerns are overstated and that externalisation interventions and techniques that encourage an engagement with such voices have proven very effective and empowering in the treatment of other conditions such as depression, anxiety, and even psychosis (Chadwick, 2003; Corstens, Longden, & May, 2011; Greenberg & Watson, 1998, 2001).

Bruch (1978) was the first to describe AN as having an internal critical voice, with a growing body of research suggesting that conceptualising AN as an internal rather than external voice provides a more valuable route for clinicians, especially where it is indicated that more than 90 percent of sufferers describe the experience of an internal anorexic voice which is distinguishable from more typical self-critical cognitions (Noordenbos, Aliakbari, & Campbell, 2014; Tierney & Fox, 2010; Williams & Reid, 2012). Such an internal voice typically emerges during the onset of the illness and, besides serving to block distressing emotions (Dolhanty & Greenberg, 2007; Tierney & Fox, 2010), is more often described as having a benign presence that fulfils positive functions by way of guidance and reassurance. As the illness advances, however, the voice typically becomes more hostile and abusive in the way that it attacks the sufferer’s self-esteem and demands an increased vigilance to strict food rules which manifests as increasingly destructive eating behaviour. Others have noticed how sufferers feel increasingly entrapped and become submissive to their anorexic voice as the illness advances (Tierney & Fox, 2010; Williams & Reid, 2012), only to eventually experience a lost sense of self and complete powerlessness to their anorexic voice (Higbed & Fox, 2010; Williams, King, & Fox, 2016). Elaborated on earlier in section 3.2.4. of Chapter 3, Oldershaw et al. (2019) also describe AN arising out of a “lost sense of emotional self” proposing the use of experiential techniques in Emotion-Focused Therapy and ST to access primary emotions underlying AN. They explain how AN dismantles an individual’s identity which is rooted in emotion, thus, deeming the sense of self “lost”. Pugh (2016) also explains the high level of resistance to treatment for individuals with AN due to the entrapment and an attachment to the powerfully held pro-illness beliefs of their internal anorexic voice, especially when such internal hostility is experienced in treatment that emphasises the need for change (e.g., CBT). Others have noted that the deeply

entrenched internal anorexic voice also accounts for the high frequency of relapse amongst AN sufferers (Fox, Federici, & Power, 2012a). While research points to the centrality of an internal anorexic voice for the vast majority of sufferers (Rawal, Park, Enayati, & Williams, 2009; Williams et al., 2016), so clinicians have become increasingly invested in better understanding the nature of this internal voice (Davies, 2008) calling for tools like imagery, for instance, to achieve better outcomes with this challenging patient population (Dolhanty & Greenberg, 2009; Mountford & Waller, 2006). Conceptualising the illness as having an internal critical voice provides clinicians with a unique opportunity to "stand shoulder-to-shoulder with sufferers against an aspect of their illness" (Pugh, 2016, p.77). This is why Forsén Mantilla, Clinton and Birgegård (2018) support the growing body of work of promising new treatment that recognises the value of clinicians conceptualising the EDs as an insidious dyadic internal relationship whereby an internal voice of health and nurturance (synonymous with the ST concept of the HeAd) needs to resist and challenge the ED.

This observation of an internal anorexic voice being countered by a healthy internal voice suggests how the multiplicity of voices that characterises the schema mode model can be a particularly relevant platform upon which to engage in treating these disorders. By suggesting imagery to identify maladaptive restrictive thoughts within a distinct "restrictive schema mode", Mountford and Waller (2006, p.533) appear to be the first to conceptualise AN as a distinct and specialist schema mode; a specific part of an individual's personality structure separated from other self-critical cognitions. More recently, Hodge and Simpson (2016) demonstrate how, through drawings, ST provides a pathway for patients to identify their ED as an entity amidst emotional states that are less accessible via verbal dialogue. Where Cruzat-Mandich et al. (2015, p.5) identify an "anorexic identity" as a means of dissociating, Hodge and Simpson (2016, p.5) speak of a "substitute identity" that instils a sense of control and certainty in the wake of a childhood filled with abuse and unpredictability. In her earlier conceptualisation of a patient with AN, Simpson (2012) described a similar mode, but categorized it as a PeOv mode. More recently she describes a distinct "Overcontroller" mode that carries dietary rules and regulations to comprehensively disconnect the Child from emotional discomfort, while also instilling a sense of power and control (Simpson, 2020). Prior to this, Edwards (2017b;2020) had already published a case study to illustrate the need for a distinct and highly specialised overcompensatory coping mode with ED-specific features; the Anorexic Overcontroller (AnOv). It is this ST conceptualisation of AN as a distinct stand-alone coping mode that I have adopted as a clinician and used in my research cases and broader private practice.

Prominently positioned in Alison's mode map is an overcompensatory Anorexic Overcontroller. While common to all AN sufferers is a hypervigilant adherence to a stringent set of dietary rules and, for some, additional compensatory behaviours to ensure weight loss or low weight maintenance, this specialised coping mode is best thought of as multidimensional in nature and varying in its strength, profile, and functions between individuals. Behind Alison's manifest preoccupation with food, weight, and shape, the unfolding therapy process revealed the

composite nature of her AnOv; the identification of several behavioural and cognitive components of the mode which serve various functions to avoid the emotional distress residing in the VuCh.

While Alison's AN only manifested in her early twenties, it emerged from existing childhood obsessive and perfectionistic qualities that developed in order to negotiate her mother's strict demands and to avoid condemnation, scolding, and shaming in an uncertain and unstable home environment. During her traumatic childhood, she developed strong Defectiveness/Shame and Failure EMSs and subsequent secondary EMSs in the form of Subjugation, Self-Sacrifice, and Unrelenting Standards EMSs. While the CoSu and the overcompensatory ObOv and PeOv coping modes were evident on Alison's mode map in her childhood and adolescent years, it was with the crisis of her father's death that the ED-specific features of the AnOv began to manifest. The loss of appetite that immediately followed her father's death led to significant weight loss which was noticed and commented upon by work colleagues. It was this heightened attention and concern from colleagues and acquaintances about her thin physical appearance that motivated the development of a new, highly specialised, and composite overcompensatory coping mode that mimicked the provision of needs that were never met throughout her childhood and adolescence.

Although Alison never resorted to compensatory weight loss behaviour like exercise, laxative abuse, or appetite suppressants, her ED manifested through a set of strict food and eating rules to ensure significant and rapid weight loss and the subsequent sustained emaciated state. At the outset of Alison's AN, she deliberately limited the amount of food that she consumed and ensured that her intake resulted in steady weight loss. She did not allow herself to consume snacks and she kept meal sizes to a minimum. Although she was never a "calorie counter", she refrained from eating all typically high calorie foods, especially those with a high refined carbohydrate and fat content. She was conscious of always needing to feel that she had an "empty stomach"; this being a cue that she was not over-consuming or "indulging" herself. While she was never aiming for a specific goal weight, she kept insisting on "losing another kilogram" in an attempt to eventually reach a suitable and desired weight. Of course, like many AN suffers, a desired weight would never be reached; a vicious cycle being created in which another kilogram would always need to be lost. Her lowest weight of 32 kilograms at the age of 31 years equated to a body mass index of 11.6, placing her significantly below the "extreme" severity level of AN outlined in the DSM-5 (APA, 2013). It was at this time that she was hospitalised for a year in a state facility.

Another important aspect of Alison's AnOv was its ability to recruit other modes. While I have already mentioned that her AnOv included the qualities of her existing perfectionistic and obsessive nature, The AnOv also co-opted or recruited the AnCh and the DPM in order to protect and consolidate its position on Alison's mode map. The AnCh was recruited as a protection, while the DPM was reflected upon in commentary pertaining to her physical appearance; a voice that was highly critical, demanding, condemning, humiliating and shaming. Provided this commentary was active, she felt assured that she would remain firmly committed to the food and weight rules,

thus, ensuring that she would never become relaxed or complacent about maintaining a strict and rigid control over her eating and weight. This was evident throughout much of the therapy by the many references to a body that was viewed with distain, revulsion and hatred. Evidence of her severely distorted body image was exposed in chair work, where the ferociously critical commentary of the AnOv condemned the Child's appearance as wholly unacceptable.

Alison described her AnOv coping mode as having a distinct identity and appearance. While this is elaborated later in an extract of chair work from S22, she provided a vivid image of the AnOv sitting in the chair oppose her. "It's a grotesque, a vile and ugly creature. It has long, extended arms with sharp claws for hands trying to grip hold of me; pulling at me," she explained with the fragile voice of her VuCh. With this figure wearing a "big, black unsightly cloak", she explained that it was "an ugly witch; the devil in disguise". It would have been useful for me to have requested Alison to provide a drawing of this vivid image of her AnOv as a homework task. As an adjunct to her already useful description, as the saying goes: "A picture is worth a thousand words".

10.1 Functions of Alison's Anorexic Overcontroller

Before providing select extracts from the therapy to chronologically demonstrate the course of therapy and the techniques and methods used to neutralise this central coping mode, I will outline the various functions that Alison's AnOv fulfilled. Such functions were already recognised as an important feature of the assessment of AN outlined by David Garner more than three decades ago (Garner & Garfinkel, 1997), and they were vigorously elaborated upon in Simpson's recently published book on ST for EDs (Simpson, 2019). Some of the functions outlined below are almost universally common amongst all AN sufferers, but some are less common and reflect the impact of specific life injuries that Alison experienced prior to the development of the ED.

10.1.1. Numbing Emotion Pain

The first of these, and an important function of the AnOv identified early in the therapy, was its purpose to numb and avoid emotional pain, especially where it protected her from feeling the anguish associated with traumatic childhood experiences. This was first evident in S2, where she recognised that her starvation served a function akin to the numbing effect of her father's alcohol abuse to eradicate memory of his traumatic wartime experiences. During S51 in which Alison was grieving the loss of her childhood and feeling the pain of a myriad of childhood experiences, she reflexively distracted from this process and completely out of context requested that we rather "talk about food and weight". It was evident that she needed to distract from the pain and address a theme that, albeit relevant, was out of context to the anguish she was feeling at that moment. It demonstrated how the food and weight theme served as a reflexive button to push when she felt emotionally uncomfortable about anything. While S100 reflected on the significant progress Alison had made over the course of her therapy, we recounted the significance with which the AnOv had served to shield her from emotion associated with the severe trauma and

emotional deprivation of her childhood. However, by now she had come to more consistently realise that such blunting had the contradictory effect of denying her the corrective experiences that her marriage could have provided for decades and the quality of life that she sacrificed in order to be "protected" by her ED.

10.1.2. Insulation from Everyday Life

A second function of the AnOv was identified as its ability to protect or insulate her from the pain of everyday life. This was well illustrated in S48 when Alison's VuCh felt extremely unworthy and undeserving of the loving attention she received during her birthday party earlier that week. The party reminded her of the many instances during her childhood in which she was expected to behave perfectly in adult company; to be quiet and, yet, almost invisible in the presence of her elders. Living in a neglected and abusive home environment left her frequently feeling terrified. As such, she created for herself "a state of invisibility in order to keep out the cruelty"; an overcompensatory Protector Child (PrCh) (see section 4.2.2.) coping mode that insulated her throughout her childhood. Through expressive work, Alison was able to see how the AnOv she developed in her early twenties served as a more manifest protection from the emotional hardship frequently triggered in the VuCh. S62 further illustrated this notion when we equated the "invisible protection" created by the PrCh coping mode in her early childhood with the invisibility that the AnOv provided her in adulthood from the emotion associated with traumatic childhood experiences.

10.1.3. Comfort and Control

As early as in S3 Alison made very evident a third and very prominent function of the AnOv when she explained how her conscious restrictive eating immediately evoking a sense of "more comfort and control". This function of "control" is well described in Lawrence's (1979) classic paper "Anorexia Nervosa – The Control Paradox" – a phenomenon that is consistently regarded as central to AN. She explains that while the sufferer exerts a powerful physical control over their food and their body weight and size, there is also a moral component of control exercised through a sense of self-denial. Such physical and moral control on the part of the sufferer can also have a strong controlling effect on others around them. Paradoxically, the sufferer also has a profound experience of being out of control at two levels. Although they are terrified of becoming physically fat, there is another more moral component that has them fearful of becoming "gluttonous and debased" (Lawrence, 1979, p.93); something that Alison alluded to quite frequently. Lawrence (1979) goes on to explain that when anorexics talk about "control", they likely mean the power with which to regulate, command, and govern their lives and actions. When this dance of engaging outwardly with the world on their own terms inevitably fails, an internal battleground is created; "a battle fought within the individual rather than between the individual and the world' (Lawrence, 1979, p.93). Of course, for the schema therapist, this equates to the internal battlefield between a constellation of modes, where the AnOv, as an overcompensatory coping mode, makes vast and magical promises to the Child. The paradox lies in the attempt of the sufferer to control the world around them, only to be diagnosed with a

condition that inevitably denies autonomy self-determination. This was frequently evident in Alison's attempts to persuade the treatment team to grant her control of her own eating habits instead of trusting and remaining accountable to a prescribed meal plan. While Orbach's (2016) thesis in "Fat is a Feminist Issue" explains weight control in AN within the socio-political battle whereby women have been denied self-determination in a paternalistically-dominated culture, it was Bruch (1978) who was first to point out the centrality of "control" in this illness. She explained how not far beneath the perfectly-controlled outer veneer laid terrifying feelings of a lack of control and a paralysing ineffectiveness residing within the sufferer. Even though Alison's rigid control of food was largely expressed within the physical domain, for her it was predominantly, as Lawrence (1979, p.95) describes it, "a kind of asceticism", frequently insist that "self-denial is a good thing"; an indicator of moral worth. This was significantly influenced by the religious code as she often made reference to the notion of "mortification"; that it was her Catholic duty to be self-denying in order to demonstrate control and discipline. Even though Alison acknowledged the illusory nature of such control early in the therapy, it did not cease her frequently reflexive response to temper distress and create a sense of control through her manipulation of the meal plan. S42 illustrated how the AnOv served its role as a means of eliciting control across a broad theme base. While reflecting on her experiences of newfound pleasure, including greater intimacy with her husband, her urge to engage in AnOv behaviour demonstrated her need to interrupt such pleasurable spontaneity. The appeal of the AnOv was also evident during chair work in S46 in demonstrating how restrictively controlled eating was strongly associated with a more generalised sense of control and order in dampening the distress residing in the Child. Not only was the AnOv serving as a protective bubble of control, but actually creating a sense of mastery and control: "But I was enjoying being in control. Yes, I enjoyed it, and I am going to continue to enjoy taking control of my life and my eating habits," she explained. During S60, Alison revealed the manner in which the HeAd was actually contaminated by the AnOv when she tried to rationalise that the role of the former was to "assume control" of the VuCh through restricted eating: "Yes, as long as I keep the eating down, this little child is going to be in control and not frightened and intimidated. This is the way it must be!" Even in S86 Alison was tempted to shift into AnOv for fear of a lifestyle that might become filled with "over-indulgence… and gluttony" if she did not severely limit her newfound lifestyle of greater spontaneity.

10.1.4. Feeling of Power

A fourth function of the AnOv, closely associated with the sense of control that it provided, was its ability to instil a feeling of power when the VuCh was feeling fragile, threatened, or exposed. Alison revealed this during chair work in S3: "You know, it gives me power… I really feel stronger, you know, really in command of things in a powerful way. This is way more than just wanting control. It's about really being powerful and all." She said this with a faint knowing smile on her face as she reflected on the feelings evoked during the years she held firmly to her emaciated state.

10.1.5. Evading Adult Responsibilities

A fifth function of the AnOv was its ability to evade the pressure of adult responsibilities. Again, reflected in chair work, S45 revealed the manner in which Alison's AnOv served as a vehicle of avoidance; the physical withdrawal from a wholesome sense of adulthood to curb the demands of adult responsibilities. This function of the AnOv clearly reflects the psychodynamic explanation for AN outlined earlier (see section 3.2.1.); whether Crisp's (1997) description of the "flight from growth" or Bruch's (1973; 1974; 1985) description of AN evolving in the face of the struggle for separation and individuation.

10.1.6. Suppress Sexuality

The sixth, and another central function of Alison's AnOv, was the extent to which it managed to specifically suppress sexuality and her broader capacity for emotional and sexual intimacy. This was achieved through extremely critical and scathing commentary from the AnOv about her physical appearance. Not only was Alison profoundly influenced by her mother's toxic and rigid messages of self-deprivation and denial of pleasure, but she was also significantly indoctrinated by the harsh and guilt-inducing nature of a Catholic code that formed the basis of the PuPa and DePa modes. This culture of a restrictive and penitential existence that dominated therapy necessitated the presence of the AnOv to supress her sexuality not only in a physical manner, but also suppressing the emotions associated with it. Early sessions brought Alison to the startling awareness of her changing body when friends and acquaintances commented (in an affirming way) about her noticeable physical recovery. This was very emotionally triggering for the VuCh. In S21 we reflected on an incident earlier that week when her husband innocently expressed his delight at her more womanly physical body. Abruptly, the Child was triggered; terrified at being suddenly confronted by the sexuality that the AnOv had so successfully and subtly hidden for decades. Very suddenly, the intrusively critical and guilt-inducing commentary of the AnOv that had its source in her mother's religiously-based beliefs denounce her newly exposed sexual identity. As the session progressed, Alison recalled more of her mother's guilt-inducing religious references relating to her developing pubescent body; echoes such as "You are not entitled to all such physical pleasures". Chair work in S24 revealed how the AnOv not only served to smother all sexual feelings, but also to chastise her whenever she had erotic thoughts. She recognised how her emaciated state had successfully suppressed the association she had of sex being "dirty and bad". S29 reiterated this when she expressed the ambivalence of the excitement of liberating her sexuality yet feeling it necessary to condemn it. Switching into the AnOv, she explained how her "sexually inviting body is dirty and is to be hidden away", as she condemned her newfound sexual identity and felt "sickened" by sexual feelings. Alison continued to shame her emerging sexuality in S30 when she uttered: "I do not want to present this bloated, hideous body with a distended stomach, big breasts, and huge thighs to my husband." This "grotesque" nature of her feminine shape frequently led to the activation of the AnOv; commentary that condemned the VuCh and insisted on weight loss to maintain asexual in her body appearance. Over the next ten sessions, and with the

sexually suppressing effect of the AnOv being significantly lifted, chair work evoked a titanic feud in which the HeAd was required to gain ascendency over the PuPa shaming and denouncing Alison's sexual identity as "grotesque, contaminated, abominable, dirty, sick, and a disgrace". In S51 Alison was able to reflect more clearly on a mother's dismal failure as a parent:

Alison: She just kept me as a child and she made me feel that growing up was something unsightly; bodily. When I was developing, everything, even the way she looked at me, was telling me to be ashamed of my physical body developing. I felt shameful and I just needed to hide my body. This feeling, this belief, never went away.

Graham: Sure, I can see how your anorexic voice must have served a very powerful and effective purpose in keeping your feelings of being a woman – of having a sexual and sensual part of you – hidden away.

Alison: Yes, my anorexia was doing that all the time; keeping me protected from her voice in me shaming me, keeping me from my body that felt so uncomfortable. Everything about physically having a woman's body felt uncomfortable, unsafe, and so shameful. But now I can see that I do not need to hide away anymore. That is all changing now.

However, even after a year of ST in S61 with Alison's weight remained comfortably within the lower end of her goal weight range, the AnOv (in this instance masquerading as HeAd) was activated as a means of suppressing vulnerability associated with her sexuality:

Alison: I have a distended, bloated, and undesirable stomach that is out of proportion, and I think that I should actually lose weight.

Graham: Okay. So, tell me Alison, which mode is insisting these things and thinks it's such a good idea to now lose weight?

Alison: It's my healthy adult that says this. I think if I went to a doctor they would say I am three months pregnant with the way that I look.

Graham: Oh, okay? So, this is HeAd talking? HeAd is actually saying these things about your appearance and thinks that it would be a good idea for you to lose weight now, even though you are now just only inside your goal weight range?

Alison: My HeAd says that I am too distended and the HeAd knows what she wants in having a healthy-looking body. Well, um, until my stomach is, at least, flatter.

The link between sexual abuse and the subsequent development of an ED was thoroughly outlined earlier (see 2.7.3d). And while there is no confirmed evidence of Alison having ever been sexually violated in a physical manner, the immense guilt and shame imposed by her mother both during and following her sexual development constituted a devastating abuse that prompted the development of the AnOv in providing what Lawrence (1979, p.96) calls "a blanket of safety". It is no wonder that Alison associated her body with defilement and badness, making AN a "logical strategy for denying this defilement and rising above it" (Lawrence, 1979, p.96).

10.1.7. Self-punishment

A seventh function of Alison's AnOv was its capacity to inflict punishment, thus providing absolution from her perceived characterological shortcomings or "sinful ways", as she often described it. The desire to be punished and

"cleansed" through starvation prompted discussion in therapy of the "fasting saints" of the late Middle Ages, where Saint Catherine of Siena is the most documented case of "anorexia mirabalis" (Bell, 1985). In S43, for instance, Alison recognised her strongly religiously based urge to restrict as a "penance" for her perceived failure as a parent to Eric when she said: "Yes, mortification is the only way to absolve me of my wrongs. I can see my anorexia did this." And, again, in S51 she realised how her restrictive eating reflected her mother's religious ideals. This was reiterated the following month during chair work in S56, where the AnOv was revealed as the means by which the "unlovable" Child should be punished: "This Child needs to be punished at times! Be punished! Be punished! You are not worthy of any love… you are in the way and you are an absolute hindrance. You need to disappear, you take up space, you are just a nobody, and you are not wanted." Here is where a means of punishing Alison, having a physically small and unobtrusive anorexic state, condemned her to be removed or distanced from her disapproving and judging parents. More than once, Alison indicated that her starvation served as a punishment for the hindrance she was made to feel to her parents. Having been raised within a very strict Catholic belief system, her decades of starvation served as an ideal means of expressing her strong religious notion for penance and mortification. This is reflected in the substantial literature that reflects the family profile of AN sufferers often demanding that especially females be sensitive, devoted, and self-sacrificing. For instance, studies by Becker, Körner, and Stöffler (1981), Dare (1985), and Bridges and Spilka (1992) all observed that a high proportion of families with an AN sufferer are not only sexually repressed, but are usually dominated by one parent who dictates the religious values of asceticism and inner-directed hostility. Andrews (1997) highlights how these devout religious values inevitably account for such deep feelings of shame amongst anorexia sufferers.

The ego-syntonic nature of this drive for self-punishment differentiates it from the unwanted and threatening critical, punitive, and demanding commentary associated with the DPMs. However, these defining qualities of the DPM were essentially recruited or co-opted by Alison's AnOv and incorporated into its broad and complex design. While I conceptualise self-punishment as a component of the AnOv, this is synonymous with Simpson's (2019) description of the Flagellating Overcontroller (FlOv) mode; a separate mode that she sees frequently occupies a position in the mode map of AN sufferers. Simpson (2019) explains how this coping mode serves as a "foot soldier" to the Inner Critic (DPM); essentially the AnCh directing anger inwards to provide temporary relief. As Alison would often say: "If I am punished, I feel better"; such self-inflicted punishment providing redemption for feelings such as guilt and shame. Simpson (2019) explains how the FlOv manifests through self-denial whereby the sufferer needs to deprive herself of anything that may provide pleasure, whether food, pleasure, or sex. This is reflected in Alison's strict Catholic upbringing that instilled a strictly penitential and repentant existence, and where self-punishment through the AnOv that echoed the fasting Holy Saints of the Middle Ages fulfilled the expected code of conduct. It is, thus, clear that Alison's restrictive eating certainly reiterates Simpson's (2019) assertion that the FlOv serves as "martyrdom"; starvation as a flagellation to make Alison (temporarily) feel more acceptable.

10.1.8. Attention, Recognition, and Identity

The eighth function identified of the AnOv was its purpose of drawing attention, gaining recognition, and providing a sense of identity for an otherwise fragile, inadequate, and invisible Lonely Child. This was illustrated during S62 in an instance where Alison flipped back into AnOv in the face of some minor weight gain that week. She realised that her emaciated body elicited attention and recognition, and provided her with a sense of identity that made her feel important and accomplishing something in her empty life. She realised that her ED provided correction for a childhood in which she felt invisible and forgotten. The study by Tan, Hope, and Stewart (2003) describes the "ego-syntonicity" that is typical amongst most AN sufferers when they describe their illness as "being a part of themselves or of their identity" (p.537). It is this sense of identity that defines them or gives them a sense of personhood instead of being shunned or forgotten by others.

10.2. A Specific Coping Mode for Anorexia Nervosa

These eight distinct functions that Alison's ED fulfilled served the purpose of avoiding the myriad of emotions triggered in the Child. Stated differently, each time one of her EMSs was activated, her AN served to numb, suppress, evade, or insulate her from feelings such as guilt, shame, and defectiveness. When not serving to avoid schema activation Alison's AN worked in an overcompensatory way to instil feelings of power and control or providing her with special attention that cast a blind spot over her belief that she was defective, weak, chaotic, or unworthy. Of course, all of these functions never created legitimate repair. They were a means of coping with her pain where nothing internally or externally healthy existed to provide genuine relief. When Alison engaged in disordered eating behaviour, rather than feeling legitimately protected, empowered, or valued, she was merely creating an illusory world where the nett effect of starvation actually disempowered her further and threw her life into deeper turmoil and isolation. This led to the re-activation of EMSs and the creation of a self-perpetuating vicious circle, whereby the ED was maintained and her ED identity reinforced. What I have described above is a coping mode; a mode that copes with decades of unresolved trauma and neglect.

I find it useful to conceptualise Alison's AN in the same manner as did Edwards (2017b) in his naturalistic case-study of Linda, whose AN also served multiple functions to evade her emotional pain. Edwards (2017b) aptly describes this distinct, highly specialised and composite overcompensatory coping mode, labelling it the "Anorexic Overcontroller" (AnOv). Similar to Alison, Edwards' (2017b) Linda evolved out of an existing Perfectionistic Overcontroller (PeOv), but the AnOv holding a specialised focus on diet, weight, shape, and body-image. It is a complex and composite coping mode; a coherent system that incorporates several distinct elements that all work together as a whole (Edwards, 2017b, 2019). While it is essential to have identified the myriad of functions that Alison's AnOv fulfilled, it is also valuable to understand that it also evolved out of existing modes. Qualities of the DPM were recruited by the AnOv into its design, evident in the frequently self-punitive, critical, and strictly

demanding commentary that insisted on a severely restrictive intake of food and commentary that frequently criticised her physical appearance as unacceptable and shameful. As already mentioned, the AnOv not only emerged out of a pre-existing PeOv, but its function reflected the purpose other pre-existing coping modes have served in Alison's need to suppress the pain associated with her EMS. Whether to numb pain, insulate her from threat, evade perceived difficult adult tasks and responsibilities, or to suppress her sexuality, it is clear that the AnOv's strive for starving and the starvation state is synonymous with avoiding coping modes like the Detached Protector (DePr) and Avoidant Protector (AvPr), both of which were coping modes that pre-existed the AnOv. There was no evidence of coping modes preceding the AnOv seeking to evoke feelings of power, comfort and control, and to elicit special attention. Here is where activation of the AnOv was a novel source of overcompensatory coping to deal with emotional pain at an EMS level. While already outlined above, I conceptualised Alison's self-punishment as a component of the AnOv rather than being a separate mode such as Simpson's (2019) FlOv that often co-exists on the mode map of the AN sufferer. My reason for this is that Alison has not displayed ego-syntonic self-imposed punishment in any form other than through her ED. Whether, as Simpson (2019) asserts, this self-imposed punishment is seen as anger of the Child turned inward, or as the recruitment of the destructive qualities of the DPM to immediately relieve the Child's distress and pain, this component of the AnOv further demonstrated the highly complex and composite architecture of this ED-specific coping mode. Amongst others, both Edwards (2019) and Simpson (2019) remind us how ST is perfectly suited to addressing the intricate and deeply ingrained automatic patterns of such mode activity.

10.3. Chronological Account of Tracking and Dismantling the Anorexic Overcontroller

I have already outlined the manner in which Alison's AnOv evolved out of existing modes and the many functions that it served to hinder the Child being exposed to EMS injury. What follows is a chronological account of the 100 ST sessions designated for the study in which the AnOv was conceptualised and incorporated into the mode map. Once Alison understood the AnOv to be a "valued" part of her personality that bypassed or provided immediate relief from emotional pain, the task of therapy was to educate her to its paradoxical nature, given that it's presence, like any coping mode, essentially preserved the deep EMS-rooted pain. Where this also prevented authentic healing and growth in the VuCh, my task was not only to reparent the child through a deeply authentic emotional connection, but to help cultivate sufficient HeAd in her to nurture and guide the Child. Select extracts from therapy will demonstrate how ST is ideally suited to fulfil these therapeutic tasks. Not only is this because the AnOv is clearly and concisely conceptualised in the ST model, but because this treatment relies less on cognitive insight to spur change but engages at a deeper emotional level where emotion-focused techniques ensure deep schema healing.

10.3.1. Session 2

Early in the therapy Alison had already recognised one of the pivotal functions of the AnOv; that of numbing the pain associated with her own traumatic childhood relationships. Psychoeducation assisted her in understanding that her father's own alcoholism served as a Detached Self-Soothing Protector (DeSS) to dampen the traumas associated with his prisoner-of-war experiences during WW2. She acknowledged that the AnOv served a similar purpose in numbing her to the persistent effects of a childhood filled with neglect and abuse:

Extract from Session 2:

Graham: So, you see, Alison, I think that your father's drinking problem didn't just pop out of nowhere. From what you are telling me about his dreadful times in the concentration camp in Italy, I think it must have been very traumatic for him. There must have been so much uncertainty in his world at the time, and no contact with the outside world or anyone back home. Just dreadful. And there must have been such neglect with little food and cold conditions in the winter. And I am sure that some of those held captive must have also got very ill and, surely, some would have died. (Alison nods) Just awful. So, does it make sense to you that when he returned from the war that he hit the bottle to, well, drown his sorrow – his pain and trauma? (Alison nods) I very much doubt that there would have been professional help for soldiers that returned. So, there would have been so much unresolved pain. (Pause) What do you think the drinking did to him?

Alison: Well, first I want to say that I think that you are probably spot on about the situation that he faced. But when he drank he just went into his own little world. Oh, sometimes he was loud and sometimes he did not even know what he was doing. But most of the time, he would just be quiet. Sitting there in his chair half asleep all the time and in his own world completely separate from all of us.

Graham: Yes, and of course, that says something about him being so absent from playing any sort of decent role as a father or as a husband. But I think he was not only separate from all of you in the family, I think he was also disconnected in himself. He was not even connecting in himself. Does that make sense? (Alison nods in agreement) We have already spoken about coping modes that serve the purpose of taking the Child away from pain and anguish. Right? All the coping modes serve to avoid pain and despair sitting in the Child part of us. We have spoken about surrender coping modes, avoidance modes, and overcompensation coping modes. And in different ways they all serve to keep the Child away from feeling pain or discomfort. So, there is this one avoidant coping mode called the Detached Self-Soother coping mode. It's quite a mouthful, but as the name implies, using something to sooth away the pain and discomfort creates an immediate relief, or even prevents the pain ever building up. So, where alcoholism is mostly described as an addiction, in schema therapy we are really more interested in describing behaviour and illness and conditions through this interplay of modes. How something triggers the Child and then coping kicks in to stop that threat to the Child. Does that make sense?

Alison: Oh, yes, it makes complete sense to me. I think it is very clever the way that his drinking problem – oh, let's call it alcoholism – was his way of trying to keep away the war memories. Just blot them out. And it is a child part of him and a coping part all in the moment, right?

Graham: Well, absolutely. Just as we have a mode map for you right here (I point to it on the table), so your father would have his own child modes and his coping modes, and there would have been a parent mode voice echoing things that he learned early in his life that put him under pressure or made him feel bad or unsafe in some way. So, yes, you are right. And his drinking problem would have been this coping mode – this DeSS – that kept him numb from war experiences. But the self-soothing would have also maybe kept him from other miserable life experiences. From what you have told me about your mother, I think it is likely that alcohol kept your father from feeling your mother's own coldness and emotional absence. He had many reasons to drink himself into a numb and disconnected state. But you know something, Alison, I want you to know that I do not judge your father for being a drinker. It's not my place to judge him as a whole. He drank to stay away from pain. So, it's not for me to judge his way of coping. But here's the important part; I do have strong feelings about his drinking

keeping him away from being a good and loving father to you. And I do think that it is terrible that you had to be exposed to his loud and sometimes not okay behaviour. That was not alright. No child should be exposed to that. And for that I am angry and sad for what you experienced and what you missed out on in not having your even basic needs being met. That's pain that you have inherited because your father never made things right. And that pain in you still needs healing. Alison, I'm saying quite a lot here. Do you get all of what I am saying?

Alison: Oh yes, thank you. You explain it all so well. Yes, I don't want to be angry with my father. But you are right that his drinking did cause a tremendous amount of pain and anguish. Always having to watch out for what was going to happen next.

Graham: Yes, okay. So, you understand that I am not judging your father for his coping behaviour, but we do need to see what this did to you and what impact it had on the family. Nothing makes it okay that he drank like that. And we need to work through all the anguish that his drinking had on you, because it partly explains why your most basic needs were never met. That's the hard work we have ahead of us. Okay, but what I also want to really say to you now is this. Can we look at your mode map here and see if there is something that you have on the map that is similar, well, kind of serving a similar purpose to your father's soothing drinking problem? What part of you deals with your pain; your emotional pain from the past?

Alison: Oh, so let me look there. Of course, I have never been much for alcohol. I think that my father's drinking ensured that I would never step into that direction. But, let me see. (There's a silent pause as she surveys her mode map)

Graham: Yes, you do not have a DeSS coping mode because you never use substances to numb your pain. But is there a mode in here that might, similar to what alcohol did for your father, might keep you numb from pain?

Alison: Well, I'm guessing that the one that really stands out for me is this Anorexic Overcontroller one. Is that right? Did I choose the correct one?

Graham: Yes, I think you are absolutely right. I think you are getting a really good understanding of these different modes. So, yes, I think your anorexia has helped to keep you numb and disconnected inside from all the pain you went through in your childhood. It's all stored up in there, and locked away; blunted. Does that make sense to you? I mean, does that resonate with you?

Alison: Oh, yes, that absolutely makes sense to me. That sounds quite right.

Graham: And, Alison, just as I was saying that it's not my place to judge your father for having his soothing coping mode, I want you to know that I do not judge you for having your AnOv either. I don't want you to feel guilty or ashamed about having an eating disorder. It's the only way that you could think of when you were in your early twenties to blot out all that childhood pain. You see, it served its purpose doing that numbing, and maybe we will see that your AnOv served some other purposes as well. But I'm not judging you for this. It's so important you know this. However, we DO need to look at the effect that this AnOv is having on the little child in you; the VuCh mode over here (referring to the mode map). Do you get what I am saying?

Alison: Well, yes, I hear you. But I think that my eating disorder has caused immense anguish for Mike and Eric …

By my elaborating on her father's coping through alcohol, I had chosen a less personal and, hence, less threatening arena to elaborate on the function of coping behaviour. By generalising coping behaviour beyond Alison's own mode map, I had hoped to normalise it. In the same way that I explained that I was not judging her father for his use of coping behaviour, Alison was amenable to identifying how her own anorexic coping served a similar function of numbing away decades of childhood trauma. Her guilt for the impact her ED had on others was a theme that

would require further work throughout the therapy, but it was important that I set the stance early on that it was not worthy of being judged. This understanding of her AnOv serving to numb extensive childhood trauma provided an opportunity for us to both appreciate the extent of childhood trauma she faced for decades. As such, I invited her to choose one standout painful childhood memory that provided the theme for the first and a very valuable piece of imagery rescripting that remained the focus for the remainder of the session.

10.3.2. Session 3

The next session immediately revealed the functions her AnOv played in creating a sense of control and power within her broader environment. It also provided an opportunity for Alison to engage in chair work, whereby the HeAd was required to confront the AnOv's influence over the Child. Extracts outlining the early part of the mode dialogue between the appropriately angry HeAd, the briefly visible AnCh, and the AnOv are documented in Chapter 8 that pertains to the development of the HeAd mode, but thereafter, we briefly explored the paradoxical role of the AnOv in the early years of her struggle with the ED:

Extract from Session 3:

Graham: So, I'd be really interested to know how it felt for you in the early years of your ED; how it felt for you in your early twenties when you were in the early battle with the AnOv. What was that time in your life like?

Alison: Well, it was a very difficult time in my life at that time. My father had died and I felt very responsible for everything going right at home. Phew, it was an exhausting time. I'm not going to lie when I say that I felt very insecure at that time. My mother was being quite dreadful at the time.

Graham: What was she doing?

Alison: Well, she was being cruel and always angry and shouting at all of us.

Graham: So she was being very abusive, especially during a time when you were all facing the crisis of your father having died and the home environment being uncertain.

Alison: Yes, you are absolutely right. To be honest, I felt very unprotected and insecure all the time.

Graham: And so, during this time, you also seemed to be more intently going into your anorexia?

Alison: Yes, that is true. Yes, I felt frightened and I had this strong urge to hold onto my anorexia. (With a slight knowing smile) You know, it gives me power. It still gives me a feeling of power having it. And I feel in control of things; everything just feels a little more in control and, yes, in control.

While, at this point in the session I could have followed this line, my priority was to pursue the VuCh who had faced enormous abuse and neglect throughout her childhood and early adult life. However, it was already evident to Alison that the AnOv had always created and continued to create a sense of power and control, albeit in an illusory

way. While this illusion would still need to be explored at a later time, its paradoxical role in her life had now been exposed.

10.3.3. Session 7

Sessions 6 and 7 reflected the strong ambivalence that Alison still experienced about relinquishing her anorexic status. While she entered S6 very proud of having achieved the goal weight assigned by her dietician, she returned the following week (S7) acknowledging that the AnOv was back with her losing weight due to deliberately excluding some snacks from her meal plan. These exclusions were precipitated by a comment made by an acquaintance at her husband's bowls club that her appearance was much improved. Although a compliment, it was clear from the written work that she brought with her to the session that it was immediately interpreted through the AnOv as a warning sign that she had gained too much weight. We explored this:

Extract from Session 7:

Graham: Okay, so it's really good that you did this cog sheet. Did you write this down as soon as you got home from the bowls club?

Alison: No, I wrote this a few days later when I realised what he had said really took me to a place where I was clouded with a black thought and I felt fat and unattractive.

Graham: Well, that's great. That's a really HeAd thing to do. And it's good that you could see that there was something unhealthy going on after you were at the bowling club. So, I think we can both agree that the event that upset you was this friend commenting on your appearance. It really triggered you. What were you feeling and what were your thoughts?

Alison: Well, I immediately felt very uncomfortable. I had this dark feeling that I was now very fat and unattractive.

Graham: Okay, so that is what you were thinking. But the feelings that you had at that moment?

Alison: Well, I just felt so uncomfortable and self-conscious. It's as though I wanted to just be away from that situation immediately.

Graham: Did you immediately leave?

Alison: No. We stayed, but I felt very disconnected for the remainder of the time that we were there.

Graham: Okay. So, which schemas do you think were triggered in the Child part of you?

Alison: Oh, I felt pretty worthless and unimportant. I felt very out of control and unsteady.

Graham: It sounds like the situation left you feeling really defective. Do you think it left you also feeling a bit alienated? Alone in the world?

Alison: Yes, I think you are right.

Graham: Right. So, do you see which modes are in the picture here? If we look at the different parts of you that entered into conversation, who was there?

Alison: Well, I was definitely hearing that Critical Parent voice saying that I am unacceptable and unworthy. That was the first thought I had at the (bowls) club.

Graham: And the Child?

Alison: Oh yes, the child part of me felt worthless and unimportant. And I felt that I was not acceptable. I could hear this voice inside me saying that I was unacceptable and that I was not alright as I was.

Graham: And this is the Critical Parent saying these horrible things? Is this a new or old belief?

Alison: Oh, it's a belief that I have held inside me all my life. It went way beyond the comment about my appearance. I know now that he was actually paying me a compliment, but it made me feel so unacceptable and unworthy; in the way I felt around my mother.

Graham: Ah, so this is an old though. And these are old feelings that go back a long way?

Alison: Oh, yes, they go back to when I was a young child.

Graham: I get it that this comment that the friend made was taken out of context, but it really brought your AnOv into focus.

Alison: Yes, I only realised afterwards that I had misinterpreted his comment, but my AnOv immediately stepped in and I started to cut back my snacks in the week to lose weight and hopefully feel better; feel more back in control of things. I can see now that our friend was giving me a compliment, and that it was my issue that made me see it differently. I know that I need to be conscious of those unreasonable thoughts, and see the importance of eating properly on my plan.

Graham: So, it seems that from doing this cog sheet that you came to the realisation that old feelings of being unworthy and unacceptable were triggered when the friend commented on your appearance, even though he was actually commending you on your improved appearance. (Alison nods) But you coped with those feelings by immediately drawing on the AnOv to make you feel better; more in control of the situation. Of course, that anorexic voice is always going to kick in at any notion of your weight improving. You see that?

Alison: Yes, that's right. And only when I had completed this form did I see that I needed to get right back onto Elliene's meal plan. Because losing weight again was not going to be the solution for the Child in me. I can see now how my anorexic behaviour was just making me temporarily dull from what my mother's voice was saying inside me. Am I right?

Graham: Absolutely. It sounds like you've got it spot on. Well, I am really impressed with how you responded to the situation, but it does show how immediately the AnOv kicks in to try and instil this notion of being more in control and less uncomfortable. It's very valuable that you are seeing the role this eating disorder plays.

I was astonished by Alison's keen understanding of the mode model and her diligent identifying of the modes that were impacting on her life. From this, she was able to successfully complete her homework task of drafting a written flashcard to protect her from any situation in which she considered tampering with the meal plan. While this was a significant accomplishment, the unfolding therapy would reveal how stubborn the AnOv would be in holding its ground, and that insight, alone, was not going to make the AnOv obsolete. However, in sessions, Alison's HeAd grew in stature to repeatedly confront the threat that the AnOv posed to the VuCh.

10.3.4. Session 12

This session was mostly defined by Alison relinquishing the CoSu coping mode in favour of expressing her honest sentiment with regards to the expectation of complying with the dietician's prescribed meal plan. While both

Alison and I were aware of the CoSu's often front stage performance to protect the Child from facing interpersonal conflict, the truth of the Child's terror and anger was exposed as the AnOv faced persistent threat. She was able to share with me the internal voices that followed her dietician consultation a few days earlier where she had gained 500g:

"I'm disgusting with the way I feel. I'm a fat and a grotty old woman. This is what the punitive voice in me was saying. So, you know something, I immediately decided that I was going to cut back on my meal plan and lose that weight that I gained last week. I just cut back a little on my snacks. So this is what I wrote in my form (reads from her weekly session bridging form): I am reluctant to tell my therapist that I felt betrayed by my support group and I regret my disgusting increase in weight."

An extract from this session in Chapter 9 that pertains to accessing the AnCh details how this child mode emerged from behind the CoSu to express the true sentiment residing in the Child as a result of feeling unheard. While there was legitimacy for an AnCh whose needs and voice were subjugated and ignored for decades, it was revealed how this emotion was not valid in the context of a team persuading Alison to follow her meal plan as part of a healing path. She, thus, acknowledged that her anger towards the team was, in fact, a coping anger that was incorporated into the AnOv to protect this prominent coping mode from outside threat. This coping anger is conceptualised as residing within the AnOv as there was no other context in which Alison displayed coping anger. What Alison had revealed was how easily she had mistaken the AnOv for the HeAd mode merely because it held a very forceful and assertive voice. Not only was this session valuable in differentiating anger that was legitimate (AnCh) from what was non-legitimate (coping anger), but it revealed the complex nature of the AnOv as a composite coping mode. Further to the AnOv being seen as serving multiple functions, it was becoming clearer how this mode was developed out of existing modes and incorporated further modes to consolidate it.

Towards the end of the session, Alison described an instance a few days earlier in which she was out socially with her husband and oblivious to the voice of her AnOv. She had already reverted to the correct meal plan and was enjoying her meal out with the voice of the AnOv being completely absent:

"You know, I actually really enjoyed the food. Look, I know that that anorexic voice hasn't just disappeared, but this was really the first time I have been out with Mike and really, really enjoyed my meal without feeling bad at all. I really enjoyed it. This is the first time I have felt this year in years; many, many years."

For the next few months Alison remained within her goal weight range and, with very few exceptions, followed her meal plan diligently. With the AnOv being more peripheral it was noticeable how more accessible was the Child whether vulnerable or angry. It was evident how the absence of coping behaviour was bringing a richness to the therapy where an appreciation for the abuse and neglect that Alison experienced throughout her childhood was the dominant focus.

10.3.5. Session 21

Having maintained her goal weight for some months now, Alison's noticeably slim figure brought frequent positive comments from friends and acquaintances regarding her now healthier physical appearance. As the Child emerged, it was brought into focus how Alison's anorexic condition had served another important function whereby her emaciated and shapeless physical frame was eclipsing a sexuality that was fraught with shame and guilt from the moment she began maturing into a young woman. Having maintained her goal weight for an extended time, she needed to deliberate whether she was going to reinstate her ED to bury everything associated with an emerging sexuality, or whether she was going to bravely explore and celebrate this newly emerging component of her identity.

While Alison expressed in this session that she was comfortable with the compliments that she was receiving from friends and acquaintances about her markedly improved physical appearance, her husband's affirming comments on her physical transformation brought into focus how unprepared she was for a sexuality that had been protectively hidden for decades by her anorexic identity:

Extract from Session 21:

Alison: Look, I'm fine with all these comments from others, but when Mike told me that it was nice to have something to hold onto, I was just shocked. Oh, oh, I was thrown into chaos.

Graham: Phew, it sounds like this was a big shock to you? How did you deal with this?

Alison: Well, I was just shocked. I immediately went to the mirror to look carefully at myself and, you know something, I looked at my body and said to myself: "I look disgusting and appalling."

Graham: Just hold this for a moment, Alison. I want you to just reflect on this moment and tell me whether you can see whose voice is saying this to Little Alison? Which mode is speaking so critically of you here?

Alison: (After pausing) Well, I suppose it was that critical and punitive parent voice inside me talking again. Am I right?

Graham: Well, I think you are right. It sounds like a very critical and abusive voice inside you saying something dreadful to Little Alison. Perhaps you could stay with that situation and see if an image or memory comes into focus. Just stay with this moment while you were in front of the mirror and tell me what you see?

Alison: I see my mother, and I'm listening to her saying things that make me feel so ashamed of my body while I am developing – developing physically. She said the most awful things that made me want to hide away in shame. It's as though her religious ideas made me feel that I needed to completely refuse to face the real changes that were happening in my body. Anything about being a woman was wrong and shameful in her eye. I felt ashamed. That's the overriding feeling.

Graham: Isn't it dreadful that she took a time in your life that should have been celebrated as you were becoming a young woman and she, instead, shamed you with her archaic religious ideas? It's just appalling and tragic that she did this to you. Does it make sense to you that when you developed anorexia this, at least partly, served to deny your body's developed state and returned you to the shape of a young child again. Was this not a hiding place from the shame in your feminine body and your sexuality altogether?

Alison: Oh, I would completely agree with you. Yes, yes, it became a place to cut off and remain hidden away. I had never thought of this before, but you are right that my weight loss did take me away from being a woman. Yes, I was not conscious of this back then, but I suppose that it did feel safer to just move away from feeling and looking like a woman.

Graham: I think it is very brave of you to acknowledge this. And here you are now; your body has repaired so much recently. And as much as you are still very slim, it is remarkable how better you are looking now, physically. Is this where you'd like to stay, or is there another voice inside you telling you to lose weight again?

Alison: Look, I have to say that I know that I need to stay here. I think I owe it to Mike after all these years that I have been anorexic to be available to him; I mean, in all ways. I have to say that I have neglected this area for most of the marriage and I have denied him unfairly. Look, I must do this for Mike. It's not fair that I have already deprived him for so, so many years. It's just not right. And, you know something, Graham, I know that I am much better where I am. So, my physical health is so much better now. That is undeniable. I also have to say that my way of relating to Mike and, oh, to all our friends is so much better.

Graham: Wow, I think that that's just amazing, Alison. Perhaps you can say a little more about how your physical relationship with Mike has changed. Is there not something wonderful about this for both of you?

Alison: (With a warm smile on her face) Well, we embraced each other. You know, Graham, it was such a beautiful sharing; such a beautiful and sharing experience.

Alison and I sat in silence for an extended time, both knowing that she needed to reflect upon this valuable shift in her marriage. She was now consciously aware of a significant function that her ED had played in suppressing the guilt and shame associated with her sexual identity; something that her mother's strict and rigid religious ideals accounted for. Despite this valuable shift, it did not prevent the DPM attitude from, again, pushing front stage to chastise Alison for the extent to which she denied her husband a sexual relationship for much of the marriage. While this was a temporary setback, the HeAd was able to reassert its authority to protect the Child. Alison was clearly seeing the benefits of the newfound intimacy in her marriage. The challenge lay in consolidating this and dissolving longstanding guilt and shame. As therapy progressed and Alison maintained her goal weight, the level of intimacy, both emotionally and sexually, matured significantly within the marriage. This would not have been possible if not for the AnOv being marginalised and Alison being able to reveal her more authentic self.

10.3.6. Session 22

Alison returned to her session the following week explaining that she had lost a kilogram, acknowledging that the AnOv had forcefully returned to threaten the Child's wellbeing. This confirmed that the AnOv was far from dismantled, despite her expanded understanding of the destructive functional role that the ED had played in suppressing her sexuality for decades. The session made for a powerful piece of chair work in which I harshly condemned the AnOv for threatening the safety of the Child, but not before that same piece of chair work revealed a vivid evil and alluring image of the AnOv:

Extract from Session 22:

Graham: Okay. So, Alison, we have your AnOv sitting in this place right over there. It got a footing, again, this past week. But what I would be really interested in right now is for you to describe what this AnOv looks like. I'd like you to take a moment to just imagine it sitting over there, and I'd like you to describe its appearance to me so that I have a better idea of who or what we are dealing with. Can you do that?

Alison: Yes, I think I can do that. I have had an image of this AnOv before, so I could definitely do this. (I nod for her to proceed) Well, it's a grotesque, a vile and ugly creature. (Her voice become more fragile, as though from a young child) And it has long, extended arms with sharp claws for hands that are trying to grip hold of me; you know, pulling at me.

Graham: That's really vivid, Alison. Do carry on. Say more.

Alison: She is wearing a big, black, unsightly cloak. Oh, it is an ugly witch; the devil in disguise.

Graham: Maybe you can talk directly to this AnOv sitting right here. Remember, I am here to support you and keep you safe. Can you do that?

Alison: Yes, I will try. (Pause) You have this cunning ability to hide away and then suddenly push in. You, you keep trying to do this. You never stop trying to pull me in and you never let go. Oh, you have this ugly, witch face. And your big eyes have this uncanny ability to see straight into me and put thoughts into my head.

Graham: Keep going. You are doing really well. What kind of thoughts does this AnOv put in your head?

Alison: Oh, it says to me "Now, Alison, you need to go on a rigid eating plan and then you can be powerful and in control of your life. Yes, powerful and protected from all of your difficulties."

Graham: So, Alison, whenever you are struggling with anything in your life, this AnOv comes through and promises you that by eating in this restricted way and losing weight you will be promised control and power? You will have renewed power and control of your life?

Alison: Yes, that is exactly it.

Graham: So, even though you paint this really evil, witch-like image of this AnOv, it still seems to have this spell-bound hold over you, promising you control and power. Is that right?

Alison: Yes.

Graham: And, yet, do you really feel real power and control in your starvation state?

Alison: Well, at first I think that I am going to be more in control and powerful, I suppose, but then I start to see that that is not really the case. It does not result in real control, if I be really honest. It just promises these things that never really come into being.

Graham: Ah, so it is a promise of control, but it turns out to be an illusion; an unfulfilled promise.

Alison: Exactly. Precisely!

This extract provided valuable information in making the AnOv visual; an evil and dark force that has the ability to persuade Alison with empty promises of control and power whenever she felt lacking of such autonomy or self-determination. As threatening as this image was to Alison, she was still very aware of its persuasive powers,

despite its illusory promises. Outlined in Chapter 8 that describes the development of the HeAd mode, I assisted Alison in harshly confronting the AnOv. Whereas in S2 some months earlier I expressed the importance of not harshly condemning the AnOv as Alison's only known means of coping with emotional difficulties, I was now deliberate adopting a harsh stance by encouraging Alison to expel the AnOv, which she did successfully by flinging a cushion out of my office. While I needed to appreciate Alison's reliance on the coping mode early in the therapy, the HeAd was now more developed as a rightful replacement guardian of the Child, and the threatening visual that Alison had of the AnOv coping mode needed to be expelled as the threat it posed. Alison's mature appreciation of the multiple components of her personality made it easier to identify those modes that needed to be expelled or deemed obsolete or redundant, while building the HeAd and healing the Child was the backbone of the therapy.

10.3.7. Sessions 23 to 35

These sessions were less required to focus on the AnOv coping mode in light of her fairly consistent compliance with her meal plan and maintaining her weight within the goal weight range (GWR). The primary focus in these sessions involved the development of the HeAd and a neutralising of the DPM so that Alison could cultivate a sexual identity that had remained suppressed for decades. While the level of intimacy in her marriage grew markedly, it was not without much threat of the DPM undermining her sexuality and bringing to the surface the shame and guilt instilled by her mother, whose religious indoctrination did much to hinder any sense of freedom, autonomy, and self-expression. The resumption of body-shaming thoughts and distorted body-image thoughts indicated where the AnOv had resurfaced. It was a reminder of where this coping mode had recruited the commentary of the DPM, but now reflected an ego-syntonicity to protect Alison's fears of being triggered by instilling strict controls. Chair work in S35 powerfully exemplified this unfolding mode sequence:

Extract from Session 35:

Alison: (Appearing to be in the DPM and speaking to the VuCh) You look frightfully fat and ugly, and sexually unappealing, and you need to be hidden away. You are an unsightly grotesque creature that wonders around, and you are not even in control of what you are doing.

Graham: Phew, and I suppose you know which mode you are speaking from right now?

Alison: Oh, I don't want to say that. I know how you try and push me into the corner here.

Graham: Look, Alison, I am not trying to push you anywhere. I am merely observing this unfolding debate; this drama here. So, I think you do know whose chair you are speaking from now; not so?

Alison: Well… (pause)

Graham: Okay, look, you carry on. Let's see where this is going to go to. You carry on talking to Little Alison over here. What needs to happen then?

Alison: (Still addressing the VuCh) Well, we are going to get someone to keep you in check, and we are going to get the AnOv involved.

Graham: Phew. Okay, so what are you going to do with this unsightly child sitting over here? What should happen now?

Alison: Oh, oh, well, I want you out of here. You need to get out of here. (Alison stands up to reach for the cushion that represented the VuCh) You, you, you get in the way of our sexual pleasures because you appear so, so, so, unsightly! (With this, she threw the cushion out of my office into the waiting area where Michael was sitting and returned to her seating to slump down, looking exhausted). I want to be a desirable woman, not an overweight, flabby, fat one. She is gone!

Graham: So, tell me now, Alison, how do you feel about what you have just done?

Alison: Well, I have to say that I feel quite relieved about this. (She flips into HeAd) Look, I don't want to be rid of the woman who can flourish and be sexually appealing. Look, I want to be in Healthy Adult.

Graham: Well, in that case, I think you need to come and sit over here, because you are not speaking from HeAd where you are sitting at the moment. I am not sure if you are aware of this?

Alison: (Repositioning herself in the HeAd position) Look, I need to be alright with her body being in its present state. But, Graham, there is still this voice saying that I have an unsightly body that should not be allowed into the bedroom.

Graham: Oh well, then I guess that you will need to go and sit in that critical chair again.

Alison: I see it in the mirror, it's plain and simple. Mike doesn't understand that this healthy-sized body, which he claims to be attractive, is so appalling.

Graham: Alison, do you not think that Mike is being honest?

Alison: Yes, I do.

Graham: So, do you not need to consider that the only place from which this criticism is coming is actually only from a place inside you?

Alison: (The HeAd comes into focus and reflects on the situation) Yes, I know that you are right. I know that this is the critical voice inside me, and this is why my AnOv voice has to also come in and tell me that I should lose weight. I know this to be the case.

Graham: Okay, I see that you have that critical voice saying that your body is unacceptable, and then your AnOv mode jumps into action and tells you to lose weight. Is that right?

Alison: Yes, that is what happens.

Graham: Okay, but I want to say this. Are you aware that when you threw that cushion out of this office, you were actually throwing a vitally important part of you out of the room? Can you see that you just threw Little Alison out of the room there?

Alison: Oh my goodness! Are you saying that I just threw the Child of me out of the room? Look, I didn't mean to do that. That is not what I wanted to do at all. Please no!

Graham: Well, I think this is an important point, Alison. You see, by throwing such dreadful criticism at Alison's body, even through your current weight is at the very lowest point that is acceptable, you were essentially just throwing the little Child – Little Alison – out of this room. That's a complete rejection of the Child; of Little Alison. Are you aware that you just did that?

Even I was having difficulty keeping up with whether Alison was operating from the DPM, where the commentary was critically shaming and demanding, or whether she was expressing herself from the AnOv coping mode. At the

outset of this extract, it appeared that Alison was occupying the DMP chair; the commentary distressing the VuCh with shaming commentary about her body and her sexuality. It was clearly distressing for her. She then realised that the solution was to introduce the AnOv; a coping mode that would instil control and keep her "in check". The AnOv then literally banished the VuCh, casting her out of the room as her physical appearance was unacceptable for engaging sexually with her husband. Here was the AnOv's function to blunt her sexuality and avoid her from being shamed, albeit at a physical level. What started out as a shaming from the DPM, the AnOv then provided immediate relief, until I alerted her to the fact that her VuCh had been entirely banished. I was then able to steadily urge the HeAd to enter the stage and take command of the situation. While, initially, the HeAd was able to reflexively see what harm was facing the VuCh, I was then able to assist her to see that the VuCh had been banished and would require urgent rescue.

While there was a new and very healthy aspect of Alison celebrating her newfound sexuality that brought a rich quality of intimacy to her marriage, there still remained a contrasting powerful and threatening voice that shamed and instilled a loathing of her new and fuller physique. This extract well-illustrated the extent to which Alison's mother had succeeded in shaming her daughter sexually, how the DPM represented an introjection of these messages, and how the AnOv served powerfully to quell these feelings for decades. Even though Alison had sustained a low normal weight for some time, it was clear how the AnOv could still return with such ease. However, the HeAd was growing in stature, and with that, the AnOv was finding it difficult to sustain control over the VuCh.

10.3.8. Session 42

Alison continued to progress well in her therapy, becoming increasingly authentic and forthright in pursuing her needs. The VuCh and AnCh were becoming more accessible under the increasingly sturdy guardianship of the HeAd mode. However, Alison remained ambivalent about maintaining her goal weight, frequently questioning the legitimacy of sustained compliance with the meal plan prescribed by her dietician. In this session she complained bitterly about having to continue consuming daily protein shakes to ensure that she reached her required daily calorie intake. However, this time it was not only about the calorie-count but the notion of them being associated with anorexia as an illness:

Extract from Session 42:

Graham: Alison, you know that we have spoken many times about your protein shakes, and I think it has been shown over and over that your weight drops when you don't have them as part of your plan. If you were to not have them, then your meal sizes would have to increase substantially. Remember, Elliene said that the meal sizes would be unrealistically big because of your high metabolism. What are your thoughts on that?

Alison: Well, the reason why I say I am unhappy with them is that they are like medication. And if I have to continue taking them for the foreseeable future, then it means that I am still a sick anorexic.

Graham: Well, it is good to hear that you want to let go of the sick role; being the anorexic. That sounds like a very healthy thing. That's really good. But I think you need to consider that you are not anorexic – well, not defined anorexic by the medication or supplements that you take. What defines your illness is the low weight and the attitudes and beliefs that you carry that make your life unmanageable. That's where you are trapped in the illness. But, you know something, by you needing to take your protein shakes is actually no different to Michael needing to take the heart medication to keep himself safe. His life is not defined by his heart condition, but taking his medication every day – just as, say, a diabetic would need to take their insulin shots – he is just keeping himself safe so that he can lead a completely normal life. And by you taking your protein shakes – which, yes, might need to be for the rest of your life – you are better assured of being able to stay at your proper weight. We know that you are hypermetabolic. You are always going to need a relatively big intake to not go underweight. So, if you need to take these two daily shakes, I'd really like you to see it as a precaution. It certainly doesn't mean that you are sick. As far as I am concerned, while you stay at the correct weight and be responsible for eating properly, you are no longer anorexic. That means that you are putting your AnOv into retirement. Do you see what I am saying?

Alison: Yes, well, when you explain it like that, I do understand what you are saying. Yes, I think you have said this before.

Graham: Yes, we have had this conversation before, but that's okay. But, Alison, might there be any other reason why you want to not do your (protein) shakes?

Alison: Well, to be honest, I also think that I need to be very careful about how much I am eating. I still have a voice inside me saying that I need to remain in control, and that means that I need to be careful about how much I am eating. So, I am still saying that I do not think that I need to be seeing Elliene for appointments every week.

Graham: Look, I do not think that that is necessarily an unhealthy request. Provided you are following your meal plan properly and still staying at your goal weight, then I do not have a problem with you discussing that with Elliene. But I think it's important that your reason to cut down those appointments is not to mess with the meal plan or not do your protein shakes. Do you get what I am saying?

Alison: Yes, but I still think that the meal plan should be adjusted (down) because I am at a reasonable and healthy weight.

Graham: Look, Alison, I have to say that I think that your AnOv is sneaking into the picture here. As I was just reminding you of a moment ago. Your current meal plan – including your shakes – is what is keeping you at a goal weight. Your weight is healthy, but it's still very much at a level that is only just good enough to stay at. You lose a couple of kilograms and you will be underweight again. Now, which mode wants to respond to that – your AnOv or your HeAd mode? I mean, who is going to ensure the physical stability of Little Alison?

Alison: Well, I know the answer to that one. You give me no choice.

Graham: Alison, it's not about me forcing you into a corner. This is where, ultimately, you are going to have to decide whether you are going to assume HeAd and look after the Child, or whether you are going to allow your mother's voice in your head to shame you for things like enjoying your sexual relationship with your husband. And then your AnOv coping comes into play to shrink your body back to its numb and disconnected state. You know what I want for you, because I am only interested in your happiness and freedom. Look, I understand that you are still ambivalent, but ask yourself if starvation has ever really met your needs, or whether your recovery, so far, has opened up new and meaningful aspects of your life?

Alison: Look, I am feeling very irresponsible. I haven't got the little Child on my mind at all. I'm not ready to help her at all, the way I am feeling right now. Yes, you are right that my HeAd is not doing the job properly right now. There is this other voice in my head right now saying "You must be absolutely in control and you must take charge of your life and reduce the food." And I know that I can't be dependent forever on others to rescue me from the trouble that I am in. I must be responsible and be out of all this mess. Look, I know that I really do need my weekly sessions with Elliene right now so that I do not be tempted to lower the amounts. I know that deep down.

Graham: Alison, I completely understand why you might feel torn about all this. It's so normal to be still torn like this. It is not possible to just switch the AnOv voice off or your mother's critical and shaming voice. This is a process and you need to be gentle with yourself, just as I am being gentle with you about all of this. While my message and guidance is clear, I get it that you are sometimes tempted to go back into that disconnect, or to try and feel control from being anorexic. I get it. But we need to really keep pushing for HeAd to win through and for your mother's critical voice and the AnOv to move out of the way. Their time is done.

Alison: I know. I know. It's just really difficult sometimes.

Graham: Yes, I know that too. It's just little steps in the right direction. That's what we are looking for. And your team is here to help you. This is not something for you to be doing on your own. Hey, Michael needs his cardiologist to monitor things and tweak his medications, I suppose.

While this extract reflected Alison's conscious understanding of the dilemma she faced, it did not necessarily equate to a consistent commitment to the recovery path. Where there still remained much shame residing in her fuller figure, the AnOv would always serve as an option to suppress her sexuality both physically and emotionally. What was promising, however, was that she also did consciously want to relinquish her anorexic identity, albeit that ceasing the protein shakes as a means of "medication" was not the solution. Instead, I reflected compassion for the significant and extended challenge she still faced in steadily dismantling her ED and deeming the AnOv obsolete. By comparing her need for protein supplements to that of her husband requiring cardiac medication, I was generalising the use of medication and the importance it played in allowing for a normal and manageable life; whether her own, her husband's, or that of a diabetic requiring regular insulin. What was evident was Alison's mentalising skills in readily identifying the voice of the DPM or AnOv, rather than automatically and unknowingly flipping into such modes to extend the destructive mode sequence. Compassion and validation of Alison's ongoing struggle remained important features of the therapy at this time.

10.3.9. Session 43

This session illustrated the means by which Alison's AnOv served as a source of self-imposed punishment whenever she believed that she had done wrong. The following extract reflects the extent by which her mother's extremely strict and penitential religious value were introjected in defining the nature of her PuPa mode which, in turn, were recruited by the AnOv coping mode through self-imposed restrictive eating:

Extract from Session 43:

Alison: Graham, I feel really devastated about something. Eric told me just a few days ago that he has started to see a therapist himself. He is seeing a psychologist named Gary. I don't know if you know him? But the point is this: I think that this is all as a result of me. I think that it is all my fault.

Graham: Oh. So, explain to me, why do you see this as you fault?

Alison: Well, as you know, I have just finished reading that book My Mother, My Self (Friday, 1997), and I know that you thought it a good idea for me to read this book, because it really helped me to understand how my own mother's shortcomings – the ways that she was unable

to love and protect me and my brothers – really explains the harm she did to us. But I cannot help think that this is exactly what I have done to Eric. The fact that he needs to see a psychologist now says that I have failed him severely. He must have so much anger and rage that he had bottled up. I am sure of this, and it is all my fault.

Graham: Alison, let's just slow down here and look at this a little bit more carefully. I am very pleased that you finished reading the book and saw how your emotional pain – the pain that has been caused to Little Alison – has much to do with the way that your mother failed to meet your needs, how she was neglectful and how she was often really, really cruel in the ways she treated you. Her coldness and cruelty had a devastating effect on you. And it is important to see that your pain and your anger has a context. It didn't just come out of nowhere. And I think that it has been such a courageous thing that you decided to come and see me to work through all of this and make the amazing progress that you have in really bringing your ED under control in the way that you have. You've done so well there. But, as you can see, under the ED we can see a very sad, scared, and angry little child who needs to be validated. She needs to be healed and helped to feel loved. And even there, you are doing amazing things. Look at your relationship with both Michael and Eric today; how these have changed?

Alison: Well, I don't think that I am entitled to such complements as you have just given me here. Oh, you are right about my relationships. What Michael and I have now is so, so wonderful. But this is what it should have been all along.

Graham: Hey, just hold it there. Tell me, who has just been allowed through the door to interfere with you here?

Alison: Oh, I think it's happened again. I know that it is that Punitive Parent mode again.

Graham: And is it actually okay that it is allowed in here to take away the work that you have done?

Alison: Well, I know what you are going to say.

Graham: Yes, but I want to know if your HeAd is going to step in and do something about this.

Alison: Oh, I don't know, Graham. I have this voice in my head saying that I should be punished for failing Eric. That is the loud voice going on inside my head.

Graham: Okay, look, I don't want you to give it a chair just yet, but please tell me what this voice is trying to convince you of?

Alison: Well, this voice is saying that I have really failed Eric. Look what my anorexia must have done to him? I have failed him horribly, and now he needs help – professional help. And, you know something, it is my mother who led me to believe that the only way to redemption is a penitential life. And that suits me being in anorexia. Being thin made me feel better; redeemed and freed from my sinful ways. It feels like a righteous punishment for my many failings.

Graham: Phew! It looks like you are saying that your anorexia has served as an expression; a means to make you feel free of your wrongs, or what you thought as wrongs. Your self-starvation in all that time was your way of somehow washing you free of your sins, well, your perceived sins. All the critical commentary in your head, that Critical and Punitive Parent mode talk, was countered by you starving yourself to feel free and clean from what your parent mode was saying. It's like those fasting saints we spoke about a long time ago, you remember, Saint Catherine? (Alison nods) You can be cleansed from your sins through fasting, well, starving in your case?

Alison: Well, yes. Mortification IS the road to be free of such sins. The church does talk of a penitential way of being. You have to be punished for your wrongs and to be clean in the eyes of God.

Graham: Yikes! Am I hearing this right? Your mother's voice is saying that you should be punished for neglecting Eric because of your anorexia? And so you need to be punished for that. And the way you should be punished is to starve; to go the anorexia route? I'm trying to wrap my head around this one, Alison? It just sounds very contradictory.

Alison: Well, I know it sounds strange. But my punitive voice still says that I should be punished for failing Eric, and starving is probably the best punishment that I can get. This is my penance. I mean, I followed in my mother's footsteps. And while my mother over-controlled me, I believe that I was overly protective of Eric, never giving him a chance to be himself.

Graham: Well. Alison, for one thing, I think we need to really bring these religious values into focus and really question their legitimacy. These don't sound like loving Christian values to me, but more like something very archaic and typical of the dreadful ideas your mother lived by.

Fortunately, this dialogue very quickly took a positive turn. With the HeAd having already developed markedly, it successfully obstructed any contemplation of a AnOv to be activated. Whereas Alison was now managing to neutralise these destructive forces before they were activated, it revealed and well-illustrated a function that was outlined earlier (see section 10.1.7.) in which the AnOv served to dispense self-punishment via restrictive eating in order for Alison to feel absolved for her perceived shortcomings.

10.3.10. Session 45

Another function of the AnOv was exposed in this session, albeit now reflected upon from a HeAd perspective. Although this was not the first time in therapy that this function was identified, the following extract well exemplified the function that the AnOv fulfilled in preserving Alison in a child-like state to protect her from the perceived pressures and responsibilities of adult life. Besides this, Alison revealed that she also insulated herself in an anorexic child-like body because her mother's strictly pious Catholic code condemned an adulthood associated with sexual pleasure, adventure, spontaneity, and fun. Alison was, thus, hesitant to enter adulthood and be exposed to these forbidden pleasures.

Extract from Session 45:

Graham: So, Alison, it's good that you can see here that your following the meal plan has often really been out of the CoSu, where you eat so that the team will not be disappointed in you. But that is now very much set aside. Now your fears about following the meal plan are more exposed. Right?

Alison: Well, yes. You are right. I am not just doing what will make the team happy. I am mostly eating on the plan because I want to stay better and healthy.

Graham: But there are still times when you are really tempted to lose weight again?

Alison: Yes. I think that when I was underweight I did not feel quite so exposed and out in the open. Now that I am at a steady proper weight and not anorexic anymore, I sometimes think that I am afraid of taking on responsibility, and I think that as I get healthier, so I get more frightened of living up to certain standards that I am not capable of living up to. As a healthy person there are so many expectations of me

that I can't reach and that I'll fall short of. This is really difficult for me to stay with. Um, I prefer the idea of being a little weak child that needs to be mothered and protected, rather than living up to expectations.

Graham: Ah, I think we have identified this feature before. So, yes, you are realising that by being anorexic, that you in many ways remain small; not just physically, but child-like in so many ways that you really don't have to face the outside world as an adult and be overwhelmed by the responsibilities that you are fearful of not living up to?

Alison: Yes, that is exactly what it is. I can remain child-like, instead of facing all these adult things. Yes, I could remain small and immature, I guess, and not venture into adult activity.

Graham: And the assumption, I think you are saying, is that you were convinced that you would not be able to hold up to adult life. Right?

Alison: Well, yes. That is really what I have thought.

Graham: And do you hear any other voice that persuades you to stay in this child-like state?

Alison: Oh, I think I immediately hear my mother's voice. I always recall her saying to me "Too much of a good thing is a bad thing."

Graham: And what does that mean to you?

Alison: Well, I saw it to mean that I should just stay a good, pure, little child all the time. You know – not be contaminated by adult pleasures.

Graham: Ah, I think I am seeing, maybe, a few things that the AnOv plays as a function here; its purpose, you know. So, let's just look at this for a moment. Alison, I am hearing one of the functions of being anorexic was to keep you in a child-like state so that you would not be overwhelmed by adult responsibilities that you feared you would not be able to carry out. Right? (Alison nods) Was this not about living up to your mother's impossible expectations; her never believing in your abilities? (Again, Alison nods) Okay, but I think I am also seeing the role of anorexia keeping you away from all things pleasurable and spontaneous. This notion of "too much of a good thing being a bad thing" that you hear in your head is an echo of your mother, right? This bad parent voice is saying that you will lose your way if you engage in adult pleasures that your mum denounced in your sexual identity, again?

Alison: Yes, of course. Adult pleasures, like sex. But she was also denouncing all this enjoying life and doing all these adventurous things.

Graham: What's horrible is that it seems that your mother really sucked all of joy out of life. It's as though she was saying that it was wrong to enjoy anything playful and spontaneous about life. It's really awful, Alison.

Alison: Yes, it is a great pity, looking at it now.

Graham: And you are going to live by these rules?

Alison: Well, I can tell you that I am not going give up any sexual pleasures.

Graham: Yes, say that again.

Alison: I am not going to tolerate some parent taking away my sexually intimate relationship with Michael. I think that this is so wrong. Just wrong, wrong, wrong!

Graham: And remember Alison, this is only a voice inside your head now. This is an inner chastising parent mode bulling the Child in you; a parent mode undermining Little Alison's free life. That is absolutely appalling. Just not okay!

Alison: Oh, I agree. It's time my HeAd stood up to this and says "It's not okay. You go away!"

Chair work immediately followed in which I proudly watched Alison's HeAd step up and realise the importance of banishing the echo of her mother's chastising voice that denounced all spontaneity, playfulness, and the fullness of life that Little Alison was tragically denied. Both Alison and I were beginning to appreciate the myriad of sometimes subtle functions that the AnOv was fulfilling in protecting the VuCh from discomfort and anguish. While such insight did not immediately cease all temptation to lose weight, an appreciation of these functions in the HeAd shifted the emphasis away from "firefighting" bouts of restrictive eating towards attending to the deprivation of core needs in the VuCh. This is where urgent healing and reparation was required.

10.3.11. Session 48

Towards the end of this session, Alison recalled a childhood memory of when she was an eight yearold who created an insulated world for herself to be protected from the threats, loneliness, and despair that she experienced at home. We realised that this Protector Child (PrCh) overcompensatory means of coping that Alison created from a young age was later maintained via her ED to insulate her or create a sense of invisibility:

Extract from Session 45:

Graham: And how old do you recall being at this moment?

Alison: Oh, I must be about eight or nine years old. I had been at the convent for a few years already; maybe three years.

Graham: Oh, okay. So, where are you in this memory? Where, exactly, are you?

Alison: Oh, I am in the sitting room and we have already eaten (dinner). At home. My brothers are busy with their own thing and my father has already drunk so much. I can smell the alcohol in the room. My mother has that cold, stern expression on her face. That was the case most of the time. She had no warmth. It was like this most of the time.

Graham: Okay, and let's just stay with this current memory; this awful situation. What are you feeling? What are you connecting with emotionally?

Alison: Well, it's strange, but I'm actually not feeling very much.

Graham: You don't have a sense of what you are feeling in this scene?

Alison: Not really. You know, I would often just go into my own little bubble and be disconnected from everything around me.

Graham: So, it's not that you are connecting with any painful feelings? You are more just cut off from feelings?

Alison: Yes, I never really feel I have a place in the house. I have no say. I'm without a voice. I think I just created a state of invisibility to keep out all the cruelty around me. That's what I think I did much of the time. Maybe not so much cruelty, but the harshness and the aloneness I felt in the home.

Graham: It sounds like you really coped by creating this insulation around yourself from all that was the despair around you. If it wasn't your mother's cold, stern nature, it was the smell of alcohol on your father's breath as he stumbled about and then sank into the chair to fall asleep. You needed to protect yourself so you created a bubble around yourself to stay relatively safe inside and disconnected from everything going on around you at home. Is that right?

Alison: Yes, that is exactly it. I think I was creating a safe, well, sort of safe space for myself. As safe as I could make it.

Graham: And I think we can say that this was a way of coping; a coping mode. You couldn't change this situation, so you created a bubble of safety all around you. You went into your own little world. Ja?

Alison: Yes, exactly. It was a coping mode way.

Graham: Tell me, did this stop when you left home?

Alison: Well, of course, I moved out of the family home as soon as I was married to Mike. I wasn't like that with Mike at all. Oh no, it was completely different.

Graham: Oh, I'm not saying that Michael is anything like you parents. Quite the opposite. But was there another way in which you might have been still protecting yourself before you even married and then carried on with after you moved into your new home with Michael?

Alison: Of course, I was deeply anorexic when we married. That started long before we married. In fact, I think my anorexia was probably the main reason we stayed engaged all those years, and only married later. Oh, but I think I know what you are getting at. Are you saying that my anorexia became my new insulating bubble way of coping?

Graham: Well, what do you think about that? Does that make sense to you?

Alison: I think that is exactly right. Yes, I think that my ED has served as a way of keeping me in my own world, away from the difficulties of life around me. It's just the same as I did all those years ago.

This extract revealed a function of the AnOv that was identified very early in therapy; that of a continuation of the effect of the PrCh coping mode that Alison created in order to detach from feelings of neglect and anguish that she experienced in her unloving home environment throughout her childhood. Although she did not face such neglect from her husband, Alison's anorexic state was already deeply entrenched to suppress all vulnerability and intimacy when she met Michael.

10.3.12. Session 51

While Alison was sustainably adhering to her meal plan and maintaining herself within the GWR, she was better equipped to reflect on the emotion underlying the shame associated with her emerging sexuality as an adolescent. Again, she was able to acknowledge the role her ED played in suppressing her sexual identity. The anger and sadness associated with this theme is detailed in earlier chapters. However, there was a brief moment much later in the session during which Alison's AnOv reflexively and surprisingly surfaced:

Extract from Session 51:

Alison: (Immediately positioning herself in the HeAd chair) Well, yes, I can see it from this place quite a bit more easily. (Hesitating before turning to the Child) It's not fair what you were put through in your childhood. It's frustrating. It makes me angry, really angry (She suddenly pauses, her face filled with sorrow). I'm on the verge of crying and I am not going to do it. I'm just not going to cry these angry feelings. I am not going to be weak and I am going to be in control. No, no. I am not going to cry. I don't even want to hear my voice, and I don't want this therapy. I am attending a funeral straight after this (appointment) and I need to be composed. Tears – these tears – should only be for the grieving.

Graham: Hmmm, it's interesting that you say that, because I think that these tears of yours are maybe not just of anger, but also for a grieving little girl; Little Alison over here. It is this little girl between us here who lost her entire childhood and her entire adolescence. Not so?

Alison: Well, I'd rather talk about food and weight at this time.

Graham: Phew! I didn't see that coming. Um, it would appear that this would be a way of steering away from these powerful feelings that you are experiencing right now. Not so?

While this was only a brief moment in the session, it is included here as a reminder that, though Alison already had significant control over her AnOv, there was still a reflexivity with which the AnOv would be activated to distract the Child from heightened distress. Even though the context of the distress was completely unrelated to food and weight, the AnOv served as a flare to distract the Child from any heightened emotion.

10.3.13. Session 54

Alison opened this session describing the defiance by which she deliberately deviated slightly from her meal plan the preceding week. She recalled how her dietician had described her behaviour in their consultation a few days earlier as being that of "an angry child". What they both realised was that her anger was not food or weight related, but something residual to the heightened anger she felt towards both her parents over the past few weeks.

Extract from Session 54:

Alison: So, even Elliene said that she thought that I was speaking to her like an angry child. I knew, and so did Elliene, that my anger was nothing to do with my weight or about needing to follow my meal plan. The small part of my snack that I left out of the plan was not about wanting to lose weight. I think it was my way of saying that I do not want to feel this anger and sadness towards my mother and father anymore. Look, I know that it is justified that I am angry for the events of the past, but I think that my skipping little parts of my snacks was really a means of just getting away from feeling the anger that has been building up inside me.

Graham: That's interesting. Of course, we identified this role that your AnOv has played quite some time ago. I cannot remember the exact situation, but do you remember how we, some time ago, saw that your ED was a means of just disconnecting from your uncomfortable feelings? A way of numbing you down and just disconnecting from the difficult feelings?

Alison: Oh, yes, I do recall that; and I also cannot remember the exact situation. But it makes sense to me. Yes, I definitely do not think that this was about trying to lose weight or to under-eat. It was just a way of being distracted from all these feelings of anger and sadness we

have been looking at these past few weeks, especially these past few weeks in our sessions. There is this very, very angry child in me. And we (Elliene and Alison) realised on Monday that I was not so angry about the food. It was all about things that happened in the past.

Graham: I think that it is very valuable that you can realise this. And I completely understand why it is difficult for you to stay with all this anger and sadness. It's not easy. You know, I think that you have been making some really good progress in connecting with these feelings around what your parents did. But it also seems that you can see how your AnOv can suddenly kick in out of nowhere and push Little Alison's feelings to the side. That's not good because those feelings need to be heard. They need to be validated.

Alison: Yes, I know this. I understand. I think even in my session with Elliene I realised that this is what I was doing.

Alison had realised, again, that her deviation from the meal plan earlier that week primarily served to numb the heightened anger towards her parents that still felt unacceptable to display. The focus of Chapter 9 deals precisely with the challenges we faced in accessing and giving a voice to Alison's AnCh mode. Even though she had learned of this function of the AnOv some months earlier, such insight was not going to deter her from still reflexively turning to the ED as a means of expressing anger that was displaced from a more pertinent source.

10.3.14. Session 56

Alison struggled with her husband's heightened sadness as he grieved the death of his sister a few days earlier. Although she misconstrued her weight concerns as emanating from her HeAd, she was more significantly than in recent months resisting the small amount of weight that she had lost the previous week. This was the most emphatic resurgence in the AnOv for months. It was important that the HeAd be "decontaminated", and that Alison recognise and acknowledge that the AnOv had resurfaced to pose a threat to the Child. This was temporarily abated by way of a paradoxical intervention which is outlined in an extract in Chapter 8 that described the development of the HeAd mode. However, the AnOv would resurface a few minutes later in the same session; its ferocity being drawn upon when the DPM called for her to be punished for failing as a wife:

Extract from Session 56:

Graham: Hang on, Alison, something very odd is going on here. A moment ago you said that your HeAd would never abandon Little Alison again, but now you say that you are prepared to leave this little child out in the cold. That's very different to what you were saying just a few minutes ago.

Alison: Well, there is no need for Mike needing to know that I am going to keep my intake where it is. In fact, is it important for me to even keep you and Elliene informed of what I am doing if I need to keep feeling more in control this way?

Graham: Look, Alison, I think you need to leave this seat right now, because this is not HeAd that you are coming from.

Alison: But I really think that what I am doing is healthy enough. My weight is not going to go down. So, I just need to do this for me right now.

Graham: As far as I am concerned, you appear to have been hijacked; taken captive. No HeAd would allow the child under their care to be subjected to this threat. I have to say that I feel quite helpless and frustrated right now. I'm just telling you how I feel. I wonder what you are feeling right now?

Alison: Well, I just feel that I am a despicable character. That's what I am feeling right now. What's more, I feel unworthy of a good husband.

Graham: Phew. That just makes me feel so sad for Little Alison. Alison, please just try and tell me what Little Alison is feeling right now?

Alison: Well, I just think that this child should just be left a bit in the background. Look, this is what I honestly feel right now. It feels that she was a little bit in the way. (While she is saying this, I ushered her to a seating position reserved for the DPM)

Graham: And you know what my thoughts are right now? (Alison nods) I'm feeling that if your HeAd is not able to be here right now, I feel that I, alone, need to look after this little child.

Alison: Well, I still think that there is a certain amount of punishment that I have to put on myself for being an unworthy wife, and the child cannot be a priority. This child needs to be punished at times! Be punished! Be punished! You are not worthy of any love. You are undeserving of love. You are in the way, and you are an absolute hinderance. You need to disappear. You take up too much space. And you are just a nobody. (Pause) And you are not wanted.

Graham: Phew. You look really exhausted, Alison. So, you know something, Alison, from where you are sitting right now, I suggest that you throw that child out of this room. Here's this cushion. Are you going to do this?

Alison: No, no,no,no. Look, I please want another chance to make amends with the Child.

This was a very difficult passage in the session. I was concerned that I might have made a risky mistake ushering her to the DPM chair; a tactic that should be practiced with caution. Although Alison had already developed a much sturdier HeAd mode, this exercise revealed the extent of ferocity still sitting in this extremely judgmental parent mode. When we reviewed the chair work in retrospect, Alison acknowledged that the AnOv was behind the comment: "You need to disappear. You take up too much space. And you are just a nobody. (Pause) And you are not wanted." This reiterated the notion that her ED served as a tool for implementing punishment; in this case, banishing the VuCh.

10.3.15. Session 59

Despite Alison consistently maintaining her goal weight, the AnOv was far from being completely dismantled. Her marked progress in silencing the CoSu coping mode in S12 allowed for the emergence of anger in defiance of the prescribed meal plan. A similar dynamic recurred in this session, whereby anger was recruited by the AnOv for the purpose of maintaining the ED. However, this time the HeAd mode was stronger and more hastily intercepted this process to gain access to the legitimate source of anger in the Child instead of it being misdirected to serve the AnOv's agenda.

Extract from Session 59:

Graham: So, again, I think it's really important that you can see that this anger that you express here is part of your AnOv. Right?

Alison: Yes, I think it is sometimes quite difficult for me to see the difference between when I am truly angry and when I am angry from the (anorexic) overcontroller.

Graham: Yes, I think it's important that you can see when it's genuine and authentic anger coming from your AnCh or the angry HeAd, and then when it is anger coming from the AnOv to kind of tell people to back off and stop talking about the meal plan.

Alison: To be truly honest, I think I know when I am being angry to just hold to my eating plans. I know that this is not the anger of the child in me and I know that this is not about looking after little me, well, Little Alison. Yes, I know more quickly now what I am doing; you know, what is real anger for the past and what is anger to push people away from the anorexia.

Graham: I think that it is very valuable that you are able to see the difference, because the authentic anger in Angry Alison and the angry HeAd you are very important to hold and express. On the other hand, this angry coping in your AnOv is bad news. So, this is good.

It was valuable that Alison had sharper insight to the distinction between legitimate and justified anger residing within the AnCh for abuses of the past and anger that was, essentially, being co-opted by the AnOv that was jeopardising the Child's well-being. In contrast to previous sessions where this anger attached to the AnOv was stubborn and difficult to dismantle, in this session it was very brief, and Alison more effectively made the distinction and implemented a healthy response. As such, another recruited "ally" of the AnOv was being markedly weakened. Alison's timeous recognition of this misdirected anger allowed for a very constructive piece of chair work that provided meaningful access to the Child.

10.3.16. Session 60

I was filled with a feeling of despondency as this session a week later (S60) opened with Alison appearing to have taken little from what had felt to be a very constructive and insightful session the week prior. She was provoked by a cautionary comment made by her dietician earlier that week that if she repeatedly lost weight, she would eventually require hospitalisation. Although admission was certainly not indicated, the comment initially triggered difficult memories of her lengthy inpatient admission to a state ED facility decades earlier. More importantly, this triggering was an awakening of painful childhood memories of feeling disempowered throughout her childhood. Despite Alison's successful efforts in strengthening the HeAd, the AnOv was still occasionally threatening the healing process.

Extract from Session 60:

Alison: Well, I feel frightened and intimidated. I am never going to allow myself to be placed back in hospital again.

Graham: So, you are feeling very frightened. And you feel intimidated?

Alison: Well, all I can say is that I despise my body. Graham, I avoid the mirror and I do not want to see the despicable shape that I am in. And I am not going to gain weight.

Graham: Are you aware which mode is operating right now?

Alison: Well, I think that this is a healthy voice. What I am doing right now is assuming firm control over the child. I don't want to lose weight. I just want to maintain where I am right now. That's all.

Graham: Really?

Alison: Well, if I be honest, it might suit me to lose some weight. Look, I am assuming control, and the little child must just follow on.

Graham: Look, Alison, just hold a moment. Let's just reflect, again, on the role of a loving parent. Can we do that?

Alison: Well, it is someone who cares for the little creature that she has in her charge. And she loves her and gives her everything that she need, wants, and deserves.

Graham: Okay, I like that. But tell me then, how is this description matching up to what you were telling me a moment ago? Because that description a minute ago was of someone very rigid, demanding, inflexible, and very determined that Little Alison needs to lose weight. Surely this is a child emotionally neglected, not to mention, undernourished. Right?

Alison: Yes, you are right.

Graham: Well, then I would really like you to come and sit here in HeAd and just explain what this little child here has been subjected to throughout her childhood.

Alison: Oh, no, no, no. I'm not going to get involved with this little child. Look, I am already in HeAd and I am not dieting. I am eating healthy meals.

Graham: Okay. Look, will you at least just come and sit next to me here (beside me on the couch) and let's reflect on something. Will you, at least, do this? (Alison nods and comes to sit alongside me in an unspecified mode, even though my intention is to make this the HeAd chair). Okay, Alison, I'd really like you to just describe the circumstances for this little child seated here next to us. How old is she? And what is she going through right now? What is she feeling?

Alison: Well, she's a 10-year-old; frightened and intimidated. And this child is very rebellious. That's what she is. She is frightened and rejected. You know, I got rejected from Elliene. This child was rejected – not cared for and not listened to. And she was misunderstood.

Graham: Yes, I get that. I get that this is the feeling that was triggered the other day. But maybe you are also talking about how your life was under your parents, not so?

Alison: Yes, it felt like cruelty and treachery from the punitive parent; my punitive mother. So, Elliene is not in my good books for mentioning hospital. I do think she just said this to frighten and shock me into following with the food plan. So, I do, do think that I am in a controlled healthy voice, and maybe this little child is going to be maybe sleeping – dormant! And we are not going to worry about feeding her and nourishing her, and nurturing her.

Graham: Phew. This sounds like another command for starvation. And, I have to say this; it sounds a lot like the way you were emotionally starved when you were young.

Alison: Well, I still think that I am HeAd in control.

Graham: Again, I have to say that when I listen to you now, you sound much like the way you were describing last week how your mother used to control you in a very, very suffocating way. That is what this feels like to me. This sounds to be anything but HeAd. I really think you need to consider that your AnOv is kind of masquerading as HeAd right now. I mean, is this the way your HeAd has learned to take care of Little Alison? And is this what we have been working towards these past months?

Alison: (Long pause) This child wants to be recognised and have an identity of her own with no strings attached to her mother. But, but, this little child needs different nutrition in order to not gain weight.

Graham: So, are you telling me that your adjustment of Elliene's meal plan is not the work of your AnOv? Let's just reflect on what has happened in the past when you reduced the meal plan. Okay?

Alison: Well, I don't want to talk about that.

Graham: Alison, tell me, is there any justifiable, any good reason to withdraw the necessary food from this little child? What I am saying is, which mode do you think Little Alison, the Child, would more benefit from listening to?

Alison: Hmmm, so who will she benefit from more? I think you are asking me whether I should be listening to the HeAd or listening to the (anorexic) overcontroller?

Graham: Yip, that's what I am asking. So, which one of these two do you think is going to take better care of Little Alison?

Alison: Well, I do know that the HeAd is the correct answer; and the answer you want to hear. But I have to say that when I was young I felt very rebellious, but I never got the chance to be that. It was certainly not safe for me to be at all rebellious in all those years.

Thankfully, my perseverance paid off after calling Alison out every time she flipped powerfully into the AnOv to assume a position of power and control. She finally conceded that her obstruction of the meal plan always resulted in weight loss, and that this was another instance in which the AnOv was compromising the efforts of the HeAd to maintain safety over the Child. The next part of this session is presented in Chapter 10, where I describe access to the Rebellious Child. At the core was the anguish associated with a childhood in which she was silenced and made to feel invisible. Despite the minimal extent of Alison's actual disordered eating behaviour, this extract demonstrates how reflexively the AnOv was still being activated in the face of her feeling that she was denied self-determination. Her fantasies of completely neglecting and starving the Child point to the extremely punitive nature of the DPM that was clearly recruited into the AnOv in this instance; it's purpose to dissolve the pain of childhood abuse and neglect. However, it had been more than a year since she had restricted in a significant manner. So powerful was the AnOv, that Alison was not even willing to occupy the HeAd chair. Without explicitly labelling the seating beside me that I invited her to occupy, she appeared more willing to switch. Even though chair work brought about an orchestrated return to a more objective HeAd stance, it was not enough to persuade Alison to relinquish a justification to leave the session still committed to slightly decreasing her meal plan. I felt dejected that I had failed to persuade Alison to re-commit herself to a HeAd stance by the time the session ended. However, I needed to appreciate that Alison's food restriction would be minimal and less a medical threat than an

emotional one in which she was adamant to hold to the AnOv as a vehicle for power, self-determination, and to suppress feelings that were deemed unacceptable from a DPM perspective.

10.3.17. Session 62

This session is comprehensively analysed in Chapter 10 as it pertains to differentiating angry coping associated with the AnOv from genuine anger residing within the Child. Alison started the session bemoaning her weight gain, despite her weight remaining comfortably within the goal weight range. And then she revealed another role that her anorexia played:

Extract 1 from Session 62:

Alison: I wasn't expecting this 400g increase this week. I especially didn't even eat all of my snacks this week. And my weight is up. Wow, can I really trust this meal plan?

Graham: So here we are talking about what is actually a really insignificant amount of weight gain in the big picture. I mean, your weight is still very stable within the required weight range, but you are completely focussing on the weight right now. Skipping snacks? Alison, I wonder what is really going on here? I mean, what is Little Alison really dealing with right now? What is really going on here?

Alison: Well, yes, I really do want to lose weight. I really want to be an anorexic walking skeleton – and getting attention for that. I want to be all skin and bones! (Long pause) Oh, alright, I know that that is not right. I know this is not the right way to be thinking. It's coming from the AnOv. It doesn't make sense, Graham. But it's how I sometimes feel.

Graham: Well, look, it is really good that there is a healthy voice that comes through and wants to put a stop to this. But I am actually quite interested in looking at what this urge is to now go back to being a skeleton; all skin and bones. What is this all about? What is this little Child here going through that makes returning to a skeleton so important, so vital?

Alison: Look, I know that this is nonsense, I don't want that. My Healthy Adult knows not to allow this.

Graham: And I think that it is excellent that the Healthy Adult part of you is stepping in, and stepping in it must do. But I am still interested in that other voice inside you; the one that feels that this little Child needs to be skin and bones. This voice that wants you to be skeletal-thin still seems to be pushing hard right now?

Alison: Okay. Yes, that skeleton thin body is what gets attention. That is when I will be noticed. Yes, it will give me back that sense of an identity, my own identity that I never had when I was young and growing up. I was never noticed then for anything good, even when I worked in the bank. It makes me feel important – standing out and being noticed – something that I never had before.

Graham: Okay, that makes sense then. Being anorexic was something that ensured that you would get attention from others – especially when all throughout your childhood you felt so invisible – so ignored and unimportant. I get that you really needed something that was going to make you be noticed and valued?

Alison: Yes, the anorexia made me feel important. It made sure that I was noticed by people when I walked in the streets. I go noticed. I wasn't ignored or invisible. Mind you, I didn't want them to come up and make a fuss of me. Just to be noticed. Not forgotten.

Graham: Sure, but I think it is very important that you are aware of the importance of being noticed, taken seriously, acknowledged, and valued. Right? Little Alison still needs to feel important, be noticed, get the loving attention that she needs.

Alison: Well, I do know now that the AnOv didn't really provide me with the kind of attention that I needed, well, that I suppose I need. I do get so much love now from everywhere now.

Many lay individuals hold the view that anorexic patients are simply trying to attract attention to their thin or emaciated state. This often evoked irritation, anger, or condemnation for what is perceived as attention-seeking behaviour. Many young sufferers inadvertently fall prey to this condition after embarking on a weight loss diet and compulsively exceeding healthy levels of weight loss. Through a combination of aetiological factors outlined in Chapter 10, particularly adolescent sufferers pursue a positive or supposedly perfect aesthetic ideal as defined by some sectors of society. This was never the case for Alison. Although she was a young adult when she first developed her illness, her attention-seeking motive for being emaciated was not aesthetic, but rather to appear noticeably vulnerable in her emaciated physique. Even though Alison was not actively seeking significant weight loss at this time in her therapy, there was still a reflexive desire to be skeletal in order to gain the attention that she required. Thankfully, I was able to guide her to recognise that the attention that she required were the core needs of the Child; especially the need for intimate emotional connection.

A few minutes later in the same session, Alison's AnCh was triggered as she reflected upon the dysfunctionality of her childhood home environment. She described how she was compelled to create safety by isolation; what most closely resembles Edwards' (2015) notion of the Protector Child coping mode. As much as she created this "semi-disappearing" coping state in her youth, her ED served as a this "protective" isolation from her mid-twenties:

Extract 2 from Session 62:

Alison: Oh yes, of course. Um, this, this was such a deplorable environment for this innocent little child here. How, how, how can you expose her to THIS! How could you have allowed this? You should have protected your children from this behaviour. Your husband should never have been allowed to behave like this. It's DEPLORABLE. IT'S ASTONISHING! And you controlled everything else, you did. Look at how you controlled this child with an iron rod, yet you allowed this deplorable behaviour to continue!

Graham: And we know how Little Alison had to deal with that when she was young.

Alison: Yes, that is where I did my semi-disappearing. I just wanted to be invisible to get away from the awful things that happened; from everything.

Graham: Yes, I can understand that you wished to be invisible to just try and protect yourself from everything at home. It's how you coped; how you survived in a horrible environment that was never really going to change for the better, right? So, you hid; you made yourself inconspicuous?

Alison: Yes. And I remember what you said to me some time ago; how this invisible hiding away that I did kind of found its form in the eating disorder later in my life. The less of me there was to see, the better.

Graham: Yes, I think you are absolutely right. Yes, how anorexia became another protection; another way of coping with difficulties around you and all the unresolved pain and feelings sitting inside you?

Alison: Yes, my AnOv did become a sort of invisible protection. Again, I feel myself being both sad and angry as I see this. One moment I am feeling so sad about this, and then this anger just wants to come through; like how dare I be treated that way through ALL those years. It's just SHOCKING! Absolutely shocking.

In contrast to the attention-seeking role that Alison's emaciated body served, she now revealed how the AnOv served to perpetuate an insulated state that she adopted from a much younger age. Recognising these various and contrasting roles of the AnOv is what makes me appreciate the ST model's lesser preoccupation with diagnostic criteria and psychiatric labels, and more its emphasis on case conceptualisation and the function that each mode plays in the challenges being faced. The value derived from understanding these contrasting functions of the AN outweighs the focus on diagnostic criteria pertaining to the fear of weight gain in a distorted and dissatisfied body.

10.3.18. Sessions 63 to 99

Even though Alison was already engaging more meaningfully in relationships at this point in her therapy, the temptation to "hold tight to the reigns of not following the meal plan" remained a reflex for the next few months. However, her adjustments to the meal plan were minor and of no significant influence on her weight. In the months that followed, Alison displayed increasing resilience in sustaining the HeAd stance and attending to the Child's needs without the AnOv having any leverage to interfere. It was telling that in the weeks in which her son, Eric, attended conjoint sessions to voice his feelings about his childhood experiences with an anorexic mother (S86 – S89), she maintained excellent care of herself physically, even gaining some weight to be better consolidated within her GWR. As we approached the 100th session, Alison felt almost entirely liberated from the influence of the AnOv and was living her life with renewed meaning and purpose. There was no longer any mention of losing weight and her HeAd was now much more consolidated and consistently present to address the needs of the Child.

10.3.19. Session 100

In this, the final session of therapy analysed for the study, Alison reflected how free she was of her AnOv coping mode, even though the DPM was still evident, and would require further work to banish. Alison was able to recognise the value of neutralising the AnOv which made more accessible her interpersonal relationships and the internal relationship between the HeAd and the Child:

Extract from Session 100:

Alison: Graham, I am feeling overwhelmed by the compassion that our dearest, darling, loveable son is prepared to offer me; me who doesn't deserve it.

Graham: Wait, hold on Alison. Do you know which voice is still coming in here?

Alison: Yes, I know this to be the punitive voice. That critical parent.

Graham: Well, when we go back to those (conjoint) sessions with Eric, he made it very clear that he has not only forgiven you for what your ED caused, but he was very clear that he wants to move forward with the way things are now. Now that you are no longer anorexic, it's so clear how both Eric and Michael are feeling a complete change in the way you connect with them. And, remember, whatever you think that you did to Eric through your anorexic years, he has still become a well-adjusted and really loving young man that loves both you and Michael very much. Yes, anorexia took its toll, but you still put everything you could into being the best mother you could be.

Alison: Well, he still was number one even though I had anorexia. He was still my main priority.

Graham: Yes, I think that was the case. But I think that you are now fully seeing now that even though your anorexia did serve as a shield and blocked you from feeling the anguish in your childhood, it sadly blunted your whole life for decades.

Alison: Yes, I can see now what an ironic thing that is. It did blunt things. It was a shield, but it shielded out all that could have been good as well. I know that I am now embracing a loving marriage and I embrace a very active and warm, loving motherhood as well.

Graham: It is very rewarding to see you recognising all this. I mean, it really tore away your ability to be vulnerable in your life.

Alison: Yes, I held back. And, and, and I know that the Child now deserves to be liberated; that Little Alison is equally deserving of the compassion and the love that I give anyone else.

Graham: This is very good, Alison. I want you to just stay with that for a moment. (Long pause) And the AnOv, what do we do with that?

Alison: Oh, (looking to the seating position usually reserved for the AnOv) I won't need you, AnOv, anymore. I now have loving relationships in my life. My relationship with Michael and Eric, and I suppose my relationship with everyone else; these relationships are all so much more meaningful and real than I have ever experienced before.

10.4. Summary

It was as early as the 1970s that AN was already being described by clinicians as a condition with its own distinct internal voice (Bruch, 1978), whether "friend or foe", a guardian (Serpell, Treasure, Teasdale & Sullivan, 1999), or a voice of seduction (Treasure, 1997). For every sufferer of this pervasive and complex condition there is almost always a furious internal dialogue in which one participant is attempting to rein control over a Child trying to evade a myriad of schema-based emotions that feel overwhelming and unmanageable. It is very evident that Alison's AN manifested as such a voice. As her illness tightened its grip in her twenties, so she became increasingly swamped by its command; her true self or identity submitting to the increasingly amplified influence of her AN. Since Mountford and Waller (2006) first conceptualised AN as a "restrictive schema mode" more than a decade ago, there has been a growing surge amongst clinicians and researchers within the ST community to discover new and increasingly creative means of conceptualising and treating this difficult-to-treat illness.

Although Alison made reasonable progress restoring her weight when we initially worked within the CBT-E model for EDs treatment, it was evident that such progress was being primarily driven by a subjugation schema that required her to meet the needs of others and to avoid overt conflict at all costs. Her physical health was steadily

being restored, but the internal voice of her anorexia was still deeply entrenched and relatively untouched. Amongst other sufferers that I was treating, so it was becoming clearer to me that the therapy with Alison was unidimensional and only provided superficial repair to her physical frame while, internally, powerfully destructive emotional forces remained untouched. Where ST addresses the multiplicity of voices within each individual, what became clear to me was how Alison's Child was lost; synonymous with the notion that Oldershaw et al. (2019) describe as the anorexic's "lost sense of self". It conceptually resonated with me that Alison not only had a significant number of modes that were both dysfunctional and severely threatening to the Child, but that her anorexia, itself, was a discreetly identifiable voice. I adopted Edwards' (2017b) notion of an Anorexic Overcontroller (AnOv) coping mode. As a distinct mode, here was a highly complex and composite coping mode that encompassed several behavioural and cognitive components that served multiple functions to stave off schema-based pain residing in the Child, whether vulnerability or anger. Its complex structure reflects its origin in the DPM and the recruitment of pre-existing coping modes, whether avoidant, perfectionistic, or obsessive. While the AnOv's functions were fewer in the beginning, over time it developed additional functions to protect the Child from exposure to the pain she has experienced throughout her childhood and adolescence. And while the AnOv served to insulate her from pain for decades to follow, like all coping modes, it failed to provide authentic healing, but merely served to provide immediate and temporary ease from the agonising injury residing within the Child.

Through emotion-focused techniques and a distinct reparenting process, Little Alison tentatively began to heal. The AnCh emerged and the VuCh cautiously revealed her pain as our therapy relationship developed trust and a sense of alliance gained momentum. As other forms of coping were steadily dismantled (most notably the CoSu coping mode), Alison's insight grew to better understand and appreciate the real damage that the AnOv was doing to the Child. What was once a protection was steadily being viewed as a foe, even if she was hesitant to completely relinquish it. It was particularly valuable for Alison to be able to conceptualise everything that pertained to her ED, whether the physical elements or the complex thought patterns, into one discreet component of her personality structure. Even my acknowledgement of the AnOv's intention to provide an immediate relief from distress for the Child made Alison feel less judged, and more empathically understood for the ambivalent battle she faced to disarm this protective vice. One-by-one, the functions of Alison's AnOv were identified as therapy progressed; whether to numb, suppress, evade, or insulate her emotional pain, or to instil an illusory sense of power and control or special attention to hinder her sense of defectiveness and unworthiness in a weakened and chaotic inner world.

Alison was only a few kilograms below her goal weight range (GWR) when we commenced ST, but she was sitting on a stubborn plateau. However, once we commenced ST, her new understanding and emotional appreciation for the true nature of the AnOv provided renewed momentum for her to enter the GWR and seldom drop below it. Emotion-focused techniques, especially chair work, brought the mode dialogues to life and enabled Alison to view

the interplay of voices on her mode map with a clear appreciation for the manner in which the Child was being compromised and deprived of her core needs for love, safety, spontaneity, and sound guidance. The AnOv was not dismantled in isolation, but became increasingly redundant as the HeAd grew in stature, the Child found her voice, and the DPM was steadily ushered into banishment. Dismantling the AnOv, in turn, provided space for the HeAd to grow and for the Child's needs to become increasingly clear and a vital part of the healing process.

CHAPTER 11: CONCLUSION – REFLECTIONS AND CLINICAL IMPLICATIONS

11.1. A New Treatment Model for Alison

Alison first consulted with me in late 2011 following much persuasion from her son, Eric, to receive treatment for her persistent AN condition. She had received significant previous treatment, including a year-long admission in a state hospital. However, none of this, including ongoing input from her psychiatrist and dietician, was assisting her towards recovery. While I have worked almost exclusively with ED and bariatric surgery patients since qualifying as a clinical psychologist in 1994, I worked almost entirely within the CBT/CBT-E (enhanced) models developed for EDs by Fairburn (Fairburn et al., 2003). This was until approximately a decade ago when I was first introduced to the ST mode model of treatment by my supervisor, Professor David Edwards. Intrigued by this, I began attending accredited workshops and reading much of the existing ST literature before applying ST to many of my existing private practice patients. I was immediately encouraged by the response. A number of researcher-clinicians in the field of EDs and ST (Simpson; 2012; Simpson, 2016b; Simpson, 2019; Waller et al., 2007; Edwards, 2015 & Munro et al., 2014) were already proposing ST as a viable alternative treatment model for patients who were unresponsive to the existing CBT and CBT-E treatment models. It was evident how attention to the EMSs and schema modes that pointed to the complexity of early childhood emotional injury might provide the impetus to the recovery process, now that treatment was significantly exploring beyond the symptomatology of EDs. While Alison had made some progress with CBT treatment prior to starting ST, we had clearly still reached an impasse in her therapy, whereby her weight was no longer being restored and the insight she had gained to the detrimental impact of her ED was insufficient to provide renewed impetus towards full recovery. It was this resistance to further change, and the inevitability that there were underlying issues that needed to be unearthed, that made her a suitable patient to start ST. The timing also made her a suitable candidate to participate in this research study. I knew that she required an approach that would not only achieve remission of her ED, but one that would engage us at a deeper emotional level where I would gain access to the complexity of issues that had significantly influenced her personality development after years of severe emotional abuse and neglect.

Given that Alison received CBT therapies from both myself and previous therapists before we began ST suitably placed her in a position to compare her experience of ST with her prior therapy experiences. Similarly, my prior experience within the CBT models before turning to ST also well-positioned me to compare the two approaches. What follows, therefore, is a discussion of some notable features in the 100 sessions of ST with Alison in exploring the effectiveness and suitability of the ST mode model of treatment for patients with EDs.

11.2. Case Conceptualisation and the emergence of Modes

The emphasis that the existing ST literature and the ISST has placed on the development of a comprehensive case conceptualisation is evidence of the pivotal role it plays in this model of treatment. While my university training pointed to the importance of conducting a thorough history in the assessment phase of therapy, ST not only emphasises the centrality of building a case conceptualisation in the assessment phase of treatment, but also to the importance of such assessment material being revised in the face of broadening information and new developments. Siegel (1999) reminds us that it is the case conceptualisation that facilitates a developing joint perspective between the therapist and patient by providing a common reference point with which to re-connect and fine-tune the therapeutic relationship. Green and Balfour's (2020) description of it as the "road map" or "scaffolding" around which the therapeutic process follows is in keeping with this. Only in hindsight did I appreciate the importance that a thorough case conceptualisation served as an essential foundation for Alison's treatment. It reminded me of her core injuries, the interplay in her constellation of modes, and the course that therapy would need to take in order for the Child to be healed. Identifying her EMS and modes was an important starting point. Alison, herself, recognised the value of the assessment phase of treatment that was central in building a case conceptualisation. When enquired about this in a study review interview conducted by an independent clinician, Alison expressed how the assessment and case conceptualisation contributed to my understanding of her; "I really felt he knew me (from the start). He was able to understand my feelings of what I was talking about the whole way through." I believe this reflected what Green and Balfour (2020) wish for the assessment and case conceptualisation process in already allowing for a particular expression of limited reparenting that is akin to the way a loving parent is with his or her child. One should show interest and be attentive to one's patients and their activities, validate their unique internal world, and provide a (schema) language and concepts that assist them in naming and making sense of their world.

One of the stand-out features of the assessment phase during which the foundation and primary pillars of the case conceptualisation were being built, was helping Alison to understand and appreciate the concept of schema modes and the way in which this multiplicity of parts of her personality engaged in dialogue. It was not an easy task to emotionally engage with the Child modes; whether the VuCh refusing to be tearful or the AnCh being too deeply entrenched in guilt to express outrage for the abuse that she faced for much of her life. However, these Child modes did emerge, and it was the engagement with these modes that was central to Alison's ultimate healing. Were it not for her appreciating and wholeheartedly resonating with the broader constellation of modes in her personality structure, I suspect that the healing process would have been significantly delayed or never achieved. Even during the assessment phase, Alison already displayed excitement at the notion of distinct parts making up her personality, and that these parts were engaged in powerful dialogue. Like many other patients in my practice, Alison's first concern was that she had a "split personality" that was akin to the common misconstrued picture of

schizophrenia. When I enquired with her if she, like me, often heard a thoughtful conversation going on inside her head battling to resolve a dilemma, for instance, she very quickly came to appreciate the existence of multiple internal views which were often in conflict with one another. This laid the platform for an executive mode that would stand guardian over the Child; a mode that would reflexively stand back from the clouded view of the Child and deliberate what was best for her. Although she quickly grasped an understanding of the purpose and functions of this HeAd mode, its construction took time and required much coaching and practice. Another repeated challenge was the phenomenon by which some dysfunctional modes, like the AnOv or PuPa, were misconstrued by Alison as the HeAd because of the strength and authority they held. Simpson (2020) makes the same observation, noting how easily the ED mode can be misconstrued as the HeAd because the former appears so "convincing, logical, rational and efficient" (p.91). It was critically important that I empathically interrupted this process, ensured that Alison recognised the true identity of these modes, and that I reinstated the HeAd to its rightful position of authority. She further recognised the function of all her coping modes to mask the disease in the Child where a healthy influence was lacking. She felt my empathy for such modes whose intention was to assist the Child, but also quickly understood the purpose of coping modes in their protective role to mask the VuCh from pain where a healthy influence was absent. She was conscious of my empathic confrontation of the coping modes, whose intention was always to protect the Child from the harmful echoes of her mother that were overly demanding, critical, punitive and mostly guilt-inducing. It was novel for Alison to witness me neither condemning nor judging the coping modes, but, nevertheless, needing to confront their contradictory effect of further hindering the Child. They needed to be made obsolete and replaced by healthy influences – whether me or, ultimately, a consolidated HeAd mode.

11.3. Measurable Changes in the Strength of Schemas and Modes

Research confirms a strong association between ED pathology and the presence of EMSs, of dysfunctional coping strategies and the perception of dysfunctional parenting experiences. For instance, studies demonstrate higher levels of EMSs for ED sufferers compared with controls (Dingemans, Spinhoven, & van Furth, 2006), and that a higher number and type of EMSs predicts the severity of ED symptomatology (Baba-ee, Khodapanahi, & Sedghpour 2007; Stein & Corte, 2008). Other studies suggest that the specific negative perceptions ED sufferers have of their parents during childhood influences the relationship between EMSs and the form of eating pathology (Murray, & Meyer, 2009). The study by Sheffield et al. (2009), for instance, indicates how the avoidant coping behaviour of ED sufferers that serves to inhibit their thoughts and emotions is associated with a perception of an emotionally inhibited mother.

As is the case with all patients entering my practice, Alison showed evidence of many strong EMSs that inevitably developed even decades before her ED manifested in her mid-twenties. With her history of an enduring and

extremely severe AN, it was not surprising that her results on the YSQ at the start of the study reflected significantly elevated scores on most of the 18 EMSs described in Appendix 1. Such results were consistent with the history gathered during the initial assessment that provided abundant evidence of a childhood punctuated by severe neglect, abuse, and a significant deprivation of basic needs. Where scores were extremely elevated on all of the EMSs in the Disconnection & Rejection domain, scores were also significantly high on the Failure, Enmeshment, Subjugation, Self-Sacrifice, Emotional Inhibition and Punitiveness EMSs. Results of repeat administration of the YSQ upon completion of the study (see Figure 21 in section 7.6.1.) reflected significantly decreased scores for all schemas in the Disconnection & Rejection domain, suggestive of significant healing with regards to unmet needs and resolve after reflecting on an original family environment that she experienced as extremely cold, detached, lonely, rejecting, abusive and, at times, explosive. It is likely that Alison's positive response to limited reparenting and subsequent growth in the HeAd mode accounted for the significant schema healing within this domain. Her score on the Vulnerability to Harm EMS had also decreased significantly by the end of the study, suggesting that she felt safer in a less hostile and dangerous world. For many EMSs in the remaining four schema domains, however, scores remained static and, in some instances, even increased marginally. For instance, the three EMSs in the Other-Directedness domain (Subjugation, Self-Sacrifice and Approval/Attention-Seeking EMSs) that manifest in compliant surrenderer and attention/approval-seeking coping mode behaviour remained relatively unchanged. So, too, did scores for the Failure, Emotional Inhibition and Punitiveness EMSs remain particularly high. Scores on the Pessimism and Unrelenting Standards EMSs in the Over-vigilance & Inhibition domain, however, reflected higher scores upon completion of the study.

While it is a priority to resolve AN pathology early in therapy for the purpose of limiting the severe mental and physical risks and complications associated with this life-threatening condition, it should be noted that such dismantling of the AnOv mode weakened some, but not all, EMSs. Although Alison made significant progress early in ST to normalise her relationship with food and seldom fell below a normal weight range, it is an interesting observation that such disabling of the AnOv coping mode still left many EMSs unchanged or even increased upon retesting on the YSQ at the end of the study. One explanation for this is that the dismantling of the AnOv as a means of coping exposed schemas that were previously lying dormant. The study by Trottier and her colleagues, for instance, demonstrated how the emotions and symptoms of PTSD were exacerbated once the suppressing effect of ED pathology had been resolved (Trottier, Monson, Wonderlich, & Olmsted, 2017). Chapters 8 and 9 provide clear evidence of how Alison's decreased ED pathology brought significant accessibility to both the VuCh and the AnCh. This more authentic engagement from the Child without the emotionally masking effect of the AnOv made for broader access to Alison's emotional injury, thus bringing deeply residing schema-based memories and experiences into focus that were previously inaccessible. Furthermore, while the AnOv was significantly curbed early in therapy, Alison still engaged, sometimes intensively, in other coping mode behaviour that reflected underlying schema activity. Persistent CoSu coping reflected still strongly entrenched subjugation and self-sacrifice

EMSs. Exaggerated scores for the Pessimism and Unrelenting Standards EMSs on retesting suggested increased schema triggering once the ED had been largely dismantled and the Child was more emotionally exposed. Two further explanations for unchanged or increased scores at the end of the study might be the heightened insight that Alison experienced through the 100 sessions to be more aware of her EMSs, and the possibility that the trust developed in the therapeutic relationship was conducive to Alison being more forthcoming as the therapy advanced.

For individuals who have a significant number of EMSs frequently being activated and blurring their psychological landscape, the development of the mode model emerged as a logical solution. Results of Alison's YSQ confirmed a broad spectrum of EMSs. Where the mode model has become increasingly popular to schema therapists and was central to my training, it was only natural that I would adopt this framework in treating Alison. Chapters 8, 9 and 10, together, address all Alison's most prominent modes. While the 14 modes measured on the SMI include the PuPa and DePa, five child modes, select coping modes, and the two healthy modes (HeAd, Contented Child), these did not comprehensively reflect everything that appeared on Alison's personalised mode map. However, Alison's pre-and post-study results of the SMI (Z-scores in comparison with normal controls) did reflect some significant changes. While her DePa decreased from 4.07 to 3.07, her PuPa actually increased from 5.97 to 6.49. This increase in the latter reflects the challenge that continued beyond the 100th session to curb Alison's reflex to be punished for any perceived fault. This sustained PuPa was well-illustrated in sessions 86 to 89 where Alison still continued to persuade her son to punish her for the way in which her AN had resulted in her emotionally neglecting him during his childhood.

Although Alison had gained a clear metacognitive understanding of how cruel, dysfunctional and inappropriate this echo of her mother's voice was, we still faced the challenge of her being able to wholeheartedly banish this introjection and replace it with a nurturing and compassionate HeAd that would also help her to accept the love and forgiveness of others. It is also possible that the amplified PuPa was due to the subdued AnOv, for which one of its functions was to serve as a punisher; what Simpson (2019) has assigned to a Self-Flagellating Overcontroller coping mode. This function was now being exclusively held by the PuPa. Comparison scores on the SMI showed the CoSu coping mode to decrease the most significantly during the course of 100 sessions. Not only was the CoSu directly confronted on many occasions in chair work, but as Alison became increasingly confident and entitled to engage with the AnCh, so the need to be submissive and avoid conflict situations decreased. There were also significant changes in the Child modes over the course of therapy. Results of the SMI indicated decreases in both the Undisciplined and Impulsive Child modes by the end of the 100th session, albeit that both the modes were very repressed from the outset and always scored in the negative when compared with normal controls. The Enraged Child also decreased over the course of therapy. However, it was the AnCh that decreased significantly, having a Z-score of 2.27 at the start of treatment and decreasing to 0.6 over the two years of therapy. This is strong statistical

evidence of the progress that Alison made in accessing her AnCh through the course of treatment and giving voice to a mode that was severely suppressed and hindered at the outset of therapy. The SMI reflected similar decreases in the VuCh through the course of therapy, decreasing from a Z-score of 2.22 to 0.45. The SMI measures the VuCh as one broad and composite Child mode, yet it is a mode that includes sub-categories that point to many of the EMSs. Alison's VuCh, for instance, felt emotionally deprived, abandoned, mistrusting, socially isolated, defective, ashamed, a failure, emotionally inhibited and pessimistic. Much of the decrease in the VuCh Z-score at the end of two years of therapy can be accounted to the significant decrease in all the EMSs of the Disconnection & Rejection domain, as confirmed in decreased scores on the YSQ after the 100 sessions of ST. Finally, Alison's healthy modes also showed significant improvement over the duration of the study. Where the Z-score of her HeAd was -2.32 at the start of the study, the subsequent score two years later of 0.0 indicates that Alison's HeAd mode was exactly aligned with the normal population. With even greater statistical significance, her Contented (Happy) Child mode was significantly lower than the normal control with a Z-score of -2.63 at the start of the study, but two years later was 0.7, indicating that her Child was more content and happier than the normal population by the time the study was completed.

11.4. Emotion-focused Work as a Platform for Change

While I have outlined how a thorough assessment and detailed case conceptualisation provides an opportunity to identify prominent schemas and modes, it is with tools like chair work, imagery work and the use of emotion-focused techniques that ST with Alison brought the modes to life. For instance, preliminary findings suggest chair work to be particularly effective in the treatment of EDs (Dolhanty & Greenberg, 2009; Pugh & Salter, 2017). In his webinar outlining the four dialogues of chair work, Scott Kellogg (2019) reminds us that chair work is not about chairs, but about the mobilising of internal voices. Rather, individuals with EDs present with diverse and often conflicting schema modes (Pugh, 2015) and chair-based techniques offer the therapy a means of identifying key modes with which to familiarise both the patient and therapist (Pugh & Rae, 2019).

In the many instances in which we did chair work, Alison was able to give voice to emotion residing in the complexity of mode dialogues. As we became increasingly attuned in our therapeutic relationship, so she was increasingly forthcoming in telling her stories; relinquishing the burden of secrets that had been suppressed into darkness for decades. Alison understood that she needed a new story – a novel view of her life upon a new platform with which to build a safe and secure life for the Child. Bringing to life the internal dialogues provided Alison with the knowledge that the sometimes even very conflicting voices could co-exist and engage with each other, with one part witnessing the other. What began with much active involvement and modelling from my side, her HeAd was able to learn from this and begin confronting chairs designated for the punitive, critical and demanding parent modes very early in therapy. Yet, even as early as S3, the AnCh was able to chastise her mother

for her deplorable abuse, albeit with much hesitancy. While the HeAd expressed much of the anger early in therapy, the AnCh steadily built confidence to assume this role, at times even enraged in the way she confronted the DPM, her abusive parents, as well as the AnOv when she gained the insight to its paradoxical nature of supposedly protecting but really perpetuating abuse. Alison was surprised by the impact chair work had on her capacity to connect emotionally. *"Wow, it is amazing that he can take me from one chair to the other and feel like a different person,"* she shared in the post-study interview with an independent clinician. At times, it was difficult to tolerate; *"He's put me in a chair where I was angry – aww, no, no, no, I don't want to think about it."* However, she also came to realise the importance of tapping into that Child anger, appreciating the "intensity" with which I persisted with this. Besides the relational encounters across the chairs providing a platform for conflict, Alison was also able to grieve the life stolen from her, appreciating the extent of the deprivation of needs and the significance of abuses that she faced in her childhood. This was an important part of the healing process and, again, chair work provided an excellent stage upon which to fully appreciate and engage in this healing process between a steadily developing HeAd and the VuCh modes; a pivotal dyad by which a Contented Child needed to evolve to feel nurtured, protected and guided. Perhaps more so than anywhere else in the therapy, chair work provided both Alison and me with the clearest arena within which to bring the mode map to life. When she mode-flipped, the chairs served as an excellent prop with which to interrupt that process, slow it down, enhance her meta-awareness of the unfolding drama and, together, work towards growth and integration.

While my preference drew us more frequently into chair work, the few instances in which we used imagery rescripting, even very early in therapy, very effectively brought vivid insight to the extent of abuse that Alison experienced early in her life. In fact, evidence points to the fact that the greater the number of ST sessions that include imagery rescripting, the better the outcome (Morina, Lancee & Arntz, 2017). Besides providing a detailed landscape to the experiences of hardship Alison experienced in her childhood home, the very first instance of imagery rescripting as early as S2 already demonstrated how responsive she was to the rescripting component of the exercise, actively contributing to the building of corrective scenarios to provide the Child with a safe and secure ending. As Goulding and Goulding explain of this process, "the drama is carefully plotted to end victoriously… we do not want to produce tragedies – we are interested in happy endings." (1997, pp.177-178). In the post-study interview, Alison described how imagery rescripting allowed her to: "really see the situation that I was having as a child – and it was so real! I don't even have to think about it." She explained how she would go home after a session of imagery rescripting and lie down for an hour from the exhaustion of the experience. As she explained, "*I realised I was an abused child, and I'm not going to – I cannot – blot it out any longer. I've got to accept it. It's a fact and I must accept it and I must be with it."* Alison realised that in order to be able to resolve the abuse she experienced, she could no longer evade the memories through coping behaviour, but would need to face the abuse directly and build a new scenario in which "Little Alison's" needs would be met. This was an essential lesson in Alison's therapy; that her pain would not disappear without running the gauntlet of acknowledging the abuse

and working through it, rather than trying to evade it. In retrospect, I suspect that Alison might have benefitted from more imagery rescripting than I provided her. Perhaps her very positive response to chair work resulted in me under-utilising this other powerful experiential domain. Some patients in my early years of doing ST viewed imagery rescripting as contrived or were concerned that the rescripting process dismissed the reality of their original trauma. However, I have since realised the importance of strongly emphasising that the rescripting scenario does not serve to nullify the existence of the initial trauma, but that it rather serves to present what should have happened, or what the patient deserved, that was not accessible to them in the original event. This points to the importance of very carefully explaining the rationale for the exercise.

When asked in the independent study interview whether she was aware of any body-focused work, Alison could not recall such instances. While there were some instances in which I did explore bodily-felt sensations with her, her non-recollection suggests a missed opportunity to more fully utilise this domain, especially where my subsequent training and clinical experience has confirmed the manner in which such work has deeply enriched the emotional connectivity for many of my patients. It might be the case, as Briedis and Startup (2020) have often observed as trainers, that I, as a therapist, was anxious to enter what was an unfamiliar arena at the time, or that I was concerned that any mention of the body would evoke strong feelings of distress and shame for Alison. In hindsight, my own ST supervision, reading of the literature and my subsequent clinical experience has broadened my appreciation for such work. Relevant to my work with Alison, I now appreciate the view held by Van der Kolk (1994, 2017) that the safest way into trauma is via body sensations. This "bottom-up" approach would have likely provided not only a safe and hastened access to Alison's trauma, but more meaningful shifts of intense emotional memory than working predominantly at a narrative (top-down) level. As Briedis and Startup (2020, p.63) so rightfully state, "there are situations when there is simply no amount of talking about the trauma that can undo its effects".

11.5. The Importance of Building the Healthy Adult Mode

What was evident in Alison's therapy was the importance of the development of the HeAd mode; a mode that forms the bedrock of guardianship, empathy and limit setting towards a safe and contented Child. This dyadic relationship defines the ultimate pursuit in ST – that the HeAd ensures that the critical, demanding and guilt-inducing presence of the DPMs be banished and that all coping modes be dismantled and deemed obsolete. Rather than a goal, the ideal would see the only modes frequenting a mode map being a sturdy and all-present HeAd standing guardianship over a contented, happy and creatively spontaneous Child; each mode requiring the other. Alison's VuCh would not have healed without the presence of a healthy (adult) influence. Similarly, there would never have been a sufficiently safe and secure context for AnCh expression unless there had been a healthy adult influence to validate and resolve the root of her anger or rage. While this essential goal of systematically

developing the HeAd mode provides the pathway towards patient autonomy, it was my task, as therapist, to initially fulfil this proxy role of Alison's HeAd, modelling all the healthy qualities that define this critically important mode until her HeAd was securely integrated.

The development of Alison's HeAd mode was an arduous task and punctuated with numerous challenges. Even towards the end of the two years of regular weekly sessions, her HeAd was still often marginalised by the PuPa mode aggressively resuming a stranglehold over the VuCh. The conjoint sessions with her son, for instance, were testimony to the strength that the PuPa mode still held more than 80 sessions into the therapy to emphatically insist that Alison still be punished, despite Eric repeatedly urging his mother that she was forgiven for her inadvertent failings as a parent due to her ED. Although there was evidence very early in therapy that Alison had already formed a strong metacognitive appreciation of the need for a loving and nurturing HeAd mode to engage with her inner child, such intellectual insight needed to progress to a deep emotional connection for real change to occur. This is where the emotion-focused work was instrumental in bringing about significant and lasting change. Such emotion-focused techniques, especially in chair work, served not only to access Alison's HeAd and Child at a deeper emotional level, but also helped me resonate at a deeper emotional level as we shared in her experiences. This shared resonance deepened the limited reparenting process – an important precursor to Alison's own HeAd development. Similarly, my expressed anger for the abuse Alison faced in her childhood made this a more valid and permissible emotion for Alison to express from both her HeAd and AnCh. Another challenge was for me to be perceptive to and interrupt the many instances in which Alison misconstrued the PuPa or the AnOv as the HeAd because of the control these former modes evoked in her. Chair work, again, served as the most convenient and opportune setting in which to disentangle the modes and ensure that Alison correctly identified modes.

Alison successfully cultivated many of the important qualities of the HeAd comprehensively, with the most important quality possibly being the need for balance and moderation. She made some headway in being increasingly mindful, having the ability to step out of a situation and to observe it without being clouded by subjective bias. Alison also reflected many of the strengths that Bernstein (2019) associates with the HeAd mode. With regards to self-directedness, Alison's sense of personal identity became clearer, more genuine and real. She became increasingly self-aware and more introspective as she reflected on the plight of her childhood experiences. Where early on in therapy she was automatically submissive, her dismantling of the CoSu coping made way for a more assertive, self-assured and bold manner. Once Alison's HeAd had significantly dismantled the AnOv, she became increasingly self-nurturing and expressed heart-felt empathy and compassion towards the wounded Child within. While these were qualities that she had always demonstrated in her interpersonal relationships, they were now being reflected at an intrapersonal level.

The value of personalising modes to each specific patient was demonstrated in Alison making the HeAd mode synonymous with Christ. Despite her mother gravely distorting her daughter's Catholic value system, Alison's image of Christ was of an unconditional all-loving, protective and nurturing guardian. This provided a very valuable and ideal blueprint by which to strive and emulate these qualities. Given Alison's strong DePa tendencies, I frequently reminded her that Christ was an ideal HeAd that she should not expect herself to emulate absolutely, but instead view His qualities as representing a very clear HeAd image.

11.6. A Place for a Specific Eating Disorder Coping Mode

Working within the ST model heightened my appreciation that Alison's AN not be viewed as the epicentre or entirety of her treatment. All too often clinicians terminate treatment once remission of the ED has been achieved and sustained. This does not, of course, refer to the many cases that require early termination due to limited resource and finances. I also appreciate the explanation that Daniel le Grange (personal communication, 2010) provides when describing how family-based treatment (FBT; Le Grange, Binford, & Loeb, 2005; Doyle, Le Grange, Loeb, Doyle, & Crosby, 2010) is frequently terminated after only the first of three phases of treatment have been completed. The first phase involves empowering parents to assume full control in restoring their anorexic adolescent child to a healthy weight and maintaining it. However, the underlying dysfunctional family dynamics are frequently addressed during this first phase of treatment, thus making it unnecessary to embark on the subsequent phases that, respectively, address the transition of control and, finally, patient autonomy and social re-integration. While I appreciate this view, I have always remained concerned whether the complexity of issues that underlie the ED are thoroughly identified and addressed. Whereas the CBT models of AN treatment are primarily concerned with the elimination of AN symptoms and diagnostic remission, a schema therapist would view this merely as the suspension of one specific, albeit important, coping mode; the AnOv. While I am not understating the importance of achieving remission of the ED, I view this as one important goal, but by no means a sufficient reason to terminate treatment. It is imperative that the therapist also addresses underlying EMSs, ensure that the patient's mode map is devoid of the DPMs, and that all coping mode behaviour is suspended and replaced by a Child trusting the nurturance and protection of the HeAd mode.

Alison made significant inroads towards dismantling her ED behaviour early in therapy, despite the AnOv coping mode still remaining consistently vocal. However, these early inroads were not due to a robust HeAd, but due to the prominence of another coping mode; the CoSu. Her submissive nature reflected the very high Subjugation and Self-Sacrifice EMSs scores of the YSQ at the start of the study. As such, much of Alison's early compliance with the treatment team, whether her diligently following her dietician's meal plan or the prescribed homework tasks, was motivated by her need to be met with approval or, perhaps more importantly, to avoid condemnation or any form of conflict. While such compliance still held value, it was clearly not being driven by a sincere and authentically

intrinsic motive. In an interview with an independent clinician after the study, Alison specifically mentioned that none of her previous therapy spanning more than three decades had any impact on her because it was, in its entirety, only attended out of a submission to please others and avoid conflict. However, she described how ST directly addressed this CoSu coping and how, once it was dismantled, paved the way for an authentic road to recovery. "… This is a totally different situation. I want to be with Graham – and I want to overcome this illness," she said in the interview. Once an embryonic HeAd mode took root, there emerged a more legitimate drive for compliance. Addiction counsellors often convey to patients the aphorism that they should "fake it 'till you make it", essentially encouraging patients' compliance with treatment, even though they have not intrinsically committed themselves to the healing process. Nielsen (2015) explains this concept, whereby imitating confidence, competence and a positive mindset, the individual can realise those qualities in a consolidated state of recovery. As far back as the 1920s, Alfred Adler had already developed a therapeutic technique of "acting as if"; a strategy that gave patients an opportunity to practice alternatives to dysfunctional behaviours (Watts, 1999). This is something that Alison and I carried out through role play or chair work. This early compliance with the meal plan was already indicative of some HeAd development through the conscious decision to follow the team's advice. She was capable of standing away for the Child's clouded judgment and, at least, be governed by a HeAd metacognitively appreciating the importance of her physical repair as an integral part of her broader healing process. As such, she was able to more mindfully stand back from the AnOv, better understand its paradoxical nature, and appreciate the importance of following the dietetic guidance that promoted the necessary weight restoration.

Alison's AN exemplifies Edwards' (2017a; 2019) conceptualisation of the AnOv – a distinct stand-alone, complex and composite overcompensatory coping mode – as a single system that incorporates many distinct elements and functions that operate together. Like all coping modes, the AnOv was born out of the persistent threats that the Child mode faced; first at the hands of her mother's abuse and then from DPM as an introjection of many of her mother's qualities that were demanding, punitive and critical. There is abundant evidence that, prior to the development of her AnOv, Alison's mode map was already frequented by many other coping modes, most notably, the CoSu, DePr, AvPr, Worrying Overcontroller (WoOv), PeOv and ObOv. While these coping modes served to protect Alison from the DPM, they were evident before the parent introjections that "protected" her in the face of significant parental abuse and neglect. The AnOv was precipitated in the wake of her father's death, where unintentional weight loss as a result of the stressors she faced after her his death exposed the first functions the AnOv fulfilled – that of eliciting attention, alerting others to the stress that she was experiencing, and creating the illusory notion that she felt more in control and powerful through strong control of her body. The full array of functions that the AnOv fulfilled are outlined in Chapter 10. The qualities of the AnOv indicate that it evolved out of four existing coping modes, namely the PeOv, ObOv, WoOv and the DePr. Yet it held a distinct and exclusively specialised focus on food, weight and body shape-related issues. Although the AnOv manifests in food, weight and

shape control behaviour, the underlying functions are mostly disrelated to concrete issues around food and weight, but pertain more to the suppression of emotion residing in the Child. Of course, this is similar to many other coping modes. A good comparison is alcohol dependency, where the DeSS coping mode manifests in the numbing effect of excess alcohol use, while the real motive for the coping mode is the anaesthetising of distressing emotion sitting in the Child. Another composite element of Alison's AnOv was the manner in which angry coping was evident as an adjunct ally to the AnOv. While there is no evidence of angry coping at any other time in Alison's life, its rare appearance, most notably in S12, was only when the AnOv was being threatened by others. As such, this intimidatory behaviour should be viewed as an integral part of the AnOv rather than being seen as an independent coping mode.

There is significant evidence of how both Alison and I benefitted immensely from conceptualising her AN as a specific stand-alone coping entity; an internal voice that defined one part of her personality, and whose sole purpose was to cope with the vast accumulation of emotional pain that she experienced throughout her childhood, adolescence and young adulthood. It was valuable to be able to confront all the ED behaviour in one specific and clearly identifiable part of her personality make-up, especially where this coping mode has a diversity of motives or functions. Furthermore, identifying the AnOv as a specific stand-alone mode also brought the ED into sharper focus, especially on platforms like chair work, as a specific component of her personality make-up. This was far more helpful for Alison than seeing it as an element that defined her whole sense of self or as an aspect that permeated every aspect of her life. Another advantage of holding the ED as a specific mode provided an opportunity for me (and even Alison) to be compassionate towards it, given that its birth and original purpose was to supposedly assist the distressed Child in the absence of sufficient HeAd. While this is equally valid for all coping modes, it was important that Alison had the opportunity to express compassion for a part of herself that would typically be outright condemned by clinicians and counsellors. Such compassion for the AnOv's existence helped towards absolving Alison of any guilt for having an ED and helped diminish her self-condemnation for having this condition.

11.7. The Therapeutic Relationship

Lambert (2013) states that the therapeutic relationship is the most influential factor that impacts upon the outcome of treatment. Where such a relationship subconsciously facilitates mutual perception, appraisal and action, one has what Siegel (1999) calls "resonance". In order to measure this therapeutic process, one needs to fully analyse both the patient's and the therapist's perspective. Because the term "transference" (and "counter-transference") is so rooted within the psychodynamic domain, Roediger and Archonti (2019) have proposed speaking of the "client-therapist chemistry" (p.222), even though one is essentially talking about the same thing. This chemistry formed a significant aspect of the success in my work with Alison; something that ST holds central to its design.

In my work with Alison, it was not only valuable for me to identify and monitor her EMSs, but also to be astutely aware of my own schemas, emotions and response behaviour. Roediger and Archonti (2019) explain how therapists are only one step ahead of their patients when it comes to identifying, understanding and dealing with their own schema activation. While, as a therapist, I have always appreciated the importance of monitoring my own emotions and reactions to a patient, working within the ST model heightened the importance of this process. I was conscious to reflect on my own feelings after sessions with Alison. However, it was my detailed analysis of each session with Alison as part of the study design and my attendance of regular supervision that broadened even further my awareness of my own emotional journey. As therapy progressed and my experience grew, I became increasingly aware of my own schema activation in real-time. By this, I was not only serving as a healthy role model for Alison, but my process became an integral part of the therapeutic dance and an integral part of both Alison's and my own growth processes. It is well established that therapists are drawn into the helping professions due to their propensity for EMSs in the Disconnection and Rejection domain (Bamber & McMahon, 2008) and that therapists with EMSs in this domain are particularly prone to vulnerability and burnout (Simpson et al., 2018). Results of the YSQ-S3 that I completed before the study showed low scores on these EMSs (see Figure 19 in section 7.6.1). However, I scored above 15 on three EMS, namely Insufficient Self-Control (22), Unrelenting Standards (21) and Self-Sacrifice (17). Kaeding et al. (2017) and Simpson et al. (2018) confirm the latter two to be typical of therapists, suggesting underlying fears of failure. Although I was very satisfied with Alison's ED recovery path, her occasional lapse from healthy eating habits after she achieved remission was something that evoked heightened anxiety in me. Especially because I was relatively new to practicing ST, and the fact that Alison was a study participant, I hoped to see her make good progress. As such, I needed to be cautious to not engage in any researcher-bias; an issue that is covered in the methodology chapter. I experienced feelings of self-doubt and even failure when her PuPa stubbornly persisted, even towards the end of the sessions designated for the study. Thankfully, various platforms of supervision helped me to normalise these feelings and not project my own Unrelenting Standards EMS onto Alison's already prominent DePa mode. It was important that I did not question my own competence, but acknowledged that Alison was dealing with decades of deeply entrenched emotional injury, and that it would take much time for deeply entrenched modes to be fully dismantled.

Lockwood and Perris (2012) describe the two contrasting tasks of the schema therapist of limited reparenting and empathic confrontation as the "maternal mode" and "paternal mode" respectively. The former, which is typically the starting point of therapy, is where Alison required of me understanding and validation, authentic warmth, empathy, safety and protection, and the freedom to safely express herself. After she more deeply appreciated the immense abuse and neglect she faced at the hands of her parents, my task was to repeatedly validate the vulnerability and anger residing in the Child. Despite strong resistance from the PuPa, I experienced the limited reparenting process to be deeply emotional, evoking strong feelings of nurturance within me. This was especially the case during chair work and emotion-focused work in imagery, where the reparenting process involved me very

actively adopting the loving and nurturing role. Although I am chronologically young enough to be Alison's son, I was often struck by the nurturing and caring parental feelings that welled up in me. There were many moments throughout therapy where I succeeded in engaging with the feelings inside "Little Alison". It did help that my own daughter was three when we started ST. I was, thus, often able to draw on my parental intuition to foster a resonance with the little child residing within Alison's fragile and tired external appearance. Of course, a vital part of the working alliance required me to pass the baton of this reparenting role to Alison in the methodical construction of her own HeAd mode. Sometimes this required a shift from the Child's more highly triggered and emotionally activated state to one that was "cooler", whereby we could collaboratively task ourselves with building the HeAd and viewing the Child's circumstances from a more objective and clearer perspective.

There were many occasions throughout therapy where I needed to be attentive to Alison's capacity for tolerating heightened emotional activation. Siegel's (1999) concept of the "window of tolerance" (see section 3.2.4. of chapter 3) best describes the manner in which the therapist needs to assume thermostatic control of the emotional temperature in the therapy space. I seldom, if ever, experienced Alison's level of engagement to be so low that she was detached or lacking motivation to learn. However, there were numerous instances in which the PuPa's aggressive threats towards the VuCh or the challenges that I directed at the AnOv resulted in her being so highly activated that she detached, or experienced what Goleman (1995) terms "emotional hijacking". Occasionally, I needed to deliberate between either conservatively lowering the thermostat to avoid Alison facing overwhelming emotion, or test the upper edge of this window to facilitate an emotionally powerful learning situation. In the latter, we not only faced the prospect of her being emotionally hijacked, but the risk that she would lose trust in my ability to hold her or the prospect that she would engage in deeper self-flagellation and self-condemnation. Thankfully, this never happened, and I was always able to maintain a sufficient engagement with Alison for her to negotiate some very challenging moments in her therapy.

Another feature that I believe enhanced the therapeutic relationship and tightened the therapeutic alliance was our contact outside sessions. Although I had encouraged Alison early in therapy to contact me on my mobile phone when she felt the need for immediate support, it was only in the week preceding S22 that she first did so. Recent sessions had been addressing her emerging sexual and emotional intimacy in her marriage after decades of suppression and guilt. This created anxiety and vulnerability, which had the effect of activating the AnOv that manifested in some restrictive eating. Although Alison was initially apologetic in S22 for having contacted me a few days earlier, I not only reassured her that it was a valid reason for contacting me, but also reminded her that it was a HeAd feature that she had reached out for support instead of struggling until her next appointment. A good analogy would be the advantage of dousing the small flames of a fire that has just started rather than facing a roaring fire much later on. What contact she made with me between sessions was also appropriate and served to stave off coping behaviour and reinstate the HeAd's position of ascendency. There were occasions when I

requested Alison to even text me daily with feedback of her level of meal plan compliance when she was strongly active in the AnOv mode. Although she sometimes expressed feeling unentitled to contact outside sessions, she eventually embraced this idea. The post-study evaluation interview conducted by an independent clinician revealed Alison's gratitude for the opportunity to contact me between sessions. *"He's so generous with his time… Wow, it was amazingly beneficial… and lovely knowing that I could phone if I needed to,"* she said to the interviewer. While some therapists are very cautious about their patients engaging with them between sessions (e.g., phone calls, texts, emails), I have encouraged it. I also believe that such out-of-session contact enhanced Alison's experience of my genuine care, especially where such support extended beyond the contractually agreed once weekly therapeutic hour. I have only once in the past decade needed to set limits with a patient who exploited this arrangement of outside contact. Her excessive contact and demands reflected an overcompensatory coping due to fears of abandonment and a strong Emotional Deprivation EMS. Despite this, and the risk of engaging in discussions on important therapy issues via text or email, I believe that contact out of therapy sessions can augment the therapy process very effectively, provided the purpose of such contact is clearly established and that limits are clearly defined.

Another feature that significantly enhanced the continuity of therapy was the provision of homework tasks; something that ST identifies as an integral aspect of treatment. While the small volume of inventories that Alison completed each week (outlined in Chapter 5) primarily served to measure her progress through the study, she found them very useful. In the post-study evaluation interview, she particularly noted how the Session Bridging Form (SBF; adapted from Beck, 1995) helped her in *"clarifying (her) feelings"*. Another regular homework task that Alison valued was to construct flashcards for the situations that highly triggered the Child mode. After completing her first draft as a homework assignment, we reviewed them and made the necessary adjustments to optimise their value. These highly triggered moments were often identified when she completed another useful worksheet: the STISA Triggering Diary and Schema/Mode Analysis (See Figure 2 in Appendix 5). Typical of many AN sufferers, Alison not only avoided eating in public, but ate alone at home because of the fear and shame she faces at meal times. During therapy, we challenged this socially isolating behaviour by steadily broadening her tolerance to eat with others. While, at first, she ate with her husband, she was eventually able to eat in restaurants, realising the liberation it offered her at a broader level. *"I've got no difficulties eating in public now,"* she expressed in the post-study interview. *"It's lovely. I feel so part of the group. It's so much nicer. It was awful having to hide away from food – oh, it was dreadful. Now I can be so much more spontaneous,"* she added. She described how her spontaneity to eat out generalised to all other social settings, and how her broader sense of spontaneity in life (a HeAd strength) was one of the most liberating accomplishments of her therapy. Such work done outside sessions was an invaluable aspect of treatment. Not only did it effectively augment the work done in sessions, but it served as an excellent measure of her HeAd development.

Another important feature in the therapy with Alison was my use of personal disclosure. While my psychodynamic training almost three decades ago strongly cautioned against therapist disclosure of personal information, this notion has never sat comfortably with me. In my own personal therapy during and following my clinical training with two different therapists, I learned very little about the character and circumstances of my therapists. While I respected their stance for privacy, not being privy to basic information such as their marital or relationship status left them less relatable to me. From my perspective, this did impact on the alliance and resonance of the therapy relationship. As a therapist I've always felt comfortable inviting patients into aspect of my personal life, provided it was relevant and added value to the therapeutic process and, most importantly, instilled a deeper sense of trust and resonance in the therapeutic alliance. When I became a schema therapist, its ethos with regards to self-disclosure reinforced my conviction of its contribution to the therapy process. In their review of the opportunities and challenges regarding therapist self-disclosure in the third-wave therapies, Köhler et al. (2017) specifically highlight the value of such self-disclosure as an opportunity for the schema therapist to model HeAd qualities in the limited reparenting process. Köhler et al. (2017) describe therapist self-disclosure not only by the sharing of personal information, but also by the therapist's own display of thoughts and feelings that are evoked in sessions. When enquired about my self-disclosure in the independent interview following the study, Alison commented on both of these. With regards to the latter, which pertains largely to the reparenting process, Alison described the rapport of the therapy relationship. She described me as *"very warm and so sincere"* and showing my willingness to provide all that I could to promote her healing. Asked to rate my empathy and compassion, she said I *"gave 100%"* of myself. She expressed how she felt very understood; *"It was remarkable. I felt a connection with him… I felt understood – he just understood everything. I felt I was on the same wavelength as him."* She believed that I was *"moved"* by what happened to her and elaborated; "*Yes, he shares – he absolutely shares – he says he feels sorry for the little child in me. He really shows his own feelings there.*" Alison went on to explain how I made reference to my relationship with my own daughter in order to engage with her VuCh; *"And he's a dad of a dear little girl, and he says he would feel – feel very sorry for his daughter* (if she experienced what my Child does).*"* She added that "*it's very moving"* the way I engaged with the burden that her Child was experiencing. She even spoke of some instances towards the end of some sessions where I cautioned her that if she did not take care of "Little Alison" between sessions, that I would keep the Child with me in my office to ensure the necessary nurturing care she needed. This impacted on her very strongly, explaining to the interviewer how this jolted her into HeAd so that she could maintain her engagement with the Child between sessions. From my own perspective, I also felt the warm resonance between us. Especially where chair work provided a very valuable platform for me to reparent Alison's Child, my adopting the HeAd mode position brought my own emotional engagement to an unexpectedly deeper and genuine level; whether empathising with the VuCh, encouraging the AnCh to speak her truth or personally engaging in banishing the DPM.

There were many instances during therapy in which my references to my wife and marriage, as well as my daughter, brought a relatability to the therapy. Alison commented how my anecdotes about my relationship with my daughter often felt to be similarly experienced in my nurturing of "Little Alison" in the reparenting process, especially because I often reminded her of how her VuCh was as lovable and entitled to her needs as my own daughter was. Although, at first, Alison thought that she was infringing on my private life by wishing to give my daughter a gift on her birthday, it was this kind of access into my personal world that I believe contributed to the natural healing process. Both Alison and I frequently made comparisons to my daughter when referring to the needs of "little Alison". This became even more meaningful since I moved my practice from a clinic setting to my home, where Alison has frequently seen my daughter and wife in person.

11.8. Alison's Capacity for Deeper Emotional Connectivity

One of the outstanding and contrasting aspects that Alison noticed about ST compared with the CBT treatment she received prior to the study was its emphasis on increasing emotional connectivity. Having spent much of her life in coping to suppress her feelings, entering this emotional arena in ST was particularly anxiety-provoking. When asked in the post-study interview whether she experienced an increased emphasis during ST in the pursuit of feelings, Alison was emphatic; *"Therapy has been frightening. I find dealing with emotions terrifying."* She described how she fought against the rising feelings and her deliberate intent on not being tearful: *"Yes, I fight against it (tears). I'll do anything to hide the tears – anything. And I feel awful when he gets me to show anger."* Although ST drew her into this arena of discomfort, she still recognised the benefit of such emotional engagement facilitating meaningful and deep psychological change; *"It's so thorough – it's amazing how he clarifies my feelings. It opens up a whole new aspect into what my problems are. It's very refreshing. Nothing has touched my emotions to the depth that this therapy does. Things were much more on the surface level. And these intense feelings that are evoked in me are coming from the results of schema therapy. I never experienced that in all my previous (therapy)."* When asked to reflect on my pursuit of her anger, Alison reflected how she was now recognising the benefits of this difficult process; *"I used to be ashamed of the feeling of anger I had for my deceased mother, but now I see that it is okay – it's okay to have had those feelings. They're justifiable. It's only in recent times that I have allowed my anger to show itself. I still feel hesitant about it sometimes… but I have become very much more aware of my feelings. I'm much more in touch with them, and I am much more consciously aware of how I'm feeling."* While realising this was still a challenging pathway to follow, Alison was now feeling the relief of expressing her anger, comforted by the notion that it was confined to specific parts (modes) of her personality.

Not only was Alison's engagement with the AnCh a significant and important component of therapy, but her engagement with positive emotion was also essential. This was especially the case given the puritanical Catholic principles instilled by Alison's mother for constraint, self-condemnation, and an inhibition to be spontaneous and playful. Reflecting on how liberated she felt once the AnOv had been largely dismantled, Alison spoke of the joy

she felt at being more spontaneous – enjoying eating out or going to the theatre on the spur of the moment. When she entered therapy to address an ED, she did not expect that ST would exceed this task to pursue a far more comprehensive agenda. She was not expecting that therapy was going to address her sexuality, something that had been buried in shame and guilt for most of her life. She realised how: *"… in anorexia I was sexually dead and a married woman. So, it was very awful leading a life like that. And now I am sexually alive and loving it." "It's been a beautiful revelation,"* she continued to explain in the study interview. She further described how *"astounded"* she was by the extent to which she *"lost touch with reality and entered into another place"* with her newfound sexual intimacy and a general sense of spontaneity. Such newfound emotional connectivity extended beyond her marriage to a growing number of family members and friends with whom she began to engage. She reflected on the past: *"I was absolutely surprised. I didn't realise I had such an empty relationship with people."* However, she now realised that she was far more interesting to others and was enjoying all aspects of social engagement with others. *"Life is so much fuller,"* she said, realising that the newfound emotional and sexual intimacy she was cultivating in her marriage had brought a new dimension to her marriage that she had never previously envisaged. She made the link with her ED: *"I've lost my obsessing about food and weight. It gave me no space to think or care about anyone else. I just had to be watching what I was eating and see that I was losing weight. Nothing else mattered. It was dreadful, but it's not like that anymore."*

11.9. Participants' Responses from Participants in the Post-Study Interview

As outlined in sections 5.7.7. and 5.8.2. of Chapter 5, an independent clinical psychologist conducted an interview 18 months into the study with all but one of the ten participants that started the study. While also contributing to the reliability of the study, the main purpose of the interviews was to elicit the participants' honest experiences of receiving ST for their ED. In my analysis of the full interview transcripts, 18 themes emerged. While the length restrictions on this dissertation prevent me from comprehensively addressing all 18 themes, I will discuss those that best illustrate common views expressed by the nine interviewees. Table 25 below provides a summary of the nine participants who attended the interview.

Table 25: Biographical Information for 9 Participants in the Study

Name*	Age**	Marital Status	Level of Education	Eating Disorder Diagnosis
Alison	64	Married	Teacher Diploma	r-AN
Anna	29	Single	Master's Degree	BED
Carla	27	Single	Honours Degree	BED
Cathy	33	Single	Undergraduate Degree	OSFED
Judy	49	Married	Undergraduate Degree	BN
Lilly	45	Divorced	Postgraduate Degree	BED
Rebecca	24	Single	Undergraduate Degree	AN-b/p
Tessa	28	Single	Postgraduate Degree	r-AN
Wendy	18	Single	Matric (Grade 12)	r-AN

* Pseudonym   ** Age at start of study   r-AN: Anorexia Nervosa (restrictive type)   AN-b/p: Anorexia Nervosa (purging type).
BED: Binge-Eating Disorder   OSFED: Other Specified Feeding or Eating Disorder

11.9.1. Assessment Phase

Many participants valued the distinctly identifiable ST assessment phase and the thorough and comprehensive manner in which information gathering occurred. *"He really knew me,"* Alison said after the six-session assessment phase of treatment. Anna, Carla, Tessa and Rebecca all recognised its distinct quality and were left feeling confident that they were thoroughly understood within a few sessions with the information they imparted. Cathy found the questionnaire battery to be particularly useful, not only in better understanding herself, but by knowing that I was privy to the important material the battery revealed. From my own perspective, I have come to the renewed appreciation of the importance of a thorough assessment in order to identify and clarify goals for therapy and to gather all the pertinent information in order to build an initial case-conceptualisation to navigate early therapy. Furthermore, the very collaborative nature of the assessment period, especially the building of the mode map, noticeably enhanced an early therapeutic alliance and resonance in the therapy relationship. The importance of this establishing a sturdy therapeutic relationship during assessment was outlined earlier in section 1.7.1.

11.9.2. The Therapeutic Relationship

Sections 1.7 of chapter 1 and section 11.7 earlier in this chapter make clear the importance of a strong therapeutic relationship in ST. Comments from participants in the interviews confirmed this important aspect of ST. They spoke of the importance of feeling understood; of trusting me; feeling my empathy, compassion and accessibility; my authenticity of care; my capacity to contain them; and not feeling judged.

Feeling somewhat ambivalent due to prior unpleasant therapist relationships, Judy remarked, *"I don't trust easily, but because I trust Graham and he believes in the schema therapy, I am persevering with it. I know Graham to be a good guy, but I struggle with trust because of the last therapist. I disclose to him where I can't with anyone else."* She went on to say, *"The schema therapy allowed me to be very honest",* indicative of the importance of trust and safety within the therapeutic relationship. Alison held a similar view: *"I trust him fully – he's remarkable."* Cathy commented how *"in that hour, I have one person in this world who I feel safe with. I really trust Graham like a parent, especially when my father died (recently)".* Rebecca spoke of the safety I provided; *"It's the only space where I feel safe, understood, helped and guided... I disclose to him where I can't with anyone else."* She continued, *"The schema therapy allowed me to be very honest. I was surprised by that."* Wendy also expressed her sense of comfort in the therapy and how it contributed to her trusting and opening up to me.

Every participant commented how empathetic and compassionate I was towards them. *"He feels with me and* [and] *he feels for the little child in me,"* explained Alison, while Rebecca commented that my empathy and compassion *"was unwavering".* Judy, who had had previously had difficult experiences with therapists, said, *"... the progress in therapy has been mostly about building a relationship and being allowed to be vulnerable in the relationship."* Tessa expressed that I was *"brilliant in confronting difficult things. He never makes me feel bad."*

Rebecca felt similarly, saying she never felt judged, *"which is a big thing for me",* she added. Anna reflected on the intensity of the limited reparenting process,*"I love him. I really do. He's the best therapist I've had. He's my dad – he's my adopted temporary dad … Look, I know he's not a friend, but I also don't feel like he is just a therapist – this clinician."* Sensing the collaborative nature of our relationship, she went on to say, *"I feel kind of a friendship, a comradeship – it's lovely, it's nice."* Wendy felt similarly, saying, *"Sometimes I look at him as a father. I know he's got my best interests."* Carla felt my care, saying, *"he's not just doing his job, he cares. At first, I thought I was paying him as a professional, but then I saw how he really cares.*" Carla, however, expressed a different view, telling the interviewer that I was *"sometimes distant and the compassion was not there"*. She put this down to my being a male clinician. While Carla has continued to be a patient of mine since the study, we have addressed a number of abuse issues, and it became clearer that her trust of males was largely influenced by this. Were it not for my access to the interview transcript, Carla's CoSu coping would have possibly denied this challenge in the therapy relationship from ever emerging. It highlights the importance of the schema therapist frequently probing about the quality of the relationship.

Participants also commented about how accessible I was to them and how therapy was not confined to the 1-hour weekly consultation. Alison spoke about how I encouraged outside session contact while Anna found it useful having email and text contact when required. Rebecca commented that *"through contact outside of sessions he was my 911. He was always contactable for good or for bad".* While Wendy seldom made contact with me outside sessions, she commented that *"it's nice knowing that he is there – just in case".* Cathy jokingly commented that she *"borderline harasses"* me. In fact, I did need to set a limit with her, as her dependency on me and sometimes excessive text messaging did infringe on my privacy at times. This has not deterred me from continuing to encourage balanced outside contact with patients, as it has often served to resolve crisis situations before they became unmanageable. I also believe that such contact has been appreciated, and it has contributed to their view of me as trustworthy and authentic.

Another factor that contributed towards participants viewing me as authentic was the extent of my self-disclosure, this being an important aspect of the therapy relationship in ST that is discussed earlier in this chapter in section 11.7. Most of the participants recognised the significance of my self-disclosure. Alison expressed how much she valued me talking about my own views and bringing my own daughter into discussions, especially how it pertained to her VuCh. Cathy explained how it made me more human, especially at the time in therapy when her father died. Lilly experienced me as more approachable because I was more forthcoming and transparent with my own views. Tessa said, *"The more Graham talks about his own life and experiences, the more I feel connected and trust him… it makes him more human."* She recalled valuing me sharing my own vulnerability when my father died during the study.

Reading the transcripts really warmed me to the fact that all the participants experienced a meaningful and close relationship with me. As I have grown in my experience as a schema therapist, I have become increasingly aware of how central the trust, warmth, honesty, and collaborative nature of the relationship is. I have always felt comfortable with self-disclosure, despite the Kleinian training I received as an intern cautioning against it. However, as a schema therapist, it feels liberating that it is endorsed, if not encouraged. Still, I am aware that self-disclosure needs to be for the benefit of the therapy, whether bringing us closer through similar life experiences or to illustrate healthy ways in which I have faced life challenges.

11.9.3. Eating Disorder as a Coping Mode

As has been outlined in Chapters 4 and 10 (specifically section 10.2.) and earlier in this chapter in section 11.6., participants confirmed the usefulness of conceptualising their ED as a coping mode, no longer viewing it in isolation as a diagnostic entity, but recognising the functions that it fulfilled as a means of suppressing or evading powerful triggering in the Child. Carla, for instance, commented that ST taught her that her ED was *"less about food and weight, and more about accepting myself"*, given that she recognised that her ED was hindering access to her authentic self. Understanding that the ED coping mode was a means of easing the emotional pain that was in the Child helped her to less judge herself for having an ED. Judy made a similar observation, understanding that her ED was less about food and more about an ineffective way of dealing with emotional pain. She felt that this helped her navigate around her ED and attend to the inner pain associated with her relationship with her mother. By learning that her ED was a means of coping, Lilly recognised that her binge eating was a displacement of her anger. Rebecca found it especially helpful to dissect her ED into components, each of which held an explanatory function. She saw how her binges served to soothe her pain, how vomiting served as self-imposed punishment, and how starvation not only created an illusory sense of power or control, but helped her to emotionally disconnect or detach. These realisations were *"like a switch being turned on"*, providing her with an explanation for these behaviours and a reason to dismantle the harm that they caused. She also saw how her turning to excessive alcohol served as a replacement to soothe away her pain. Finally, Shannon explained how having a coping mode that represented her AN helped her to separate it from the Child and how this made it easier to dismantle that part of her.

11.9.4. Schema Therapy Techniques

All the participants commented on the value of ST techniques that were used during treatment, and how they benefitted from these. While many of these techniques and exercises are not exclusive to ST but were integrated into ST from other therapeutic modalities, they are, nevertheless, a prominent aspect of ST.

Alison described all the techniques that were used as *"amazing"*. She found the regular use of the mode map very helpful in being reminded of the parts of self, but she also made regular use of her flashcards and cog sheets[12] at home. Alison also found the experiential exercises of chair work and imagery particularly helpful in visualising modes. Anna also valued the mode map, which allowed her to *"identify where the fight exists".* Being a professional actress, I was not surprised that she found chair work very useful, sharing that she at times did it on her own at home. Carla also valued the use of the mode map, but it was chair work that was most powerful. She recalled how she sometimes felt *"freaked out"* when I occupied the Demanding Parent chair. However, she also noted that she found it particularly useful when I occupied the Critical Parent chair because it demonstrated how damaging this mode was to her. The literature cautions the therapist to occupy the chair of the dysfunctional parent mode as it can strengthen these modes. Growing experience has taught me to be wisely selective in this decision. Cathy found chair work *"uncomfortable"* but acknowledged that it was very helpful in us both being an active part of the therapy experience. She expressed how difficult it was to be in the HeAd chair because she was so disinvested in developing this mode for fear that growing autonomy would activate feelings of abandonment. For Judy, the stand-out exercise was having a doll that represented her VuCh. With my encouragement, the doll was with her at all times, even sitting on her desk at work. She would engage in dialogue with the doll as a means of developing the HeAd/VuCh relationship. As much as she valued the mode map, she found chair work *"very hard … and too invasive".* My experience is that she found chair work to be particularly triggering for the VuCh. Like most of the participants, Judy found the battery of weekly questionnaires helpful, even though it felt laborious at times. Lilly explained how imagery rescripting powerfully helped her to connect to her emotionally injured 3-year-old childhood experiences. So powerful was the somatisation that she sometimes experienced physical hurt in her body during imagery work. Rebecca found the mode map *"extremely interesting in understanding the different modes and how they all act together. Visually it was like being able to look at myself."* Chair work brought this concept alive for her, explaining that *"it's not theatre, it's real".* She experienced occupying the VuCh chair *"overwhelming at times, however he* (Graham) *always took me to a safe place afterwards",* referring to the safe place. While guided imagery very powerfully *"brought up a lot of trauma",* she ultimately found it very helpful. Outside of sessions Rebecca also made good use of cog sheets to identify highly triggering moments and she made use of flashcards to subsequently gain resolve when triggered. Rebecca also valued the meditation CD that I made for her and valued the dreamwork that we did. Like Anna, Tessa felt that the multiplicity of modes helped her to see *"the pull between different parts of* [her]*".* Wendy found it very beneficial listening to the recording of her sessions during the week to recall important points. While this is not an identifiable exercise in ST, it is something that my supervisor has suggested, where he offers all his patients the opportunity to listen to the recordings.

[12] What is more commonly referred to as "Schema and Mode Worksheet for identifying and breaking self-defeating patterns"

11.9.5. Overview

Participants were asked to express their overview of the ST experience. For those who had experienced therapy prior to receiving ST, it was a chance to reflect on the contrast between the different modalities. Alison said that she found ST *"refreshing"* and a way to *"see problems in a new light".* She felt that ST touched her emotions in a way unlike her previous therapies. Anna, who had also been in therapy many times before, said that ST provided insight unlike her other therapies and a model that provided a way of confronting problems unlike before. She felt that her goals for therapy were more clearly defined than other therapy experiences she had experienced. She found ST to be action-based and very practical when she said, *"My VuCh had a chance to get the upbringing it needed… and we were able to work in very practical ways to get there."* Similarly, Carla said that ST helped to, *"fix the problems in a very direct way. Not just identify them."* She explained how *"parenting* (her) *inner child was quite unique… especially where we used chair work".* Where Carla remembers always having numbed herself, she was now realising that she was connecting to her emotions in a very powerful way. She also explained how I helped her connect with childhood memories that, *"were previously hidden out of consciousness. Graham helped me to see that we needed to go there to be able to do the healing."* Even though Cathy was consciously aware of how much she resisted allowing the ST to work, she acknowledged how the different modes brought the VuCh into focus. She explained how her attitude to change slowly shifted and how ST *"is the main contributor to my change".* She expressed how ST was the only therapy that really benefited her in addressing her ED. While Judy was very wary about therapy, she acknowledged that ST helped issues to be *"dissected"* and better understood. Rebecca acknowledged that she has not responded to any of her previous therapy in the way that she did to ST. With the different modes, her HeAd was able to *"stand beside me and see the forces at work – seeing the different coping modes working on me".* She found previous therapies *"too clinical"* while she felt ST *"to be coming from the heart … visually seeing things and interacting, engaging and bringing them to life and facing them* (issues)*".* She experienced ST to be *"amazing"* and definitely thought it helped deal with her ED in ways that previous therapy did not. While Tessa did not feel that ST helped her ED, she did acknowledge that it helped to view her issues in a broader context without only focusing on the ED.

11.10. Closing Thoughts

The case study of Alison reflects her very positive response to ST. Not only has she sustained remission from AN during the further five years of therapy since the study ended, but she has continued to emotionally mature as an individual. She is comfortable in her body and confidently enjoys warm and authentically meaningful relationships with her husband and son, extended family, and friends. Beyond the study period, Alison has also made significant inroads to banish the internal voice that has criticised, punished and set unrealistic and unfair demands upon the VuCh. Confirmed by the post-study interview, it is evident that ST has been particularly conducive to Alison gaining a clearer understanding of the functions that her AN served. While her ED served to inhibit access to deep schema-

based injury, she also realised its contradictory role in inhibiting her personal growth and denying her core needs for love, safety, spontaneity, and a creative existence being met. Although not documented in the thesis, I experienced all the participants in the study benefitted from ST, whether gaining remission from their EDs or, more broadly, finding a pathway to personal growth and greater self-care. Despite this, there still remain many challenges in the application of this very integrative treatment model for this difficult-to-treat patient population.

Low motivation and a reluctance to change is pronounced in the EDs. Patients may flatly deny being ill, be dismissive of the seriousness of their symptoms, or refuse treatment altogether. Such ambivalence is often a result of the perceived value of the ED, where Waller et al. (2007) point to how these illnesses can be very effective in managing distress by either entirely avoiding the activation of EMSs or, at least, diluting the impact of them once activated. For others, it might be the wish to sustain the feeling of control or the sense of identity their ED provides them. Cathy's ambivalence to relinquish her ED was due to her fear that its absence would force her to face an independent and autonomous life that she would struggle to sustain. We learned in therapy that her ED insulated the VuCh from facing the intensity of her Defectiveness and Fear of Abandonment EMSs. Only by focusing on building her HeAd mode was she more willing to relinquish the AnOv, knowing that she would then have a legitimate inner source of protection and guidance. Rebecca, who was another participant in the study, faced the challenge of having to address a prominent CoSu coping mode that developed from an early age. Therapy revealed that her compliance to restore weight was driven by a need to please others and to avoid anticipated condemnation if she resisted treatment. By dismantling this surrender coping mode, we gained access to legitimate and previously suppressed anger residing within the AnCh mode that pertained to years of childhood abuse and neglect. Validating this anger and rage also disarmed the AN, where her purging served as an expression of her anger. Had we never dismantled the CoSu and accessed the AnCh, it is unlikely that Rebecca would have made significant progress.

Ambivalence in EDs is linked to three key forms of motivation-related appraisal: negative appraisal about behaviour change, positive appraisal about the status quo, and doubt about the ability to change (Pugh, 2019). Breaking through these beliefs is an arduous task for any therapist, but the broader integrative nature of ST provides an opportunity to apply a myriad of techniques from behavioural pattern breaking to emotion-focused work to bolster motivation across both the cognitive and affective domains. This is where chairwork and imagery can serve as powerful forums in which to elicit very revealing mode dialogues. Schema therapists also have the opportunity to conceptualise ambivalence in terms of schema modes that block progress. Here, Bernstein et al. (2012) provide some valuable exemplar ED-related statements typified by each mode which are outlined in Table 26 of the Appendix 19. Their examples listed for the category of overcompensatory coping modes are all very typical of the Anorexic Overcontroller and reveal the functions of the AnOv outlined in section 10.1 of Chapter 10. Special attention should be given to the therapeutic relationship, where limited reparenting and an empathic means of

confronting resistance are the best means of ensuring authentic and intrinsic change. Therapists need to acknowledge the patient's ambivalence to change, validate the functionality of their ED symptoms, and instil a curiosity for change rather than using persuasion. By working collaboratively on these tasks, the schema therapist should encourage patient autonomy and always ask for honest feedback from their patient so as to ensure that change is tolerable. It should never be forgotten that change needs to be solicited from the patient and can never be imposed by the therapist. While limit-setting might be essential for the high-risk patient, Abbate-Daga et al. (2013) remind us that such a patient still needs to experience their therapist holding and handling their destructive tendencies. Vitousek and her colleagues encourage therapists to remind their patients "that the EDs are a poor solution to real problems, and clear in characterising the purpose of treatment as a search for better alternatives" (Vitousek, Watson & Wilson, 1998: p403).

Another challenge that all therapists face is their patients' expectations of an unrealistically quick recovery. While I have experienced most new patients to be very excited when introduced to ST, they soon face significant challenges when confronted with the deep schema-based injury residing behind the ED. This brings them to the broader realisation of significant unmet needs residing behind the ED. The schema therapist is tasked with balancing the dual provision of healing through limited reparenting and an empathic confrontation of all coping behaviour to bring about sustained change. While the dismantling of the AnOv coping mode should always remain a central component of treatment, it is equally important that all other coping behaviour is neutralised. Only through this important healing process is it possible that the repeated cycle of dysfunctional coping behaviour will be securely interrupted.

It was outlined in chapter two how EDs seldom exist in isolation and that the therapist is inevitably required to address their patient's broader diagnostic profile that stretches beyond the ED. Whether the patient has a pre-existing or subsequent depressive disorder, or whether there is indication of obsessive compulsive disorder or personality profile, the challenge facing the therapist is to address this broader spectrum of their patient's problems. I value the ST model design being less concerned with diagnostic boxes and the concept of "co-morbidities" but, rather, conceptualising and addressing the broader spectrum of an individual's psychopathology within the context of a multitude of modes and the conflicts that arises between them. A depression might be conceptualised as a prominent Detached Protector coping mode shutting down emotion, while OCD may be viewed as a dominant Obsessive Overcontroller and/or Perfectionistic Overcontroller trying to create order and control in a world where the VuCh feels uncontained or defective. Even the dysregulated mood of someone diagnosed with Bipolar Affective Disorder might be conceptualised and better addressed within the context of rapid mode flipping between an Impulsive Child, avoidant coping modes like the Detached Protector or Detached Self-Soother, and a Lonely Child mode. Not only will the patient's clearer and broader understanding of their

condition through the ST lens provide greater hope for the future, but they will likely feel less stigmatised in not being defined by multiple diagnostic labels.

My introduction to ST almost two decades into my career as a therapist has brought rejuvenated passion and confidence to the work I do. While literature on EDs seldom fails to remind us of the poor prognosis and high mortality rate of a difficult-to-treat patient population, schema therapists and researchers are confidently suggesting ST as a promising approach if the more established and recognised treatments have failed. My own inclination is to use ST as a first-line treatment. Not only does the highly integrative approach make room for the numerous cognitive and behavioural strategies that are important in directly addressing ED behaviour, but the emphasis on conceptualisation in ST and the identifying of schema modes provide the patient with a valuable and early insight to the function of their ED and its position in their broader life context.

Finally, it is the significance of the therapeutic relationship in ST that cannot be underestimated as a powerful factor in establishing trusting rapport and a collaborative effort towards dismantling the ED and, further, guiding the individual towards deeper personal growth and a creative and meaningful existence. Here is where the delegated balance between the two pillars of limited reparenting and empathic confrontation form the bedrock of the therapeutic relationship. To the latter, I have no doubt that Alison's progress was built on her healthy response to the empathic manner in which I confronted urgent change; whether the urgency to relinquish ED behaviour or the need to ultimately banish the introjected influence of her abusive mother. However, it was through the process of limited reparenting that Alison's VuCh invited my provision of the core needs for love, care and protection, and where my own growth as a schema therapist provided a genuine and authentically shared experience.

REFERENCES

Abbate-Daga, G., Amianto, F., Delsedime, N., De-Bacco, C., & Fassino, S. (2013). Resistance to treatment and change in anorexia nervosa: a clinical overview. *BMC psychiatry*, *13*(1), 1-18.

Ackard, D. M., Brehm, B. J., & Steffen, J. J. (2002). Exercise and eating disorders in college-aged women: Profiling excessive exercisers. *Eating Disorders, 10*(1), 31-47.

Adler, G., & Myerson, P. G. (1991). *Confrontation in psychotherapy* Jason Aronson.

Agnew-Davies, R., Stiles, W. B., Hardy, G. E., Barkham, M., & Shapiro, D. A. (1998). Alliance structure assessed by the agnew relationship measure (ARM). *British Journal of Clinical Psychology, 37*(2), 155-172.

Agras, S., Hammer, L., & McNicholas, F. (1999). A prospective study of the influence of eating-disordered mothers on their children. *International Journal of Eating Disorders, 25*(3), 253-262.

Agras, W. S., Walsh, B. T., Fairburn, C. G., Wilson, G. T., & Kraemer, H. C. (2000). A multicenter comparison of cognitive-behavioral therapy and interpersonal psychotherapy for bulimia nervosa. *Archives of General Psychiatry, 57*(5), 459-466.

Agras, W. S., Wilfley, D. E., & Wilson, G. T. (2015). Rapid response in psychological treatments for binge eating disorder. *Journal of Consulting and Clinical Psychology, 83*(3), 649–654.

Agras, W. S., Schneider, J. A., Arnow, B., Raeburn, S. D., & Telch, C. F. (1989). Cognitive-behavioral and response-prevention treatments for bulimia nervosa. *Journal of Consulting and Clinical Psychology, 57*(2), 215-221.

Ainsworth, M. D. S., Blehar, M. C., Waters, E., & Wall, S. (2014). *Patterns of attachment: A psychological study of the strange situation* Psychology Press.

Alexander, F. (1950). Analysis of the therapeutic factors in psychoanalytic treatment. *The Psychoanalytic Quarterly,*

Alexander, F., & French, T. M. (1946). *Psychoanalytic therapy; principles and application.* Ronald Press.

Algozzine, B., & Hancock, D. (2016). *Doing case study research: A practical guide for beginning researchers* Teachers College Press.

Allen, C., Nodelman, U., & Zalta, E. N. (2003, May). Stanford encyclopaedia of philosophy: a dynamic reference work. In Digital Libraries, Joint Conference on (pp. 383-383). IEEE Computer Society.

Allen, H. N., & Craighead, L. W. (1999). Appetite monitoring in the treatment of binge eating disorder. *Behavior Therapy, 30*(2), 253-272.

Allen, J. G., Fonagy, P., & Bateman, A. W. (2008a). *Mentalizing in clinical practice* American Psychiatric Pub.

Allen, J. G., Fonagy, P., & Bateman, A. W. (2008b). *Mentalizing in clinical practice* American Psychiatric Pub.

Allen, K. L., Byrne, S. M., Lampard, A., Watson, H., & Fursland, A. (2011). Confirmatory factor analysis of the eating disorder examination-questionnaire (EDE-Q). *Eating Behaviors, 12*(2), 143-151.

Allen, P. J., Batra, P., Geiger, B. M., Wommack, T., Gilhooly, C., & Pothos, E. N. (2012). Rationale and consequences of reclassifying obesity as an addictive disorder: Neurobiology, food environment and social policy perspectives. *Physiology & Behavior, 107*(1), 126-137.

Allport, G. W. (1937). *Personality* Holt New York.

Aloi, M., Rania, M., Caroleo, M., Bruni, A., Palmieri, A., Cauteruccio, M. A., Segura-García, C. (2015). Decision making, central coherence and set-shifting: A comparison between binge eating disorder, anorexia nervosa and healthy controls. *BMC Psychiatry, 15*(1), 94-114.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev. ed.). Washington, DC: American Psychiatric Association.

American Psychiatric Association, & American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (DSM). *Washington, DC: American Psychiatric Association,* , 143-147.

Amianto, F., Ottone, L., Abbate Daga, G., & Fassino, S. (2015). Binge-eating disorder diagnosis and treatment: A recap in front of DSM-5.*BMC Psychiatry, 15*(1), 1-22.

Anderluh, M. B., Tchanturia, K., Rabe-Hesketh, S., & Treasure, J. (2003). Childhood obsessive-compulsive personality traits in adult women with eating disorders: Defining a broader eating disorder phenotype. *American Journal of Psychiatry, 160*(2), 242-247.

Anderson, Kristen & Byrne, Catherine & Goodyear, Alexandria & Reichel, Ryan & le Grange, Daniel. (2015). Telemedicine of family-based treatment for adolescent anorexia nervosa: A protocol of a treatment development study. *Journal of eating disorders*. 3. 25. 10.1186/s40337-015-0063-1.

Anderson, K., Rieger, E., & Caterson, I. (2006). A comparison of maladaptive schemata in treatment-seeking obese adults and normal-weight control subjects. *Journal of Psychosomatic Research, 60*(3), 245-252.

Anderson, K. P., LaPorte, D. J., Brandt, H., & Crawford, S. (1997). Sexual abuse and bulimia: Response to inpatient treatment and preliminary outcome. *Journal of Psychiatric Research, 31*(6), 621-633.

Andrews, B. (1997). Bodily shame in relation to abuse in childhood and bulimia: A preliminary investigation. *British Journal of Clinical Psychology, 36*(1), 41-49.

Andrews, B., Qian, M., & Valentine, J. D. (2002). Predicting depressive symptoms with a new measure of shame: The experience of shame scale. *British Journal of Clinical Psychology, 41*(1), 29-42.

Anestis, M. D., Silva, C., Lavender, J. M., Crosby, R. D., Wonderlich, S. A., Engel, S. G., & Joiner, T. E. (2012). Predicting nonsuicidal self-injury episodes over a discrete period of time in a sample of women diagnosed with bulimia nervosa: An analysis of self-reported trait and ecological momentary assessment based affective lability and previous suicide attempts. *International Journal of Eating Disorders, 45*(6), 808-811.

Angen, M. J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research, 10*(3), 378-395.

Angen, M. J. (2000). Evaluating interpretive inquiry: Reviewing the validity debate and opening the dialogue. *Qualitative Health Research, 10*(3), 378-395.

Appendix 1: St george's anorexia nervosa database proforma, 1960–1995. (2006). *European Eating Disorders Review, 14*(3), 183-188.

Arcelus, J., Whight, D., Brewin, N., & McGrain, L. (2012). A brief form of interpersonal psychotherapy for adult patients with bulimic disorders: A pilot study. *European Eating Disorders Review, 20*(4), 326-330.

Arcelus, J., Whight, D., Langham, C., Baggott, J., McGrain, L., Meadows, L., & Meyer, C. (2009). A case series evaluation of a modified version of interpersonal psychotherapy (IPT) for the treatment of bulimic eating disorders: A pilot study. *European Eating Disorders Review, 17*(4), 260-268.

Armstrong, J. G., & Roth, D. M. (1989). Attachment and separation difficulties in eating disorders: A preliminary investigation. *International Journal of Eating Disorders, 8*(2), 141-155.

Arntz, A. (2008). Schema-focused therapy for borderline personality disorder: Effectiveness and cost-effectiveness, evidence from a multicenter trial. *European Psychiatry, 23, Supplement 2*(0), S65-S66.

Arntz, A., & Bögels, S. (2000). Schemagerichte cognitieve therapie voor persoonlijkheidsstoornissen. praktijkreeks gedragstherapie.

Arntz, A., & Jacob, G. (2013). *Schema therapy in practice: An introductory guide to the schema mode approach.* Wiley-Blackwell.

Arntz, A., Klokman, J., & Sieswerda, S. (2005). An experimental test of the schema mode model of borderline personality disorder. *Journal of Behavior Therapy and Experimental Psychiatry, 36*(3), 226-239.

Arntz, A. (2012). Personality disorders. *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research and Practice,* , 397.

Arntz, A., Klokman, J., & Sieswerda, S. (2005). An experimental test of the schema mode model of borderline personality disorder. *Journal of Behavior Therapy and Experimental Psychiatry, 36*(3), 226-239.

Arntz, A., Sofi, D., & van Breukelen, G. (2013). Imagery rescripting as treatment for complicated PTSD in refugees: A multiple baseline case series study. *Behaviour Research and Therapy, 51*(6), 274-283.

Arntz, A., Tiesema, M., & Kindt, M. (2007a). Treatment of PTSD: A comparison of imaginal exposure with and without imagery rescripting. *Journal of Behavior Therapy and Experimental Psychiatry, 38*(4), 345-370.

Arntz, A., & Weertman, A. (1999). Treatment of childhood memories: Theory and practice. *Behaviour Research and Therapy, 37*(8), 715-740.

Ashton, K., Drerup, M., Windover, A., & Heinberg, L. (2009). Brief, four-session group CBT reduces binge eating behaviors among bariatric surgery

Aveline, M. (2005). Clinical case studies: Their place in evidence-based practice. *Psychodynamic Practice, 11*(2), 133-152.

Ayers, T. S., Sandier, I. N., West, S. G., & Roosa, M. W. (1996). A dispositional and situational assessment of children's coping: Testing alternative models of coping. *Journal of Personality, 64*(4), 923-958.

Baba-ee, S., Khodapanahi, M. K., & Sedghpour, B. S. (2007). The relation between beliefs and symptoms of eating disorders. *Developmental Psychology, 4*(13), 3-12.

Babbie, E. R. (2020). *The practice of social research*. Cengage learning.

Bach, B., & Bernstein, D. P. (2019). Schema therapy conceptualization of personality functioning and traits in ICD-11 and DSM-5. *Current Opinion in Psychiatry, 32*(1), 38–49.

Bachar, E., Latzer, Y., Kreitler, S., & Berry, E. M. (1999). Empirical comparison of two psychological therapies: Self psychology and cognitive orientation in the treatment of anorexia and bulimia. *The Journal of Psychotherapy Practice and Research, 8*(2), 115.

Bagley, C., & Mallick, K. (1997). Self-esteem and religiosity: Comparison of 13-to 15-year-old students in catholic and public junior high schools. *Canadian Journal of Education/Revue Canadienne De L'Éducation, 22*(1), 89-92.

Bakalar, J. L., Shank, L. M., Vannucci, A., Radin, R. M., & Tanofsky-Kraff, M. (2015). Recent advances in developmental and risk factor research on eating disorders. *Current Psychiatry Reports, 17*(6), 1-10.

Baker, C. W., Whisman, M. A., & Brownell, K. D. (2000). Studying intergenerational transmission of eating attitudes and behaviors: Methodological and conceptual questions. *Health Psychology, 19*(4), 376.

Baker, L., Minuchin, S., Liebman, R., & Rosman, B. L. (1978). *Psychosomatic families: Anorexia nervosa in context* Harvard University Press.

Ball, J. R., Mitchell, P. B., Corry, J. C., Skillecorn, A., Smith, M., & Malhi, G. S. (2006). A randomized controlled trial of cognitive therapy for bipolar disorder: Focus on long-term change.[CME]. *The Journal of Clinical Psychiatry, 67*(2), 277-286.

Ball, J., & Mitchell, P. (2004). A randomized controlled study of cognitive behavior therapy and behavioral family therapy for anorexia nervosa patients. *Eating Disorders, 12*(4), 303-314.

Ball, J., Mitchell, P., Malhi, G., Skillecorn, A., & Smith, M. (2003). Schema-focused cognitive therapy for bipolar disorder: Reducing vulnerability to relapse through attitudinal change. *Australian & New Zealand Journal of Psychiatry, 37*(1), 41-48.

Ball, S. A., Maccarelli, L. M., LaPaglia, D. M., & Ostrowski, M. J. (2011). Randomized trial of dual-focused vs. single-focused individual therapy for personality disorders and substance dependence. *The Journal of Nervous and Mental Disease, 199*(5), 319-328.

Ball, S. A. (2007). Comparing individual therapies for personality disordered opioid dependent patients. *Journal of Personality Disorders, 21*(3), 305-321.

Ball, S. A. (1998). Manualized treatment for substance abusers with personality disorders: Dual focus schema therapy. *Addictive Behaviors, 23*(6), 883-891.

Ball, S. A., & Young, J. E. (2000). Dual focus schema therapy for personality disorders and substance dependence: Case study results.*Cognitive and Behavioral Practice, 7*(3), 270-281.

Ball, S. A., & Cecero, J. J. (2001). Addicted patients with personality disorders: Traits, schemas, and presenting problems. *Journal of Personality Disorders, 15*(1), 72-83.

Ball, S. A., Cobb-Richardson, P., Connolly, A. J., Bujosa, C. T., & O'Neall, T. W. (2005). Substance abuse and personality disorders in homeless drop-in center clients: Symptom severity and psychotherapy retention in a randomized clinical trial. *Comprehensive Psychiatry, 46*(5), 371-379.

Bamber, M., & McMahon, R. (2008). Danger—Early maladaptive schemas at work!: The role of early maladaptive schemas in career choice and the development of occupational stress in health workers. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice, 15*(2), 96-112.

Bamelis, L. L., Evers, S. M., Spinhoven, P., & Arntz, A. (2014). Results of a multicenter randomized controlled trial of the clinical effectiveness of schema therapy for personality disorders. *American Journal of Psychiatry,*

Bamelis, L. L., Renner, F., Heidkamp, D., & Arntz, A. (2011). Extended schema mode conceptualizations for specific personality disorders: An empirical study. *Journal of Personality Disorders, 25*(1), 41.

Bamelis, L., Bloo, J., Bernstein, D., & Arntz, A. (2012). Effectiveness studies. *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice,* , 493-510.

Bandura, A. (1997). Self-efficacy: The exercise of control. New York, New York.

Bankoff, S. M., Karpel, M. G., Forbes, H. E., & Pantalone, D. W. (2012). A systematic review of dialectical behavior therapy for the treatment of eating disorders. *Eating Disorders, 20*(3), 196-215.

Baranoff, J., Oei, T. P. S., Cho, S. H., & Kwon, S. (2006). Factor structure and internal consistency of the young schema questionnaire (short form) in Korean and Australian samples. *Journal of Affective Disorders, 93*(1–3), 133-140.

Barker, C., Pistrang, N., & Elliot, R. (1994). *Research methods in clinical and counselling psychology.* John Wiley & Sons.

Barker, C., Pistrang, N., & Elliott, R. (2015). *Research methods in clinical psychology: An introduction for students and practitioners*. John Wiley & Sons.

Barker, C., Pistrang, N., & Elliott, R. (2002). Foundations of qualitative methods. *Research Methods in Clinical Psychology: An Introduction for Students and Practitioners, Second Edition,* , 72-93.

Barkham, M., Hardy, G. E., & Mellor-Clark, J. (2010). *Developing and delivering practice-based evidence: A guide for the psychological therapies* John Wiley & Sons.

Barkham, M., Mellor-Clark, J., Connell, J., Evans, C., Evans, R., & Margison, F. (2010). Clinical outcomes in routine evaluation (CORE)-the CORE measures and system: Measuring, monitoring and managing quality evaluation in the psychological therapies.

Barlow, D. H. (1981). On the relation of clinical research to clinical practice: Current issues, new directions. *Journal of Consulting and Clinical Psychology, 49*(2), 147.

Barnes, R. D., Masheb, R. M., White, M. A., & Grilo, C. M. (2011). Comparison of methods for identifying and assessing obese patients with binge eating disorder in primary care settings. *International Journal of Eating Disorders, 44*(2), 157-163.

Bateman, A. W., & Fonagy, P. (2004). Mentalization-based treatment of BPD. *Journal of Personality Disorders, 18*(1), 36-51.

Baumeister, R. F., & Scher, S. J. (1988). Self-defeating behavior patterns among normal individuals: Review and analysis of common self-destructive tendencies. *Psychological Bulletin, 104*(1), 3.

Beck, A.T.(1967). depression: Causes and treatment. *Philadelphia: University of Pennsylvania,*

Beck, A. T., & Beck, J. S. (1991). The personality belief questionnaire. *Unpublished Assessment Instrument. Bala Cynwyd, PA: The Beck Institute for Cognitive Therapy and Research*

Beck, A., Emery, G., & Greenberg, R. (1985). Anxiety Disorders and Phobias. A Cognitive Perspective (pp. 300-368). New York: Basic Books.

Beck, A. T., Freeman, A., & Davis, D. (1990). Cognitive therapy of personality disorders. Guilford. *New York,*

Beck, A. T. (1970). Role of fantasies in psychotherapy and psychopathology. *The Journal of Nervous and Mental Disease, 150*(1), 3-17.

Beck, A. T. (2004). Cognitive patterns in dreams and daydreams. *Cognitive Therapy and Dreams,* , 27-32.

Beck, A. T., Butler, A. C., Brown, G. K., Dahlsgaard, K. K., Newman, C. F., & Beck, J. S. (2001). Dysfunctional beliefs discriminate personality disorders. *Behaviour Research and Therapy, 39*(10), 1213-1225.

Becker-Stoll, F., & Gerlinghoff, M. (2004). The impact of a four-month day treatment programme on alexithymia in eating disorders. *European Eating Disorders Review: The Professional Journal of the Eating Disorders Association, 12*(3), 159-163.

Becker, H., Körner, P., & Stöffler, A. (1981). Psychodynamics and therapeutic aspects of anorexia nervosa. *Psychotherapy and Psychosomatics, 36*(1), 8-16.

Beebe, B., & Lachmann, F. M. (2013). *Infant research and adult treatment: Co-constructing interactions* Routledge.

Bell, L. (2002). Does concurrent psychopathology at presentation influence response to treatment for bulimia nervosa? *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity, 7*(3), 168-181.

Bell, R. M. (1985). *Holy anorexia.* Chicago: University of Chicago Press.

Bell, R. M. (2014). *Holy anorexia* University of Chicago Press.

Bennett-Goleman, T. (2003). Emotional alchemy: How your mind can heal your heart. Random House.

Benowitz-Fredericks, C. A., Garcia, K., Massey, M., Vasagar, B., & Borzekowski, D. L. (2012). Body image, eating disorders, and the relationship to adolescent media use. *Pediatric Clinics of North America, 59*(3), 693-704.

Ben-Tovim, D. I., Walker, K., Gilchrist, P., Freeman, R., Kalucy, R., & Esterman, A. (2001). Outcome in patients with eating disorders: A 5-year study. *The Lancet, 357*(9264), 1254-1257.

Berg, K. C., Frazier, P., & Sherr, L. (2009). Change in eating disorder attitudes and behavior in college women: Prevalence and predictors.*Eating Behaviors, 10*(3), 137-142.

Berg, K. C., Peterson, C. B., Frazier, P., & Crow, S. J. (2012). Psychometric evaluation of the eating disorder examination and eating disorder examination-questionnaire: A systematic review of the literature. *International Journal of Eating Disorders, 45*(3), 428-438.

Berge, J. M., Loth, K., Hanson, C., Croll-Lampert, J., & Neumark-Sztainer, D. (2012). Family life cycle transitions and the onset of eating disorders: A retrospective grounded theory approach. *Journal of Clinical Nursing, 21*(9-10), 1355-1363.

Bergh, C., Osgood, M., Alters, D., Maletz, L., Leon, M., & Södersten, P. (2006). How effective is family therapy for the treatment of anorexia nervosa? *European Eating Disorders Review, 14*(6), 371-373.

Berghout, C. C., Zevalkink, J., Katzko, M. W., & de Jong, J. T. (2012). Changes in symptoms and interpersonal problems during the first 2 years of long-term psychoanalytic psychotherapy and psychoanalysis. *Psychology and Psychotherapy: Theory, Research and Practice, 85*(2), 203-219.

Berkman, N. D., Lohr, K. N., & Bulik, C. M. (2007). Outcomes of eating disorders: A systematic review of the literature. *International Journal of Eating Disorders, 40*(4), 293-309.

Bernstein, D. P., de Vos, M. E., & Van den Broek, E. (2009). Mode observation scale (MOS). *Unpublished Manuscript,*

Bernstein, D., & Arntz, A. (2009). S18-04 schema focused therapy for forensic patients with personality disorders: New research findings. *European Psychiatry, 24, Supplement 1*(0), S94.

Bernstein, D. P., Arntz, A., & Vos, M. d. (2007). Schema focused therapy in forensic settings: Theoretical model and recommendations for best clinical practice. *International Journal of Forensic Mental Health, 6*(2), 169-183.

Bernstein, D. P., Nijman, H. L., Karos, K., Keulen-de Vos, M., de Vogel, V., & Lucker, T. P. (2012). Schema therapy for forensic patients with personality disorders: Design and preliminary findings of a multi-center randomized clinical trial in the Netherlands. *International Journal of Forensic Mental Health, 11*(4), 312-324.

Bernstein, D. P., & van den Broek, E. (2009). Schema Mode Observer Rating Scale (SMORS). Department of Psychology, Maastricht University.

Bernstein, D. (2020, in press). Building Strengths in Schema Therapy and Beyond. A Guide to Using iModes, the Complete System. Maastricht, The Netherlands. iModes Publications.

Beumont, P. J., Garner, D., & Touyz, S. W. (1994). Comments on the proposed criteria for eating disorders in DSM IV. *European Eating Disorders Review*, *2*(2), 63-75.

Bers, S. A., Blatt, S. J., & Dolinski, A. (2004). The sense of self in anorexia-nervosa patients. *The Psychoanalytic Study of the Child, 59*, 294-315.

Birbeck, D. J., & Drummond, M. J. (2009). Body image and the pre-pubescent child. *The Journal of Educational Enquiry, 4*(1)

Birbeck, D., & Drummond, M. (2006). Very young children's body image: Bodies and minds under construction. *International Education Journal, 7*(4), 423-434.

Birmingham, C. L., Su, J., Hlynsky, J. A., Goldner, E. M., & Gao, M. (2005). The mortality rate from anorexia nervosa. *International Journal of Eating Disorders, 38*(2), 143-146.

Blackburn, I., James, I. A., Milne, D. L., Baker, C., Standart, S., Garland, A., & Reichelt, F. K. (2001). The revised cognitive therapy scale (CTS-R): Psychometric properties. *Behavioural and Cognitive Psychotherapy, 29*(04), 431-446.

Blackledge, J. T. (2007). Disrupting verbal processes: Cognitive defusion in acceptance and commitment therapy and other mindfulness-based psychotherapies. *The Psychological Record*, *57*(4), 555-576.

Blake, W., Turnbull, S., & Treasure, J. (1997). Stages and processes of change in eating disorders: Implications for therapy. *Clinical Psychology & Psychotherapy, 4*(3), 186-191.

Blanchard, K. A., Morgenstern, J., Morgan, T. J., Labouvie, E., & Bux, D. A. (2003). Motivational subtypes and continuous measures of readiness for change: Concurrent and predictive validity. *Psychology of Addictive Behaviors, 17*(1), 56. .

Blinder, B. J., Cumella, E. J., & Sanathara, V. A. (2006). Psychiatric comorbidities of female inpatients with eating disorders. *Psychosomatic medicine*, *68*(3), 454-462.

Blomquist, K. K., Ansell, E. B., White, M. A., Masheb, R. M., & Grilo, C. M. (2012). Interpersonal problems and developmental trajectories of binge eating disorder. *Comprehensive Psychiatry, 53*(8), 1088-1095.

Bohn, K., Doll, H. A., Cooper, Z., O'Connor, M., Palmer, R. L., & Fairburn, C. G. (2008). The measurement of impairment due to eating disorder psychopathology. *Behaviour Research and Therapy, 46*(10), 1105-1110.

Bohn, K., & Fairburn, C. G. (2008). The clinical impairment assessment questionnaire (CIA). *Cognitive Behavioral Therapy for Eating Disorders,*

Bond, M., Gardner, S. T., Christian, J., & Sigal, J. J. (1983). Empirical study of self-rated defense styles. *Archives of General Psychiatry, 40*(3), 333-338.

Bordin, E. S. (1979). The generalizability of the psychoanalytic concept of the working alliance. *Psychotherapy: Theory, Research & Practice, 16*(3), 252.

Bornstein, M. (2013). Winnicott's contribution to my psychoanalytic development. *Psychoanalytic Inquiry, 33*(1), 50-58.

Bosi, A. T. B., Çamur, D., & Güler, Ç. (2007). Prevalence of orthorexia nervosa in resident medical doctors in the faculty of medicine (Ankara, Turkey). *Appetite, 49*(3), 661-666.

Bosma, H. A., and Kunnen, E. S. (2001). *Identity & Emotion: Development through Self-Organization.* Cambridge: Cambridge University Press.

Boughtwood, D., Halse, C., & Honey, A. (2007). *Inside anorexia: The experiences of girls and their families* Jessica Kingsley Publishers.

Bowlby, J. (1973). Attachment and Loss—Vol. 2: Separation, basic books.

Bowlby, J. (1982). Citation classic-attachment and loss, vol 1, attachment. *Current Contents/Social & Behavioral Sciences,* (29), 18.

Bowlby, J. (1979). The making and breaking of affectional bonds. London (Tavistock) 1979.

Bowlby, J. (1980). *Attachment and loss* Basic books.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development.* Basic Books.

Bowlby, J. (2005). *A secure base: Clinical applications of attachment theory* Taylor & Francis.

Brennan, K. A., & Shaver, P. R. (1998). Attachment styles and personality disorders: Their connections to each other and to parental divorce, parental death, and perceptions of parental caregiving. *Journal of Personality, 66*(5), 835-878.

Brewerton, T. D. (2007). Eating disorders, trauma, and comorbidity: Focus on PTSD. *Eating Disorders, 15*(4), 285-304.

Brewerton, T. D., & Costin, C. (2011). Long-term outcome of residential treatment for anorexia nervosa and bulimia nervosa. *Eating Disorders, 19*(2), 132-144.

Brewerton, T. D., Hand, L. D., & Bishop, E. R. (1993). The tridimensional personality questionnaire in eating disorder patients. *International Journal of Eating Disorders, 14*(2), 213-218.

Bricker, D., & Labin, M. (2012). Teaching mindfulness meditation within a schema therapy framework. *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice,* , 259-270.

Bricker, D., Young, J. E., & Flanagan, C. M. (1993). Schema-focused cognitive therapy: A comprehensive framework for characterological problems.

Bridges, M. R. (2006). Activating the corrective emotional experience. *Journal of Clinical Psychology, 62*(5), 551-568.

Bridges, R. A., & Spilka, B. (1992). Religion and the Mental Health. *Religion and mental health*, (84), 43.

Briedis, J., & Startup, H. (2020). Somatic perspective in Schema Therapy: The role of the body in the awareness and transformation of modes and schemas. In *Creative Methods in Schema Therapy* (pp. 60-75). Routledge.

Britten, N. (1995). Qualitative interviews in medical research. *BMJ (Clinical Research Ed.), 311*(6999), 251-253.

Brody, L. R., & Hall, J. A. (2009). Gender, emotion, and socialization. *Handbook of Gender Research in Psychology*, 429-454.

Bromley, D. B. (1986). *The case-study method in psychology and related disciplines* John Wiley & Sons.

Brown, J. M., Selth, S., Stretton, A., & Simpson, S. (2016). Do dysfunctional coping modes mediate the relationship between perceived parenting style and disordered eating behaviours? *Journal of Eating Disorders*, *4*(1).

Brown, L. S., Waller, G., Meyer, C., Bamford, B., Morrison, T., & Burditt, E. (2003). Socially driven eating and restriction in the eating disorders. *Eating Behaviors, 4*(3), 221-228.

Brown, T. A., Haedt-Matt, A., & Keel, P. K. (2011). Personality pathology in purging disorder and bulimia nervosa. *International Journal of Eating Disorders, 44*(8), 735-740. doi:10.1002/eat.20904

Byrne, S. M., Allen, K. L., Dove, E. R., Watt, F. J., & Nathan, P. R. (2008). The reliability and validity of the dichotomous thinking in eating disorders scale. *Eating Behaviors, 9*(2), 154-162.

Brownell, K. D., & Rodin, J. (1994). The dieting maelstrom: Is it possible and advisable to lose weight? *American Psychologist, 49*(9), 781.

Brownell, P. (2010). *Gestalt therapy: A guide to contemporary practice* Springer Publishing Company.

Bruce, K. R., & Steiger, H. (2006). Prognostic implications of personality disorders in eating disorders. *Personality Disorders and Eating Disorders: Exploring the Frontier .Routledge, New York,* , 247-262.

Bruce, K.R. & Steiger, H. (2006). Prognostic implications of personality disorders in eating disorders. In Sansone, R.A. & Levitt, J.L. (Ed.), *Personality disorders and eating disorders: Exploring the frontier* (pp. 247-262). New York: Routledge.

Bruch, H. (1978). The golden cage Cambridge.

Bruch, H. (1973). *Eating disorders: Obesity, anorexia nervosa, and the person within* Basic Books.

Bruch, H. (1974). Eating disorders: Anorexia, obesity and the person within. *London and Boston: Routledge and Kegan Paul,*

Bruch, H. (2001). *The golden cage: The enigma of anorexia nervosa* Harvard University Press.

Bulik, C. (1997). Predictors of the development of bulimia nervosa in women with anorexia nervosa. *J Nerv Ment Disease, 185*, 704-707.

Bulik, C. M. (2002). Anxiety, depression, and eating disorders. In C. G. Fairburn, & K. D. Brownell (Eds.), *Eating disorders and obesity* (pp. 193-198). New York: Guilford New York.

Bulik, C. M., Baucom, D. H., Kirby, J. S., & Pisetsky, E. (2010). Uniting couples (in the treatment of) anorexia nervosa (UCAN). *International Journal of Eating Disorders*, *44*(1), 19-28.

Bulik, C. M., Hebebrand, J., Keski-Rahkonen, A., Klump, K. L., Reichborn-Kjennerud, T., Mazzeo, S. E., & Wade, T. D. (2007). Genetic epidemiology, endophenotypes, and eating disorder classification. *International Journal of Eating Disorders, 40*, S52-S60.

Bulik, C. M., Reba, L., Siega-Riz, A., & Reichborn-Kjennerud, T. (2005). Anorexia nervosa: Definition, epidemiology, and cycle of risk. *International Journal of Eating Disorders, 37*, 2-9. doi:10.1002/eat.20107

Bulik, C. M., & Reichborn-kjennerud, T. (2003). Medical morbidity in binge eating disorder. *International Journal of Eating Disorders, 34*, S39-S46.

Bulik, C. M., Reba, L., Siega-Riz, A., & Reichborn-Kjennerud, T. (2005). Anorexia nervosa: Definition, epidemiology, and cycle of risk. *International Journal of Eating Disorders, 37*(S1), S2-S9.

Bulik, C. M., Sullivan, P. F., Tozzi, F., Furberg, H., Lichtenstein, P., & Pedersen, N. L. (2006). Prevalence, heritability, and prospective risk factors for anorexia nervosa. *Archives of General Psychiatry, 63*(3), 305-312.

Bulik, C. M., Sullivan, P. F., Wade, T. D., & Kendler, K. S. (2000). Twin studies of eating disorders: A review. *International Journal of Eating Disorders, 27*(1), 1-20.

Bulik, C. M., Tozzi, F., Anderson, C., Mazzeo, S. E., Aggen, S., & Sullivan, P. F. (2003). The relation between eating disorders and components of perfectionism. *American Journal of Psychiatry*, *160*(2), 366-368. .

Burke, B. L., Arkowitz, H., & Menchola, M. (2003). The efficacy of motivational interviewing: A meta-analysis of controlled clinical trials. *Journal of Consulting and Clinical Psychology, 71*(5), 843.

Button, E. J., Sonuga-Barke, E., Davies, J., & Thompson, M. (1996). A prospective study of self-esteem in the prediction of eating problems in adolescent schoolgirls: Questionnaire findings. *British Journal of Clinical Psychology, 35*(2), 193-203.

Byely, L., Archibald, A. B., Graber, J., & Brooks-Gunn, J. (2000). A prospective study of familial and social influences on girls' body image and dieting. *International Journal of Eating Disorders, 28*(2), 155-164.

Byram, V., Wagner, H. L., & Waller, G. (1995). Sexual abuse and body image distortion. *Child Abuse & Neglect, 19*(4), 507-510.

Byrne, D. (2013). Evaluating complex social interventions in a complex world. *Evaluation, 19*(3), 217-228.

Byrne, S., & McLean, N. (2002). Elite athletes: Effects of the pressure to be thin. *Journal of Science and Medicine in Sport*, *5*(2), 80-94.

Cahill, J., Stiles, W. B., Barkham, M., Hardy, G. E., Stone, G., Agnew-Davies, R., & Unsworth, G. (2012). Two short forms of the agnew relationship measure: The ARM-5 and ARM-12. *Psychotherapy Research, 22*(3), 241-255.

Carano, A., De Berardis, D., Campanella, D., Serroni, N., Ferri, F., Di Iorio, G., . . . Di Giannantonio, M. (2012). Alexithymia and suicide ideation in a sample of patients with binge eating disorder. *Journal of Psychiatric Practice, 18*(1), 5-11.

Cardi, V., Krug, I., Perpiñá, C., Mataix-Cols, D., Roncero, M., & Treasure, J. (2012). The use of a non-immersive virtual reality programme in anorexia nervosa: A single Case-Report. *European Eating Disorders Review, 20*(3), 240-245.

Cardi, V., Lounes, N., Kan, C., & Treasure, J. (2013). Meal support using mobile technology in anorexia nervosa. contextual differences between inpatient and outpatient settings. *Appetite, 60*, 33-39.

Carlson, L. E., Taenzer, P., Koopmans, J., & Casebeer, A. (2003). Predictive value of aspects of the transtheoretical model on smoking cessation in a community-based, large-group cognitive behavioral program. *Addictive Behaviors, 28*(4), 725-740.

Carter, F. A., McIntosh, V. V., Joyce, P. R., & Bulik, C. M. (2001). Abstention during cue reactivity assessment is associated with better outcome among women with bulimia nervosa. *Eating Behaviors, 2*(3), 273-278.

Carter, F. A., Jordan, J., McIntosh, V. V., Luty, S. E., McKenzie, J. M., Frampton, C., Joyce, P. R. (2011). The long-term efficacy of three psychotherapies for anorexia nervosa: A randomized, controlled trial. *International Journal of Eating Disorders, 44*(7), 647-654.

Carter, J. C., Aimé, A. A., & Mills, J. S. (2001). Assessment of bulimia nervosa: A comparison of interview and self-report questionnaire methods. *International Journal of Eating Disorders, 30*(2), 187-192.

Carter, W. P., Hudson, J. I., Lalonde, J. K., Pindyck, L., Mcelroy, S. L., Pope, H. G., & Jr. (2003). Pharmacologic treatment of binge eating disorder. *International Journal of Eating Disorders, 34*, S74-S88.

Cash, T. F., Jakatdar, T. A., & Williams, E. F. (2004). The body image quality of life inventory: Further validation with college men and women. *Body Image, 1*(3), 279-287.

Cash, T. F., Fleming, E. C., Alindogan, J., Steadman, L., & Whitehead, A. (2002). Beyond body image as a trait: The development and validation of the body image states scale. *Eating Disorders, 10*(2), 103-113.

Cash, T. F., Melnyk, S. E., & Hrabosky, J. I. (2004). The assessment of body image investment: An extensive revision of the appearance schemas inventory. *International Journal of Eating Disorders, 35*(3), 305-316.

Cash, T. F., & Fleming, E. C. (2002). The impact of body image experiences: Development of the body image quality of life inventory. *International Journal of Eating Disorders, 31*(4), 455-460.

Cashdan, S. (1988). *Object relations therapy: Using the relationship.* WW Norton & Co.

Castellini, G., Lo Sauro, C., Mannucci, E., Ravaldi, C., Rotella, C. M., Faravelli, C., & Ricca, V. (2011). Diagnostic crossover and outcome predictors in eating disorders according to DSM-IV and DSM-V proposed criteria: A 6-year follow-up study. *Psychosomatic Medicine, 73*(3), 270-279.

Castonguay, L. G., Eubanks, C. F., Goldfried, M. R., Muran, J. C., & Lutz, W. (2015). Research on psychotherapy integration: Building on the past, looking to the future. *Psychotherapy Research, 25*(3), 365-382.

Chadwick, P. (2003). Two chairs, self-schemata and a person based approach to psychosis. *Behavioural and Cognitive Psychotherapy, 31*(4), 439-449.

Channon, S., De Silva, P., Hemsley, D., & Perkins, R. (1989). A controlled trial of cognitive-behavioural and behavioural treatment of anorexia nervosa. *Behaviour Research and Therapy, 27*(5), 529-535.

Charlesworth, M. (1996). What's the use of bioethics? In J. Daly (Ed.), Ethical intersections: Health research, methods and researcher responsibility (pp. 5-14). St. Leonards, Australia: Allen and Unwin.

Chen, E. Y., Brown, M. Z., Harned, M. S., & Linehan, M. M. (2009). A comparison of borderline personality disorder with and without eating disorders. *Psychiatry research*, *170*(1), 86-90.

Chen, E. Y., & Safer, D. L. (2010). Dialectical behavior therapy for bulimia nervosa and binge-eating disorder. *Treatment of Eating Disorders: A Clinical Handbook,* , 294-316.

Chen, E., Roehrig, M., Herbozo, S., McCloskey, M. S., Roehrig, J., Cummings, H., . . . Le Grange, D. (2009). Compensatory eating disorder behaviors and gastric bypass surgery outcome. *International Journal of Eating Disorders, 42*(4), 363-366.

Chen, E., Touyz, S. W., Beumont, P. J., Fairburn, C. G., Griffiths, R., Butow, P., . . . Basten, C. (2003). Comparison of group and individual cognitive-behavioral therapy for patients with bulimia nervosa. *International Journal of Eating Disorders, 33*(3), 241-254.

Chen, L. P., Murad, M. H., Paras, M. L., Colbenson, K. M., Sattler, A. L., Goranson, E. N., . . . Prokop, L. J. (2010). Sexual abuse and lifetime diagnosis of psychiatric disorders: Systematic review and meta-analysis. Paper presented at the *Mayo Clinic Proceedings, , 85*(7) 618-629.

Ciao, A. C., Anderson, K., & Le Grange, D. (2015). Family approaches to treatment. *The Wiley Handbook of Eating Disorders,* , 828-842.

Claes, L., Jimenez-Murcia, S., Agüera, Z., Sánchez, I., Santamaría, J., Granero, R., & Fernández-Aranda, F. (2012). Eating disorders and pathological gambling in males: Can they be differentiated by means of weight history and temperament and character traits?*Eating Disorders, 20*(5), 395-404.

Claes, L., Soenens, B., Vansteenkiste, M., & Vandereycken, W. (2012). The scars of the inner critic: Perfectionism and nonsuicidal Self-Injury in eating disorders. *European Eating Disorders Review, 20*(3), 196-202.

Clark, V. L. P., & Creswell, J. W. (2008). *The mixed methods reader* Sage.

Clinton, D. (2006). Affect regulation, object relations and the central symptoms of eating disorders. *European Eating Disorders Review, 14*(4), 203-211.

Clinton, D., & Norring, C. (2005). The comparative utility of statistically derived eating disorder clusters and DSM-IV diagnoses: Relationship to symptomatology and psychiatric comorbidity at intake and follow-up. *Eating Behaviors, 6*(4), 403-418.

Cnattingius, S., Hultman, C. M., Dahl, M., & Sparén, P. (1999). Very preterm birth, birth trauma, and the risk of anorexia nervosa among girls. *Archives of General Psychiatry, 56*(7), 634-638.

Cockram, D. M., Drummond, P. D., & Lee, C. W. (2010). Role and treatment of early maladaptive schemas in vietnam veterans with PTSD. *Clinical Psychology & Psychotherapy, 17*(3), 165-182.

Colli, A., Gentile, D., Tanzilli, A., Speranza, A. M., & Lingiardi, V. (2016). Therapeutic interventions in the treatment of eating disorders: A naturalistic study. *Psychotherapy, 53*(2), 152.

Comerci, G. D. (1990). Medical complications of anorexia nervosa and bulimia nervosa. *The Medical Clinics of North America, 74*(5), 1293-1310.

Compare, A., Callus, E., & Grossi, E. (2012). Mindfulness trait, eating behaviours and body uneasiness: A case-control study of binge eating disorder. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity, 17*(4), e244-e251.

Compas, B. E., Orosan, P. G., & Grant, K. E. (1993). Adolescent stress and coping: Implications for psychopathology during adolescence. *Journal of Adolescence, 16*(3), 331-349.

Connan, F., Campbell, I. C., Katzman, M., Lightman, S. L., & Treasure, J. (2003). A neurodevelopmental model for anorexia nervosa.*Physiology & Behavior, 79*(1), 13-24.

Conner, T. S., Tennen, H., Fleeson, W., & Barrett, L. F. (2009). Experience sampling methods: A modern idiographic approach to personality research. *Social and Personality Psychology Compass, 3*(3), 292-313.

Connors, M. E., & Morse, W. (1993). Sexual abuse and eating disorders: A review. *International Journal of Eating Disorders, 13*(1), 1-11.

Cook, B. J., Steffen, K. J., Mitchell, J. E., Otto, M., Crosby, R. D., Cao, L., . . . Le Grange, D. (2015). A pilot study examining diagnostic differences among exercise and weight suppression in bulimia nervosa and binge eating disorder. *European Eating Disorders Review, 23*(3), 241-245.

Cooper, M. J., Cohen-Tovee, E., Todd, G., Wells, A., & Tovee, M. (1997). A questionnaire to assess assumptions and beliefs in eating disorders: Preliminary findings. *Behaviour Research and Therapy, 35*, 381-388.

Cooper, M. J., Wells, A., & Todd, G. (2004). A cognitive model of bulimia nervosa. *British Journal of Clinical Psychology, 43*(1), 1-16.

Cooper, M. (2008). *Essential research findings in counselling and psychotherapy: The facts are friendly* Sage.

Cooper, M. J. (2005). Cognitive theory in anorexia nervosa and bulimia nervosa: Progress, development and future directions. *Clinical Psychology Review, 25*(4), 511-531.

Cooper, M. J. (2011). Working with imagery to modify core beliefs in people with eating disorders: A clinical protocol. *Cognitive and Behavioral Practice, 18*(4), 454-465.

Cooper, M. J., Rose, K. S., & Turner, H. (2006). The specific content of core beliefs and schema in adolescent girls high and low in eating disorder symptoms. *Eating Behaviors, 7*(1), 27-35.

Cooper, M. J., & Warren, L. (2011). The relationship between body weight (body mass index) and attachment history in young women.*Eating Behaviors, 12*(1), 94-96.

Cooper, M. J., Todd, G., & Wells, A. (1998). Content, origins, and consequences of dysfunctional beliefs in anorexia nervosa and bulimia nervosa. *Journal of Cognitive Psychotherapy, 12*(3), 213-230.

Cooper, M. J., Wells, A., & Todd, G. (2004). A cognitive model of bulimia nervosa. *British Journal of Clinical Psychology, 43*(1), 1-16.

Cooper, M., Cohen-Tovée, E., Todd, G., Wells, A., & Tovée, M. (1997). The eating disorder belief questionnaire: Preliminary development.*Behaviour Research and Therapy, 35*(4), 381-388.

Cooper, M., Stockford, K., & Turner, H. (2007). Stages of change in anorexic and bulimic disorders: The importance of illness representations. *Eating Behaviors, 8*(4), 474-484.

Cooper, M., & Turner, H. (2000). Underlying assumptions and core beliefs in anorexia nervosa and dieting. *British Journal of Clinical Psychology, 39*(2), 215-218.

Cooper, P. J., & Goodyer, I. (1997). Prevalence and significance of weight and shape concerns in girls aged 11-16 years. *The British Journal of Psychiatry: The Journal of Mental Science, 171*, 542-544.

Cooper, P. J., & Steere, J. (1995). A comparison of two psychological treatments for bulimia nervosa: Implications for models of maintenance. *Behaviour Research and Therapy, 33*(8), 875-885.

Cooper, Z., & Fairburn, C. (1987). The eating disorder examination: A semi-structured interview for the assessment of the specific psychopathology of eating disorders. *International Journal of Eating Disorders, 6*(1), 1-8.

Cooper, Z., & Fairburn, C. (2006). The eating disorder examination: A semi-structured interview for the assessment of the specific psychopathology of eating disorders. *International Journal of Eating Disorders, 6*(1), 1-8.

Cooper, Z., & Fairburn, C. G. (2003). Refining the definition of binge eating disorder and non-purging bulimia nervosa. *International Journal of Eating Disorders, 34*, S89-S95.

Corbin, J. M., & Strauss, A. (1990). Grounded theory research: Procedures, canons, and evaluative criteria. *Qualitative Sociology*, *13*(1), 3-21.

Corstens, D., Longden, E., & May, R. (2012). Talking with voices: Exploring what is expressed by the voices people hear. *Psychosis, 4*(2), 95-104.

Cousineau, P. (2012). Strategies to enhance the healthy adult mode. *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice,* , 249.

Couturier, J., Kimber, M., & Szatmari, P. (2013). Efficacy of family-based treatment for adolescents with eating disorders: A systematic review and meta-analysis. *International Journal of Eating Disorders, 46*(1), 3-11.

Cowers, S., Norton, K., Halek, C., & Crisp, A. H. (1994). Outcome of outpatient psychotherapy in a random allocation treatment study of anorexia nervosa. *International Journal of Eating Disorders, 15*(2), 165-177.

Creswell, J. W., Fetters, M. D., & Ivankova, N. V. (2004). Designing a mixed methods study in primary care. *Annals of Family Medicine, 2*(1), 7-12.

Creswell, J. W. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches.* Sage publications.

Creswell, J. W., & Clark, V. L. P. (2007). Designing and conducting mixed methods research.

Creswell, J. W., & Poth, C. N. (2017). *Qualitative inquiry and research design: Choosing among five approaches* Sage publications.

Crowell, S. E., Beauchaine, T. P., & Linehan, M. M. (2009). A biosocial developmental model of borderline personality: Elaborating and extending Linehan's theory. *Psychological Bulletin*, *135*(3), 495-510.

Crisp, A. H., Palmer, R. L., & Kalucy, R. S. (1976). How common is anorexia nervosa? A prevalence study. *The British Journal of Psychiatry: The Journal of Mental Science, 128*, 549-554.

Crisp, A. H. (1997). Anorexia nervosa as flight from growth: Assessment and treatment based on the model. *Handbook of Treatment for Eating Disorders,* , 248-277.

Crisp, A. H. (1995). *Anorexia nervosa: Let me be* Psychology Press.

Crits-Christoph, P., & Gibbons, M. (2003). No title. *Interpretive and Supportive Psychotherapies: Matching Therapy and Patient Personality,*

Crow, S. (2007). Eating disorder not otherwise specified: Next steps. *International Journal of Eating Disorders, 40*, S104-S106. doi:10.1002/eat.20449

Crow, S. J., Mitchell, J. E., Roerig, J. D., & Steffen, K. (2009). What potential role is there for medication treatment in anorexia nervosa?*International Journal of Eating Disorders, 42*(1), 1-8.

Crow, S. J., Peterson, C. B., Swanson, S. A., Raymond, N. C., Specker, S., Eckert, E. D., & Mitchell, J. E. (2009). Increased mortality in bulimia nervosa and other eating disorders. *American Journal of Psychiatry,*

Cruzat-Mandich, C., Díaz-Castrillón, F., Escobar-Koch, T., & Simpson, S. (2015). From eating identity to authentic selfhood: Identity transformation in eating disorder sufferers following psychotherapy. *Clinical Psychologist,*

Cullum, J. L. (2009). Maladaptive schemas as a predictor of residential treatment outcomes in females with eating disorders. *Graduate Theses and Dissertations,* , 459.

Cumella, E. J., & Kally, Z. (2008). Profile of 50 women with midlife-onset eating disorders. *Eating Disorders, 16*(3), 193-203.

Cummings, N. A., & Pallak, M. S. (1994). Which managed care tools hurt psychologists most? *PsycEXTRA Dataset*.

Dalle Grave, R., Calugi, S., Doll, H. A., & Fairburn, C. G. (2013). Enhanced cognitive behaviour therapy for adolescents with anorexia nervosa: An alternative to family therapy? *Behaviour Research and Therapy, 51*(1), R9-R12.

Dalle Grave, R., Rigamonti, R., Todisco, P., & Oliosi, E. (1996). Dissociation and traumatic experiences in eating disorders. *European Eating Disorders Review, 4*(4), 232-240.

Dallos, R. (1997). *Interacting stories: Narratives, family beliefs, and therapy* Karnac Books.

Dallos, R. (2004). Attachment narrative therapy: Integrating ideas from narrative and attachment theory in systemic family therapy with eating disorders. *Journal of Family Therapy, 26*(1), 40-65.

Dancyger, I., Krakower, S., & Fornari, V. (2013). Eating disorders in adolescents: Review of treatment studies that include psychodynamically informed therapy. *Child and Adolescent Psychiatric Clinics of North America, 22*(1), 97-117.

Daniel, S. I. F., Poulsen, S., & Lunn, S. (2016). Client attachment in a randomized clinical trial of psychoanalytic and cognitive-behavioral psychotherapy for bulimia nervosa: Outcome moderation and change. *Psychotherapy, 53*(2), 174.

Dare, C., Eisler, I., Russell, G., Treasure, J., & Dodge, L. (2001). Psychological therapies for adults with anorexia nervosa: Randomised controlled trial of out-patient treatments. *The British Journal of Psychiatry : The Journal of Mental Science, 178*, 216-221.

Dare, C. (1985). The family therapy of anorexia nervosa. *Journal of Psychiatric Research, 19*(2), 435-443.

Dare, C. (1993). The starving and the greedy: Inner and outer objects in anorexia nervosa. *Journal of Child Psychotherapy, 19*(2), 3-22.

Dare, C. (1997). Chronic eating disorders in therapy: Clinical stories using family systems and psychoanalytic approaches. *Journal of Family Therapy, 19*(3), 319-351.

Darke, P., Shanks, G., & Broadbent, M. (1998). Successfully completing case study research: Combining rigour, relevance and pragmatism. *Information Systems Journal, 8*(4), 273-289.

Dattilio, F. M. (2006). Case-Based research in family therapy. *Australian and New Zealand Journal of Family Therapy, 27*(4), 208-213.

Dattilio, F. M., Edwards, D. J., & Fishman, D. B. (2010). Case studies within a mixed methods paradigm: Toward a resolution of the alienation between researcher and practitioner in psychotherapy research. *Psychotherapy: Theory, Research, Practice, Training, 47*(4), 427.

Davidson, R. (1992). Prochaska and DiClemente's model of change: A case study? *British Journal of Addiction, 87*(6), 821-822.

Davies, D., & Dodd, J. (2002). Qualitative research and the question of rigor. *Qualitative Health Research, 12*(2), 279-289.

Davies, S. (2008). Letting others know what helps: How young people with eating disorders can explain their preferences to others.*Mental Health and Learning Disabilities Research and Practice, 5*(1), 51-61.

Davies, S., Parekh, K., Etelapaa, K., Wood, D., & Jaffa, T. (2008). The inpatient management of physical activity in young people with anorexia nervosa. *European Eating Disorders Review, 16*(5), 334-340.

Davison, K. K., Markey, C. N., & Birch, L. (2000). Etiology of body dissatisfaction and weight concerns among 5-year-old girls. *Appetite, 35*(2), 143-151.

Damiano, S. R., Reece, J., Reid, S., Atkins, L., & Patton, G. (2015). Maladaptive schemas in adolescent females with anorexia nervosa and implications for treatment. *Eating Behaviors, 16*, 64-71.

Dingemans, A. E., Spinhoven, P., & Van Furth, E. F. (2006). Maladaptive core beliefs and eating disorder symptoms. *Eating Behaviors, 7*(3), 258-265.

Dolhanty, J., & Greenberg, L. S. (2007). Emotion-focused therapy in the treatment of eating disorders. *European Psychotherapy, 7*(1), 97-116.

Dolhanty, J., & Greenberg, L. S. (2009). Emotion-focused therapy in a case of anorexia nervosa. *Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice, 16*(4), 336-382.

Doyle, P. M., Le Grange, D., Loeb, K., Doyle, A. C., & Crosby, R. D. (2010). Early response to family-based treatment for adolescent anorexia nervosa. *International Journal of Eating Disorders, 43*(7), 659-662.

de Castro, J. M., & Goldstein, S. J. (1995). Eating attitudes and behaviors of pre-and postpubertal females: Clues to the etiology of eating disorders. *Physiology & Behavior, 58*(1), 15-23.

de Groot, J., & Rodin, G. (1998). Coming alive: The psychotherapeutic treatment of patients with eating disorders. *Canadian Journal of Psychiatry.Revue Canadienne De Psychiatrie, 43*(4), 359-356.

de Groot, J., & Rodin, G. M. (1999). The relationship between eating disorders and childhood trauma. *Psychiatric Annals, 29*(4), 225-229.

De Keijser, J. (2004). Gecompliceerde rouw. *Tijdschrift voor psychotherapie*, *30*(2), 60-69.

De la Rie, S., Noordenbos, G., Donker, M., & Van Furth, E. (2008). The quality of treatment of eating disorders: a comparison of the therapists' and the patients' perspective. *International Journal of Eating Disorders*, *41*(4), 307-317.

Dickhaut, V., & Arntz, A. (2014). Combined group and individual schema therapy for borderline personality disorder: A pilot study. *Journal of Behavior Therapy and Experimental Psychiatry, 45*(2), 242-251.

Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2006). Blurring boundaries in qualitative health research on sensitive topics. *Qualitative Health Research, 16*(6), 853-871.

DiClemente, C. C., & Prochaska, J. O. (1998). Toward a comprehensive, transtheoretical model of change: Stages of change and addictive behaviors.

DiClemente, C. C., & Velasquez, M. M. (2002). Motivational interviewing and the stages of change. *Motivational Interviewing: Preparing People for Change, 2*, 201-216.

DiLillo, V., Siegfried, N. J., & West, D. S. (2003). Incorporating motivational interviewing into behavioral obesity treatment. *Cognitive and Behavioral Practice, 10*(2), 120-130.

Dingemans, A. E., Spinhoven, P., & van Furth, E. F. (2006). Maladaptive core beliefs and eating disorder symptoms. *Eating Behaviors, 7*(3), 258-265.

Dohm, F., Striegel-Moore, R., Wilfley, D. E., Pike, K. M., Hook, J., & Fairburn, C. G. (2002). Self-harm and substance use in a community sample of black and white women with binge eating disorder or bulimia nervosa. *International Journal of Eating Disorders, 32*(4), 389-400.

Dohnt, H. K., & Tiggemann, M. (2006). Body image concerns in young girls: The role of peers and media prior to adolescence. *Journal of Youth and Adolescence, 35*(2), 135-145.

Dohnt, H., & Tiggemann, M. (2006). The contribution of peer and media influences to the development of body satisfaction and self-esteem in young girls: A prospective study. *Developmental Psychology, 42*(5), 929.

Doidge, N. (2015). *The brain's way of healing: Remarkable discoveries and recoveries from the frontiers of neuroplasticity* Penguin.

Dolhanty, J., & Greenberg, L. S. (2007). Emotion-focused therapy in the treatment of eating disorders. *European Psychotherapy, 7*(1), 97-116.

Dolhanty, J., & Greenberg, L. S. (2009). Emotion-focused therapy in a case of anorexia nervosa. *Clinical Psychology & Psychotherapy, 16*(4), 336-382.

Donini, L. M., Marsili, D., Graziani, M. P., Imbriale, M., & Cannella, C. (2004). Orthorexia nervosa: A preliminary study with a proposal for diagnosis and an attempt to measure the dimension of the phenomenon. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity, 9*(2), 151-157.

Donini, L. M., Marsili, D., Graziani, M. P., Imbriale, M., & Cannella, C. (2005). Orthorexia nervosa: Validation of a diagnosis questionnaire.*Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity, 10*(2), e28-e32.

Douglas, C. J. (2008). Teaching supportive psychotherapy to psychiatric residents. *American Journal of Psychiatry, 165*(4), 445-452.

Doyle, A. C., McLean, C., Washington, B. N., Hoste, R. R., & le Grange, D. (2009). Are single-parent families different from two-parent families in the treatment of adolescent bulimia nervosa using family-based treatment? *International Journal of Eating Disorders, 42*(2), 153-157.

Dray, J., & Wade, T. D. (2012). Is the transtheoretical model and motivational interviewing approach applicable to the treatment of eating disorders? A review. *Clinical Psychology Review, 32*(6), 558-565.

Drieschner, K. H., Lammers, S. M., & van der Staak, Cees PF. (2004). Treatment motivation: An attempt for clarification of an ambiguous concept. *Clinical Psychology Review, 23*(8), 1115-1137.

Duarte, C., Pinto-Gouveia, J., & Ferreira, C. (2015). Ashamed and fused with body image and eating: Binge eating as an avoidance strategy. *Clinical Psychology & Psychotherapy,*

Dunn, C., Deroo, L., & Rivara, F. P. (2001). The use of brief interventions adapted from motivational interviewing across behavioral domains: A systematic review. *Addiction, 96*(12), 1725-1742.

Eddy, K. T., Swanson, S. A., Crosby, R. D., Franko, D. L., Engel, S., & Herzog, D. B. (2010). How should DSM-V classify eating disorder not otherwise specified (EDNOS) presentations in women with lifetime anorexia or bulimia nervosa? *Psychological Medicine, 40*(10), 1735.

Eddy, K. T., Dorer, D. J., Franko, D. L., Tahilani, K., Thompson-Brenner, H., & Herzog, D. B. (2007). Should bulimia nervosa be subtyped by historyof anorexia nervosa? A longitudinal validation. *International Journal of Eating Disorders, 40*, S67-S71.

Eddy, K. T., Dorer, D. J., Franko, D. L., Tahilani, K., Thompson-Brenner, H., & Herzog, D. B. (2008). Diagnostic crossover in anorexia nervosa and bulimia nervosa: Implications for DSM-V. *American Journal of Psychiatry, 165*(2), 245-250.

Eddy, K. T., Doyle, A. C., Hoste, R. R., Herzog, D. B., & Le Grange, D. (2008). Eating disorder not otherwise specified in adolescents. *Journal of the American Academy of Child & Adolescent Psychiatry*, *47*(2), 156-164.

Eddy, K. T., Keel, P. K., Dorer, D. J., Delinsky, S. S., Franko, D. L., & Herzog, D. B. (2002). Longitudinal comparison of anorexia nervosa subtypes. *International Journal of Eating Disorders, 31*(2), 191-201.

Edelson, M. (1986). Causal explanation in science and in psychoanalysis: Implications for writing a case study. *The Psychoanalytic Study of the Child, 41*(1), 89-127.

Edler, C., Lipson, S. F., & Keel, P. K. (2007). Ovarian hormones and binge eating in bulimia nervosa. *Psychological Medicine, 37*(01), 131-141.

Edwards (2020) in Simpson, S., & Smith, E. (Eds.). (2019). *Schema therapy for eating disorders: Theory and practice for individual and group settings*. Routledge.

Edwards, D. (2007). Restructuring implicational meaning through memory-based imagery: Some historical notes. *Journal of Behavior Therapy and Experimental Psychiatry, 38*(4), 306-316.

Edwards, D., & Jacobs, M. (2003). *Conscious and unconscious* Open University Press.

Edwards, D. (2005). Treating PTSD in south african contexts: A theoretical framework and a model for developing evidence-based practice. *Journal of Psychology in Africa, 15*(2), 209-220.

Edwards, D. J. (1990). Cognitive therapy and the restructuring of early memories through guided imagery. *Journal of Cognitive Psychotherapy,*

Edwards, D. J. A. (2017). An interpretative phenomenological analysis of schema modes in a single case of anorexia nervosa: Part 2 - coping modes, healthy adult mode, superordinate themes, and implications for research and practice. *Indo-Pacific Journal of Phenomenology, 17*(1), 1-12.

Edwards, D. J. (1989). Cognitive restructuring through guided imagery. *Comprehensive handbook of cognitive therapy* (pp. 283-297) Springer.

Edwards, D. J. (1990). Cognitive-behavioral and existential-phenomenological approaches to therapy: Complementary or conflicting paradigms? *Journal of Cognitive Psychotherapy, 4*(2), 105-120.

Edwards, D. J. (1996). Case study research: The cornerstone of theory and practice. Paper presented at the *Based on a Paper Presented at the World Congress of Cognitive Therapy, Oxford, England, Jun 1989.*

Edwards, D. J. (1998). Types of case study work: A conceptual framework for case-based research. *Journal of Humanistic Psychology, 38*(3), 36-70.

Edwards, D. J. (2007). Collaborative versus adversarial stances in scientific discourse: Implications for the role of systematic case studies in the development of evidence-based practice in psychotherapy. *Pragmatic Case Studies in Psychotherapy, 3*(1)

Edwards, D. J. (2009). Treating posttraumatic stress disorder in south africa: An integrative model grounded in case-based research.*Journal of Psychology in Africa, 19*(2), 189-198.

Edwards, D. J. (2010). Using systematic case studies to investigate therapist responsiveness: Examples from a case series of PTSD treatments. *Pragmatic Case Studies in Psychotherapy, 6*(4)

Edwards, D. J., Dattilio, F. M., & Bromley, D. B. (2004). Developing evidence-based practice: The role of case-based research. *Professional Psychology: Research and Practice, 35*(6), 589.

Edwards, D., & Arntz, A. (2012). Schema therapy in historical perspective. *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research and Practice.*

Edwards, D., & Young, C. (2013). Assessment in routine clinical and counselling settings. *Psychological Assessment in South Africa: Research and Applications,* , 320-335.

Edwards, D. (2019). Finding and reparenting the lonely child behind the anorexic overcontroller. *Schema Therapy for Eating Disorders: Theory and Practice for Individual and Group Settings,* , 4.

Eells, T. D. (2007). History and current status of psychotherapy case formulation. *Handbook of Psychotherapy Case Formulation, 2*, 3-32.

Eells, T. D. (2007). Generating and generalizing knowledge about psychotherapy from pragmatic case studies. *Pragmatic Case Studies in Psychotherapy, 3*(1)

Ehsan, H. b., & Bahramizadeh, H. (2011). Early maladaptive schemas and agreeableness in personality five factor model. *Procedia - Social and Behavioral Sciences, 30*(0), 547-551.

Eisler, I. (1995). Family models of eating disorders. *Handbook of Eating Disorders: Theory, Treatment and Research,* , 155-176.

Eisler, I. (2005). The empirical and theoretical base of family therapy and multiple family day therapy for adolescent anorexia nervosa.*Journal of Family Therapy, 27*(2), 104-131.

Eisler, I., Dare, C., Hodes, M., Russell, G., Dodge, E., & Le Grange, D. (2000). Family therapy for adolescent anorexia nervosa: The results of a controlled comparison of two family interventions. *Journal of Child Psychology and Psychiatry, 41*(06), 727-736.

Eisler, I., Dare, C., Russell, G. F., Szmukler, G., le Grange, D., & Dodge, E. (1997). Family and individual therapy in anorexia nervosa: A 5-year follow-up. *Archives of General Psychiatry, 54*(11), 1025-1030.

Elliott, R. K., Greenberg, L. S., & Lietaer, G. (2004). Research on experiential psychotherapies.

Elliott, R., Fischer, C. T., & Rennie, D. L. (1999). Evolving guidelines for publication of qualitative research studies in psychology and related fields. *British Journal of Clinical Psychology, 38*(3), 215-229.

Elliott, R., Greenberg, L. S., Watson, J. C., Timulak, L., & Freire, E. (2013). Research on humanistic-experiential psychotherapies.

Elliott, R., Partyka, R., Alperin, R., Dobrenski, R., Wagner, J., Messer, S. B., . . . Castonguay, L. G. (2009). An adjudicated hermeneutic single-case efficacy design study of experiential therapy for panic/phobia. *Psychotherapy Research, 19*(4-5), 543-557.

Elliott, R., Watson, J. C., Goldman, R. N., & Greenberg, L. S. (2004). *Learning emotion-focused therapy: The process-experiential approach to change.* American Psychological Association.

Elliott, R., & Greenberg, L. S. (2007). The essence of process-experiential/emotion-focused therapy. *American Journal of Psychotherapy, 61*(3), 241-254.

Ellis, A. (1969). A cognitive approach to behavior therapy. International Journal of Psychiatry, 1969, 8, 896-900.

Ellis, C. (2007). Telling secrets, revealing lives: Relational ethics in research with intimate others. *Qualitative Inquiry, 13*(1), 3-29.

Ellison, R., Rhodes, P., Madden, S., Miskovic, J., Wallis, A., Baillie, A., . . . Touyz, S. (2012). Do the components of manualized family-based treatment for anorexia nervosa predict weight gain? *International Journal of Eating Disorders, 45*(4), 609-614.

Elran-Barak, R., Sztainer, M., Goldschmidt, A. B., Crow, S. J., Peterson, C. B., Hill, L. L., . . . Le Grange, D. (2015). Dietary restriction behaviors and binge eating in anorexia nervosa, bulimia nervosa and binge eating disorder: Trans-diagnostic examination of the restraint model. *Eating Behaviors, 18*, 192-196.

Emanuelli, F., Ostuzzi, R., Cuzzolaro, M., Watkins, B., Lask, B., & Waller, G. (2003). Family functioning in anorexia nervosa: British and italian mothers' perceptions. *Eating Behaviors, 4*(1), 27-39.

Engel, S. G., Wittrock, D. A., Crosby, R. D., Wonderlich, S. A., Mitchell, J. E., & Kolotkin, R. L. (2006). Development and psychometric validation of an eating disorder-specific health-related quality of life instrument. *International Journal of Eating Disorders, 39*(1), 62-71.

Erickson, F. (2012). Comments on causality in qualitative inquiry. *Qualitative Inquiry, 18*(8), 686-688.

Eriksson, L., Baigi, A., Marklund, B., & Lindgren, E. (2008). Social physique anxiety and sociocultural attitudes toward appearance impact on orthorexia test in fitness participants. *Scandinavian Journal of Medicine & Science in Sports, 18*(3), 389-394.

Etherington, K. (2004). *Becoming a reflexive researcher: Using ourselves in research* Jessica Kingsley Publishers.

Fairburn, C. G. (1985). Cognitive-behavioral treatment for bulimia. *Handbook of Psychotherapy for Anorexia Nervosa and Bulimia,* , 160-192.

Fairburn, C. G., & Cooper, Z. (2011). Eating disorders, DSM-5 and clinical reality. *The British Journal of Psychiatry : The Journal of Mental Science, 198*(1), 8-10.

Fairburn, C. G., Cooper, Z., Doll, H. A., Norman, P., & O'Connor, M. (2000). The natural course of bulimia nervosa and binge eating disorder in young women. *Archive of General Psychiatry, 57*, 659-665.

Fairburn, C. G., Jones, R., Peveler, R. C., Hope, R. A., & O'Connor, M. (1993). Psychotherapy and bulimia nervosa: Longer-term effects of interpersonal psychotherapy, behavior therapy, and cognitive behavior therapy. *Archives of General Psychiatry, 50*(6), 419.

Fairburn, C. G., Shafran, R., & Cooper, Z. (1999). A cognitive behavioural theory of anorexia nervosa. *Behaviour Research and Therapy, 37*(1), 1-13.

Fairburn, C. G., & Walsh, B. T. (2002). *Atypical eating disorders*. New York: Guilford Press.

Fairburn, C. (1981). A cognitive behavioural approach to the treatment of bulimia. *Psychological Medicine, 11*(04), 707-711.

Fairburn, C. G. (2008). *Cognitive behavior therapy and eating disorders* Guilford Press.

Fairburn, C. G. (2005). Evidence-based treatment of anorexia nervosa. *International Journal of Eating Disorders, 37*, 26-30.

Fairburn, C. G., & Bohn, K. (2005). Eating disorder NOS (EDNOS): An example of the troublesome "not otherwise specified" (NOS) category in DSM-IV. *Behaviour Research and Therapy, 43*(6), 691-701.

Fairburn, C. G., & Brownell, K. D. (Eds.). (2002a). *Eating disorders and obesity: A comprehensive handbook* (2nd ed.). New York: Guilford Press.

Fairburn, C. G., & Brownell, K. D. (2002b). *Atypical eating disorders (eating disorder not otherwise specified)*

Fairburn, C. G., & Cooper, Z. (2007). Thinking afresh about the classification of eating disorders. *International Journal of Eating Disorders, 40*, S107-S110.

Fairburn, C. G., Cooper, Z., & Shafran, R. (2003). Cognitive behaviour therapy for eating disorders: A "transdiagnostic" theory and treatment. *Behaviour Research and Therapy, 41*(5), 509-528. doi:http://dx.doi.org/10.1016/S0005-7967(02)00088-8

Fairburn, C. G., & Harrison, P. J. (2003). Eating disorders. *The Lancet, 361*(9355), 407-416. doi:http://dx.doi.org/10.1016/S0140-6736(03)12378-1

Fairburn, C. G., Stice, E., Cooper, Z., Doll, H. A., Norman, P. A., & O'Connor, M. E. (2003). Understanding persistence in bulimia nervosa: A 5-year naturalistic study. *Journal of Consulting and Clinical Psychology, 71*(1), 103-109.

Fairburn, C. G., & Beglin, S. J. (1994). Assessment of eating disorders: Interview or self-report questionnaire? *International Journal of Eating Disorders, 16*(4), 363-370.

Fairburn, C. G., Cooper, Z., Doll, H. A., & Davies, B. A. (2014). Identifying dieters who will develop an eating disorder: A prospective, population-based study. *American Journal of Psychiatry,*

Fairburn, C. G., Cooper, Z., Doll, H. A., O'Connor, M. E., Palmer, R. L., & Dalle Grave, R. (2013). Enhanced cognitive behaviour therapy for adults with anorexia nervosa: A UK–Italy study. *Behaviour Research and Therapy, 51*(1), R2-R8.

Fairburn, C. G., Cooper, Z., Doll, H. A., & Welch, S. L. (1999). Risk factors for anorexia nervosa: Three integrated case-control comparisons. *Archives of General Psychiatry, 56*(5), 468-476.

Fairburn, C. G., Doll, H. A., Welch, S. L., Hay, P. J., Davies, B. A., & O'Connor, M. E. (1998). Risk factors for binge eating disorder: A community-based, case-control study. *Archives of General Psychiatry, 55*(5), 425-432.

Fairburn, C. G., & Garner, D. M. (1988). Diagnostic criteria for anorexia nervosa and bulimia nervosa: The importance of attitudes to shape and weight.

Fairburn, C. G., Jones, R., Peveler, R. C., Carr, S. J., Solomon, R. A., O'Connor, M. E., Hope, R. A. (1991). Three psychological treatments for bulimia nervosa: A comparative trial. *Archives of General Psychiatry, 48*(5), 463-469.

Fairburn, C. G., Jones, R., Peveler, R. C., Hope, R. A., & O'Connor, M. (1993). Psychotherapy and bulimia nervosa: Longer-term effects of interpersonal psychotherapy, behavior therapy, and cognitive behavior therapy. *Archives of General Psychiatry, 50*(6), 419-428.

Fairburn, C. G., Kirk, J., O'Connor, M., & Cooper, P. J. (1986). A comparison of two psychological treatments for bulimia nervosa. *Behaviour Research and Therapy, 24*(6), 629-643.

Fairburn, C. G., Norman, P. A., Welch, S. L., O'Connor, M. E., Doll, H. A., & Peveler, R. C. (1995). A prospective study of outcome in bulimia nervosa and the long-term effects of three psychological treatments. *Archives of General Psychiatry, 52*(4), 304-312.

Fairburn, C. G., Shafran, R., & Cooper, Z. (1999). A cognitive behavioural theory of anorexia nervosa. *Behaviour Research and Therapy, 37*(1), 1-13.

Fairburn, C. G., Welch, S. L., Doll, H. A., Davies, B. A., & O'Connor, M. E. (1997). Risk factors for bulimia nervosa: A community-based case-control study. *Archives of General Psychiatry, 54*(6), 509-517.

Fairchild, H., & Cooper, M. (2010). A multidimensional measure of core beliefs relevant to eating disorders: Preliminary development and validation. *Eating Behaviors, 11*(4), 239-246.

Fanshawe, J. P., & Burnett, P. C. (1991). Assessing school-related stressors and coping mechanisms in adolescents. *British Journal of Educational Psychology, 61*(1), 92-98.

Farber, S. K. (2008). Dissociation, traumatic attachments, and self-harm: Eating disorders and self-mutilation. *Clinical Social Work Journal, 36*(1), 63-72.

Farber, S. K., Jackson, C. C., Tabin, J. K., & Bachar, E. (2007). Death and annihilation anxieties in anorexia nervosa, bulimia, and self-mutilation. *Psychoanalytic Psychology, 24*(2), 289-305.

Farmer, R. F. (2000). Issues in the assessment and conceptualization of personality disorders. *Clinical Psychology Review, 20*(7), 823-851.

Farrell, C., Shafran, R., & Lee, M. (2006). Empirically evaluated treatments for body image disturbance: A review. *European Eating Disorders Review, 14*(5), 289-300.

Farrell, E. M. (1995). *Lost for words: The psychoanalysis of anorexia and bulimia* Other Press, LLC.

Farrell, J. M., & Shaw, I. A. (2010). Schema therapy groups for borderline personality disorder patients: The best of both worlds of group psychotherapy. *Fortschritte Der Schematherapie.(Advances in Schema Therapy).Göttingen: Hogrefe,*

Farrell, J. M., & Shaw, I. A. (1994). Emotional awareness training: A prerequisite to effective cognitive-behavioral treatment of borderline personality disorder. *Cognitive and Behavioral Practice, 1*(1), 71-91.

Farrell, J. M., Shaw, I. A., & Webber, M. A. (2009). A schema-focused approach to group psychotherapy for outpatients with borderline personality disorder: A randomized controlled trial. *Journal of Behavior Therapy and Experimental Psychiatry, 40*(2), 317-328.

Farrell, J. M., Reiss, N., & Shaw, I. A. (2014). *The schema therapy clinician's guide: A complete resource for building and delivering individual, group and integrated schema mode treatment programs* John Wiley & Sons.

Farrell, J. M., & Shaw, I. A. (2012). *Group schema therapy for borderline personality disorder: A step-by-step treatment manual with patient workbook* John Wiley & Sons.

Fasick, F. A. (1977). Some uses of untranscribed tape recordings in survey research. *The Public Opinion Quarterly, 41*(4), 549-552.

Fassino, S., Amianto, F., Gramaglia, C., Facchini, F., & Daga, G. A. (2004). Temperament and character in eating disorders: Ten years of studies. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity, 9*(2), 81-90.

Fassino, S., Abbate-Daga, G., Amianto, F., Leombruni, P., Boggio, S., & Rovera, G. G. (2002). Temperament and character profile of eating disorders: A controlled study with the temperament and character inventory. *International Journal of Eating Disorders, 32*(4), 412-425.

Faull, C., Windridge, K., Ockleford, E., & Hudson, M. (2012). Anticipatory prescribing in terminal care at home: What challenges do community health professionals encounter? *BMJ Supportive & Palliative Care*, *3*(1), 91-97.

Favaro, A., Tenconi, E., & Santonastaso, P. (2006). Perinatal factors and the risk of developing anorexia nervosa and bulimia nervosa.*Archives of General Psychiatry, 63*(1), 82.

Favaro, A., Ferrara, S., & Santonastaso, P. (2003). The spectrum of eating disorders in young women: A prevalence study in a general population sample. *Psychosomatic Medicine, 65*(4), 701-708.

Favaro, A., & Santonastaso, P. (2002). The spectrum of self-injurious behavior in eating disorders. *Eating Disorders, 10*(3), 215-225.

Favaro, A., Tenconi, E., & Santonastaso, P. (2006). Perinatal factors and the risk of developing anorexia nervosa and bulimia nervosa.*Archives of General Psychiatry, 63*(1), 82-88.

Fawcett, J., Epstein, P., Fiester, S. J., Elkin, I., & Autry, J. H. (1987). NIMH treatment of depression collaborative research program. clinical management—imipramine/placebo administration manual. *Psychopharmacol Bull, 23*(2), 309-324.

Federici, A. (2011). Handbook of assessment methods for eating behaviors and weight-related problems: Measures, theory, and research (2nd ed.). *Eating Disorders, 19*(4), 371-373.

Federici, A., & Kaplan, A. S. (2008). The patient's account of relapse and recovery in anorexia nervosa: A qualitative study. *European Eating Disorders Review, 16*(1), 1-10.

Feeney, J. A., Noller, P., & Hanrahan, M. (1994). Assessing adult attachment.

Feld, R., Woodside, D. B., Kaplan, A. S., Olmsted, M. P., & Carter, J. C. (2001). Pre-treatment motivational enhancement therapy for eating disorders: A pilot study. *International Journal of Eating Disorders, 29*(4), 393-400.

Ferenczi, S. (1930). The principle of relaxation and neocatharsis. *The International Journal of Psycho-Analysis, 11*, 428.

Ferguson, C. J., Muñoz, M. E., Garza, A., & Galindo, M. (2014). Concurrent and prospective analyses of peer, television and social media influences on body dissatisfaction, eating disorder symptoms and life satisfaction in adolescent girls. *Journal of Youth and Adolescence, 43*(1), 1-14.

Fernández-Aranda, F., Pinheiro, A. P., Thornton, L. M., Berrettini, W. H., Crow, S., Fichter, M. M., . . . Bulik, C. M. (2008). Impulse control disorders in women with eating disorders. *Psychiatry Research, 157*(1–3), 147-157.

Ferrier, A. G., & Martens, M. P. (2008). Perceived incompetence and disordered eating among college students. *Eating Behaviors, 9*(1), 111-119.

Ferrier-auerbach, A., & Martens, M. P. (2009). Perceived incompetence moderates the relationship between maladaptive perfectionism and disordered eating. *Eating Disorders, 17*(4), 333-344.

Fichter, M. M., & Quadflieg, N. (2007). Long-term stability of eating disorder diagnoses. *International Journal of Eating Disorders, 40*, S61-S66.

Fidel, R. (1993). Qualitative methods in information retrieval research. *Library and Information Science Research, 15*, 219.

Field, A. E., Camargo Jr, C. A., Taylor, C. B., Berkey, C. S., Roberts, S. B., & Colditz, G. A. (2001). Peer, parent, and media influences on the development of weight concerns and frequent dieting among preadolescent and adolescent girls and boys. *PEDIATRICS*, *107*(1), 54-60.

Field, A. E., Javaras, K. M., Aneja, P., Kitos, N., Camargo, C. A., Taylor, C. B., & Laird, N. M. (2008). Family, peer, and media predictors of becoming eating disordered. *Archives of Pediatrics & Adolescent Medicine, 162*(6), 574-579.

Finlay, L. (2011). *Phenomenology for therapists: Researching the lived world* John Wiley & Sons.

Finlay, L., & Gough, B. (2008). *Reflexivity: A practical guide for researchers in health and social sciences* John Wiley & Sons.

First, M. B., Gibbon, M., Spitzer, R. L., Williams, J. B., & Benjamin, L. (1997). Structured clinical interview for DSM-IV personality disorders (SCID-II): Interview and questionnaire. *Washington D.C: American Psychiatric Publishing,*

Fischer, S., & Grange, D. l. (2007). Comorbidity and high-risk behaviors in treatment-seeking adolescents with bulimia nervosa. *International Journal of Eating Disorders, 40*(8), 751-753.

Fischer, S., Smith, G. T., & Anderson, K. G. (2003). Clarifying the role of impulsivity in bulimia nervosa. *International Journal of Eating Disorders, 33*(4), 406-411.

Fischer, S., Stojek, M., & Hartzell, E. (2010). Effects of multiple forms of childhood abuse and adult sexual assault on current eating disorder symptoms. *Eating Behaviors, 11*(3), 190-192.

Fisher, M. M., Rosen, D. S., Ornstein, R. M., Mammel, K. A., Katzman, D. K., Rome, E. S., . . . Walsh, B. T. (2014). Characteristics of avoidant/restrictive food intake disorder in children and adolescents: A “New disorder” in DSM-5. *Journal of Adolescent Health, 55*(1), 49-52.

Fishman, D. B., Messer, S. B., Edwards, D., & Dattilio, F. M. (2017). *Case studies within psychotherapy trials: Expanding the gold standard*. Oxford University Press.

Fishman, D. (1999). *The case for pragmatic psychology.* NYU Press.

Fishman, D. (2012). Editor's introduction: Combining pragmatic case studies within a single case experimental design. *Pragmatic Case Studies in Psychotherapy, 8*(4), 245-254.

Fishman, D. B. (2000). Transcending the efficacy versus effectiveness research debate: Proposal for a new, electronic "Journal of pragmatic case studies.". *Prevention and Treatment, 3*(8)

Fishman, D. B. (2004). Editor's introduction to PCSP-from single case to database: A new method for enhancing psychotherapy practice. *Pragmatic Case Studies in Psychotherapy, 1*(1)

Fishman, D. B. (2005). Editor's introduction to PCSP--from single case to database: A new method for enhancing psychotherapy practice. *Pragmatic Case Studies in Psychotherapy,*

Fishman, D. B. (2007). Seeking an equal place at the therapy research table: An introduction to a series on the pragmatic case study method. *Pragmatic Case Studies in Psychotherapy, 3*(1)

Fishman, D. B. (2009). Using case studies to develop theory: Roadmap to a dialogue. *Pragmatic Case Studies in Psychotherapy, 5*(3), 1-8.

Fishman, D. B. (2013). The pragmatic case study method for creating rigorous and systematic, practitioner-friendly research. *Pragmatic Case Studies in Psychotherapy, 9*(4), 403-425.

Fishman, D. B., & Peterson, D. R. (1987). On getting the right information and getting the information right. *Assessment for Decision, 1*, 395.

Fittig, E., Jacobi, C., Backmund, H., Gerlinghoff, M., & Wittchen, H. (2008). Effectiveness of day hospital treatment for anorexia nervosa and bulimia nervosa. *European Eating Disorders Review, 16*(5), 341-351.

Flanagan, C. M. (2010). The case for needs in psychotherapy. *Journal of Psychotherapy Integration, 20*(1), 1.

Flanagan, C. M. (2014). Unmet needs and maladaptive modes: A new way to approach longer-term problems. *Journal of Psychotherapy Integration*, *24*(3), 208-222.

Flanagan, C., Atkinson, T., & Young, J. (2020). An introduction to schema therapy: Origins, overview, research status and future directions. *Creative methods in schema therapy* (pp. 1-16) Routledge.

Flegal, K. M., Graubard, B. I., Williamson, D. F., & Gail, M. H. (2005). Excess deaths associated with underweight, overweight, and obesity. *Jama, 293*(15), 1861-1867.

Fletcher, B., Kupshik, G. A., Uprichard, S., Shah, S., & Nash, A. S. (2008). Eating disorders and concurrent psychopathology: A reconceptualisation of clinical need through rasch analysis. *European Eating Disorders Review, 16*(3), 191-198.

Florio-Ruane, S. (1986). Conversation and narrative in collaborative research. occasional paper no. 102.

Flyvbjerg, B. (2006). Five misunderstandings about case-study research. *Qualitative Inquiry, 12*(2), 219-245.

Fombonne, E. (1995). Anorexia nervosa. no evidence of an increase. *The British Journal of Psychiatry : The Journal of Mental Science, 166*(4), 462-471.

Fonagy, P. G., Jurist, G., & Target, E.M.(2002) affect regulation, mentalization, and the development of the self ed. *New York, NY: Other Press203-251,*

Fonagy, P. (1998). An attachment theory approach to treatment of the difficult patient. *Bulletin of the Menninger Clinic, 62*, 147-169.

Ford, G., Waller, G., & Mountford, V. (2011). Invalidating childhood environments and core beliefs in women with eating disorders. *European Eating Disorders Review*, *19*(4), 316-321.

Forman, M., & Davis, W. (2005). Characteristics of middle-aged women in inpatient treatment for eating disorders. *Eating Disorders, 13*(3), 231-243.

Fornari, V., & Dancyger, I. F. (2003). Psychosexual development and eating disorders. *Adolescent Medicine Clinics, 14*(1), 61.

Forney, K. J., Haedt-Matt, A. A., & Keel, P. K. (2014). The role of loss of control eating in purging disorder. *International Journal of Eating Disorders, 47*(3), 244-251.

Forsén Mantilla, E., Clinton, D., & Birgegård, A. (2018). Insidious: The relationship patients have with their eating disorders and its impact on symptoms, duration of illness, and self-image. *Psychology and Psychotherapy: Theory, Research and Practice*, *91*(3), 302-316.

Forthun, L. F., Pidcock, B. W., & Fischer, J. L. (2003). Religiousness and disordered eating: Does religiousness modify family risk? *Eating Behaviors, 4*(1), 7-26.

Fosha, D. (2003). Dyadic regulation and experiential work with emotion and relatedness in trauma and disorganized attachment. *Healing trauma: Attachment, mind, body, and brain*, 221-281.

Fosse, G. K., & Holen, A. (2006). Childhood maltreatment in adult female psychiatric outpatients with eating disorders. *Eating Behaviors, 7*(4), 404-409.

Fournier, J. C., DeRubeis, R. J., & Beck, A. T. (2012). Dysfunctional cognitions in personality pathology: The structure and validity of the personality belief questionnaire. *Psychological Medicine, 42*(04), 795-805.

Fox, A., Harrop, C., Trower, P., & Leung, N. (2009). A consideration of developmental egocentrism in anorexia nervosa. *Eating Behaviors, 10*(1), 10-15.

Fox, J. R., & Harrison, A. (2008). The relation of anger to disgust: The potential role of coupled emotions within eating pathology. Clinical Psychology & Psychotherapy: An International Journal of Theory & Practice, 15(2), 86-95.

Fox, A. P., & Leung, N. (2009). Existential well-being in younger and older people with anorexia nervosa—a preliminary investigation. *European Eating Disorders Review, 17*(1), 24-30.

Fox, J. R. E., & Power, M. J. (2009). Eating disorders and multi-level models of emotion: An integrated model. *Clinical Psychology & Psychotherapy, 16*(4), 240-267.

Fox, J. R., Federici, A., & Power, M. J. (2012). Emotions and eating disorders. *Eating and its Disorders, ,* 167-184.

Francis, L. A., & Birch, L. L. (2005). Maternal influences on daughters' restrained eating behavior. *Health Psychology, 24*(6), 548-554.

Frank, G. K., Bailer, U. F., Henry, S. E., Drevets, W., Meltzer, C. C., Price, J. C., . . . Ziolko, S. (2005). Increased dopamine D2/D3 receptor binding after recovery from anorexia nervosa measured by positron emission tomography and [11 C] raclopride. *Biological Psychiatry, 58*(11), 908-912.

Franko, D. L. (2007). Race, ethnicity, and eating disorders: Considerations for DSM-V. *International Journal of Eating Disorders, 40*, S31-S34.

Franko, D. L., & Erb, J. (1998). Managed care or mangled care?: Treating eating disorders in the current healthcare climate. *Psychotherapy: Theory, Research, Practice, Training, 35*(1), 43-53.

Freedman, G., Leichner, P., Manley, R., Sandhu, P. S., & Wang, T. C. (2006). Understanding anorexia nervosa through analysis of thematic content of letters in an adolescent sample. *European Eating Disorders Review, 14*(5), 301-307.

Freeman, A., & Dolan, M. (2001). Revisiting prochaska and DiClemente's stages of change theory: An expansion and specification to aid in treatment planning and outcome evaluation. *Cognitive and Behavioral Practice, 8*(3), 224-234.

Freeman, L. M. Y., & Gil, K. M. (2004). Daily stress, coping, and dietary restraint in binge eating. *International Journal of Eating Disorders, 36*(2), 204-212.

French, S. A., Story, M., Downes, B., Resnick, M. D., & Blum, R. W. (1995). Frequent dieting among adolescents: Psychosocial and health behavior correlates. *American Journal of Public Health, 85*(5), 695-701.

Freud, S. (1912). The dynamics of transference. *Classics in Psychoanalytic Techniques,* 3-8.

Freyberger, H. (1985). No title. *Anorexia-Nervosa-a Clinician Guide to Treatment-Vandereycken, W, Meerman, R,*

Friday, N. (1997). *My mother/my self: The daughter's search for identity*. Delta.

Friedlander, M. L., & Siegel, S. M. (1990). Separation-individuation difficulties and cognitive-behavioral indicators of eating disorders among college women. *Journal of Counseling Psychology, 37*(1), 74-78.

Friedman, S. (2008). Everybody's different: A positive approach to teaching about health, puberty, body image, nutrition, self-esteem and obesity prevention. *Eating Disorders, 16*(3), 275-278.

Fulton, J. J., Lavender, J. M., Tull, M. T., Klein, A. S., Muehlenkamp, J. J., & Gratz, K. L. (2012). The relationship between anxiety sensitivity and disordered eating: The mediating role of experiential avoidance. *Eating Behaviors, 13*(2), 166-169.

Gabbard, G. O. (2010). *Long-term psychodynamic psychotherapy: A basic text* American Psychiatric Pub.

Gamble, C., Bryant-Waugh, R., Turner, H., Jones, C., Mehta, R., & Graves, A. (2006). An investigation into the psychometric properties of the stirling eating disorder scales. *Eating Behaviors, 7*(4), 395-403.

Gammage, K. L., Francoeur, C., Mack, D. E., & Klentrou, P. (2009). Osteoporosis health beliefs and knowledge in college students: The role of dietary restraint. *Eating Behaviors, 10*(1), 65-67.

Garcia, F. D., Houy-Durand, E., Thibaut, F., & Dechelotte, P. (2009). Obsessive compulsive disorder as a cause of atypical eating disorder: A case report. *European Eating Disorders Review, 17*(6), 444-447. doi:10.1002/erv.961

Gard, M. C., & Freeman, C. P. (1996). The dismantling of a myth: A review of eating disorders and socioeconomic status. *International Journal of Eating Disorders, 20*(1), 1-12.

Gardiner, M., Freud, S., & Brunswick, R. M. (1971). *The wolf-man by the wolf-man: With the case of the wolf-man* Basic Books.

Garfinkel, P. E., Lin, E., Goering, P., Spegg, C., Goldbloom, D. S., Kennedy, S., . . . Woodside, D. B. (1995). Bulimia nervosa in a canadian community sample: Prevalence and comparison of subgroups. *American Journal of Psychiatry, 152*(7), 1052-1058.

Garfinkel, P. E., & Garner, D. M. (1982). *Anorexia nervosa: A multidimensional perspective* Bruner Meisel U.

Garner, D. M., & Bemis, K. M. (1985). Cognitive therapy for anorexia nervosa. in dm garner & pe garfinkel (eds.), handbook ofpsychotherapy for anorexia nervosa and bulimia (pp. 107-146).

Garner, D. M., & Garfinkel, P. E. (Eds.). (1997). *Handbook of treatment for eating disorders* (2nd. ed.). New York: The Guilford Press.

Garner, D. M., Olmstead, M. P., & Polivy, J. (2006). Development and validation of a multidimensional eating disorder inventory for anorexia nervosa and bulimia. *International Journal of Eating Disorders, 2*(2), 15-34.

Garner, D. M. (1991). *Eating disorder inventory-2* psychological assessment resources Odessa, FL.

Garner, D. M. (1993). Pathogenesis of anorexia nervosa. *The Lancet, 341*(8861), 1631-1635.

Garner, D. M., & Bemis, K. M. (1982). A cognitive-behavioral approach to anorexia nervosa. *Cognitive Therapy and Research, 6*(2), 123-150.

Garner, D. M., & Garfinkel, P. E. (1980). Socio-cultural factors in the development of anorexia nervosa. *Psychological Medicine, 10*(04), 647-656.

Garner, D. M., & Garfinkel, P. E. (1997). *Handbook of treatment for eating disorders* Guilford Press.

Garner, D. M., Garfinkel, P. E., & Bemis, K. M. (1982). A multidimensional psychotherapy for anorexia nervosa. *International Journal of Eating Disorders, 1*(2), 3-46.

Garner, D. M., Rockert, W., & Davis, R. (1993). Therapy for bulimia nervosa. *Am J Psychiatry, 150*(1), 37-46.

Garner, D. M., Vitousek, K. M., & Pike, K. M. (1997). Cognitive-behavioral therapy for anorexia nervosa. *Handbook of Treatment for Eating Disorders, 2*, 121-134.

Garner, D. M., & Garfinkel, P. E. (1997). *Handbook of treatment for eating disorders* Guilford Press.

Gavey, N., & Braun, V. (1997). Ethics and the publications of clinical case material. *Professional Psychology: Research and Practice, 28*(4), 399.

Gearhardt, A. N., White, M. A., Masheb, R. M., Morgan, P. T., Crosby, R. D., & Grilo, C. M. (2012). An examination of the food addiction construct in obese patients with binge eating disorder. *International Journal of Eating Disorders, 45*(5), 657-663.

Geller, J., Brown, K. E., & Srikameswaran, S. (2011). The efficacy of a brief motivational intervention for individuals with eating disorders: A randomized control trial. *International Journal of Eating Disorders, 44*(6), 497-505.

Geller, J., Johnston, C., Madsen, K., Goldner, E. M., Remick, R. A., & Birmingham, C. L. (1998). Shape-and weight-based self-esteem and the eating disorders. *International Journal of Eating Disorders, 24*(3), 285-298.

Geller, J., & Srikameswaran, S. (2006). Treatment non-negotiables: Why we need them and how to make them work. *European Eating Disorders Review, 14*(4), 212-217.

Geller, J., Williams, K. D., & Srikameswaran, S. (2001). Clinician stance in the treatment of chronic eating disorders. *European Eating Disorders Review, 9*(6), 365-373.

Gendlin, E. T. (1978). Heidegger and the philosophy of psychology. *Review of Existential Psychology and Psychiatry, 16*(1-3), 43-71.

Gendlin, E. T. (1991). On emotion in therapy. *Emotion, Psychotherapy, and Change,* 255-279.

Gendlin, E. T. (2003). *Focusing* Random House.

Gendlin, E. T. (2012). *Focusing-oriented psychotherapy: A manual of the experiential method* Guilford Press.

George, L., Thornton, C., Touyz, S. W., Waller, G., & Beumont*, P. J. (2004). Motivational enhancement and schema-focused cognitive behaviour therapy in the treatment of chronic eating disorders. *Clinical Psychologist, 8*(2), 81-85.

Ghaderi, A. (2003). Structural modeling analysis of prospective risk factors for eating disorder. *Eating Behaviors, 3*(4), 387-396.

Gibbons, L. M., Sarwer, D. B., Crerand, C. E., Fabricatore, A. N., Kuehnel, R. H., Lipschutz, P. E., . . . Wadden, T. A. (2006). Previous weight loss experiences of bariatric surgery candidates: How much have patients dieted prior to surgery? *Surgery for Obesity and Related Diseases, 2*(2), 159-164.

Giesen-Bloo, J., Van Dyck, R., Spinhoven, P., Van Tilburg, W., Dirksen, C., Van Asselt, T., . . . Arntz, A. (2006). Outpatient psychotherapy for borderline personality disorder: Randomized trial of schema-focused therapy vs transference-focused psychotherapy. *Archives of General Psychiatry, 63*(6), 649-658.

Gilbert, A. A., Shaw, S. M., & Notar, M. K. (2000). The impact of eating disorders on family relationships. *Eating Disorders, 8*(4), 331.

Gilbert, P. (1992). Depression. the evolution of powerlessness. hillsdale, NJ (erlbaum) 1992.

Gilbert, P. (2009). The compassionate mind: A new approach to facing the challenges of life. *London: Constable Robinson,*

Gilbert, P., & Allan, S. (1998). The role of defeat and entrapment (arrested flight) in depression: An exploration of an evolutionary Gillberg, I.C., Råstam, M., Wentz, E., & Gillberg, C. (2007). Cognitive and executive functions in anorexia nervosa ten years after onset of eating disorder. *Journal of Clinical and Experimental Neuropsychology*, *29*(2), 170-178.
view.*Psychological Medicine, 28*(03), 585-598.

Gilboa-Schechtman, E., Avnon, L., Zubery, E., & Jeczmien, P. (2006). Emotional processing in eating disorders: Specific impairment or general distress related deficiency? *Depression and Anxiety, 23*(6), 331-339.

Giles, L. (2010). A gallery of chinese immortals: Selected biographies translated from Chinese sources.

Gill, M. J. (2014). The possibilities of phenomenology for organizational research. *Organizational research methods*, *17*(2), 118-137.

Gillberg, I. C., Billstedt, E., Wentz, E., Anckarsäter, H., Råstam, M., & Gillberg, C. (2010). Attention, executive functions, and mentalizing in anorexia nervosa eighteen years after onset of eating disorder. *Journal of Clinical and Experimental Neuropsychology, 32*(4), 358-365.

Gillberg, I.C., Råstam, M., Wentz, E., & Gillberg, C. (2007). Cognitive and executive functions in anorexia nervosa ten years after onset of eating disorder. *Journal of Clinical and Experimental Neuropsychology*, *29*(2), 170-178.

Given, L. M. (2008). *The sage encyclopedia of qualitative research methods* Sage Publications.

Glaser, B., & Strauss, A. (1967). Grounded theory: The discovery of grounded theory. *Sociology the Journal of the British Sociological Association, 12*, 27-49.

Glauert, R., Rhodes, G., Byrne, S., Fink, B., & Grammer, K. (2009). Body dissatisfaction and the effects of perceptual exposure on body norms and ideals. *International Journal of Eating Disorders, 42*(5), 443-452.

Gleaves, D. H., Williamson, D. A., & Barker, S. E. (1993). Confirmatory factor analysis of a multidimensional model of bulimia nervosa.*Journal of Abnormal Psychology, 102*(1), 173-176.

Godart, N. T., Flament, M. F., Perdereau, F., & Jeammet, P. (2002). Comorbidity between eating disorders and anxiety disorders: A review.*International Journal of Eating Disorders, 32*(3), 253-270.

Goddard, E., Macdonald, P., Sepulveda, A. R., Naumann, U., Landau, S., Schmidt, U., & Treasure, J. (2011). Cognitive interpersonal maintenance model of eating disorders: Intervention for carers. *The British Journal of Psychiatry : The Journal of Mental Science, 199*(3), 225-231.

Godt, K. (2008). Personality disorders in 545 patients with eating disorders. *European Eating Disorders Review, 16*(2), 94-99.

Goldberg, S., Muir, R., & Kerr, J. (2013). *Attachment theory: Social, developmental, and clinical perspectives* Routledge.

Goldner, E. M., Srikameswaran, S., Schroeder, M. L., Livesley, W. J., & Birmingham, C. L. (1999). Dimensional assessment of personality pathology in patients with eating disorders. *Psychiatry Research, 85*(2), 151-159.

Goldner, E. (1989). Treatment refusal in anorexia nervosa. *International Journal of Eating Disorders, 8*(3), 297-306.

Goldstein, M., Peters, L., Baillie, A., McVeagh, P., Minshall, G., & Fitzjames, D. (2011). The effectiveness of a day program for the treatment of adolescent anorexia nervosa. *International Journal of Eating Disorders, 44*(1), 29-38.

Goleman, D. (1995). Anatomy of an emotional hijacking. *Emotional Intelligence (13-29). New York, NY: Bantam Books*.

Gomm, R., Hammersley, M., & Foster, P. (2000). *Case study method: Key issues, key texts* Sage.

Goncalves, M. D., Moore, R. H., Stunkard, A. J., & Allison, K. C. (2009). The treatment of night eating: The patient's perspective. *European Eating Disorders Review, 17*(3), 184-190.

Gongora, V. C., Derksen, J. J., & van Der Staak, C. P. (2004). The role of core beliefs in the specific cognitions of bulimic patients. *The Journal of Nervous and Mental Disease, 192*(4), 297-303.

Gonzalez Diez, Z., Calvete Zumalde, E., & Orue Sola, I. (2012). P-129 - early maladaptative schemas and social anxiety: The moderating effect of avoidant vs. overcompensation coping. *European Psychiatry, 27, Supplement 1*(0), 1.

Goodheart, C. D. (2005). Placing psychotherapy case studies within the framework of the APA evidence-based practice in psychology (EBPP) model. *Pragmatic Case Studies in Psychotherapy, 1*(3)

Goodheart, C. D., Kazdin, A. E., & Sternberg, R. J. (2006). *Evidence-based psychotherapy: Where practice and research meet.* American Psychological Association.

Goodwin, H., Haycraft, E., Willis, A., & Meyer, C. (2011). Compulsive exercise: The role of personality, psychological morbidity, and disordered eating. *International Journal of Eating Disorders, 44*(7), 655-660.

Gordon, K. H., & Dombeck, J. J. (2010). The associations between two facets of narcissism and eating disorder symptoms. *Eating Behaviors, 11*(4), 288-292.

Gordon, K., Holm-Denoma, J., Smith, A., Fink, E., & Joiner Jr., T. (2007). Taxometric analysis: Introduction and overview. *International Journal of Eating Disorders, 40*, S35-S39.

Gore, S. A., Foster, J. A., DiLillo, V. G., Kirk, K., & Smith West, D. (2003). Television viewing and snacking. *Eating Behaviors, 4*(4), 399-405.

Gorin, A. A., Le Grange, D., & Stone, A. A. (2003). Effectiveness of spouse involvement in cognitive behavioral therapy for binge eating disorder. *International Journal of Eating Disorders, 33*(4), 421-433.

Goss, K., & Allan, S. (2009). Shame, pride and eating disorders. *Clinical Psychology & Psychotherapy, 16*(4), 303-316.

Goulding, M. M., & Goulding, R. L. (1997). *Changing lives through redecision therapy* Grove Press.

Gowers, S. G., & Shore, A. (2001). Development of weight and shape concerns in the aetiology of eating disorders. *The British Journal of Psychiatry : The Journal of Mental Science, 179*, 236-242.

Graber, J. A., Brooks-Gunn, J., Paikoff, R. L., & Warren, M. P. (1994). Prediction of eating problems: An 8-year study of adolescent girls.*Developmental Psychology, 30*(6), 823.

Grant, J. E., Kim, S. W., & Eckert, E. D. (2002). Body dysmorphic disorder in patients with anorexia nervosa: prevalence, clinical features, and delusionality of body image. *International Journal of Eating Disorders*, *32*(3), 291-300.

Gratz, K. L., & Tull, M. T. (2010). The relationship between emotion dysregulation and deliberate self-harm among inpatients with substance use disorders. *Cognitive Therapy and Research, 34*(6), 544-553.

Green, T. C., & Balfour, A. (2020). 1 Assessment and formulation in Schema Therapy. *Creative Methods in Schema Therapy: Advances and Innovation in Clinical Practice*.

Greenberg, J. R., & Mitchell, S. A. (1983). Object relations in psychoanalytic theory. Cambridge, MA (Harvard University Press) 1983.

Greenberg, L. S., Rice, L., & Elliott, R. (1993). Process-experiential therapy: Facilitating emotional change. *New York: Guilford,*

Greenberg, L. S., & Watson, J. (2001). Experimental therapy of depression: Differential effects of client-centered relationship conditions and process experiential interventions. *Year Book of Psychiatry and Applied Mental Health, 2001*(1), 119.

Greenberg, L. S., & Safran, J. D. (1984). Integrating affect and cognition: A perspective on the process of therapeutic change. *Cognitive Therapy and Research, 8*(6), 559-578.

Greenberg, L. S., & Safran, J. D. (1989). Emotion in psychotherapy. *American Psychologist, 44*(1), 19.

Greenberg, L., & Brownell, P. (1997). Validating gestalt. *Gestalt, 1*(1)

Greenberg, L. (2006). Emotion-focused therapy: A synopsis. Journal of Contemporary Psychotherapy, 36(2), 87-93.

Greenberg, L. (2008). Emotion and cognition in psychotherapy: The transforming power of affect. *Canadian Psychology/Psychologie Canadienne, 49*(1), 49.

Greenberg, L. S. (2010). Emotion-focused therapy: A clinical synthesis. *Focus, 8*(1), 32-42.

Greenberg, L. S. (2015). *Emotion-focused therapy: Coaching clients to work through their feelings* American Psychological Association.

Greenberg, L. S., & Johnson, S. M. (1988). *Emotionally focused therapy for couples* Guilford Press.

Greenberg, L. S., & Malcolm, W. (2002). Resolving unfinished business: Relating process to outcome. *Journal of Consulting and Clinical Psychology, 70*(2), 406.

Greenberg, L. S., & Paivio, S. C. (2003). *Working with emotions in psychotherapy* Guilford Press.

Greenberg, L. S., & Pascual-Leone, A. (2006). Emotion in psychotherapy: A practice-friendly research review. *Journal of Clinical Psychology, 62*(5), 611-630.

Greenberg, L. S., & Safran, J. D. (1987). Emotions in psychotherapy: Affect, cognition, and the process of change.

Greenberg, L., & Watson, J. (1998). Experiential therapy of depression: Differential effects of client-centered relationship conditions and process experiential interventions. *Psychotherapy Research, 8*(2), 210-224.

Greenberg, M. T. (1999). Attachment and psychopathology in childhood.

Greenberg, L. S., & Safran, J. D. (1984). Integrating affect and cognition: A perspective on the process of therapeutic change. *Cognitive Therapy and Research, 8*(6), 559-578.

Greenberg, L. S., & Watson, J. C. (2006). *Emotion-focused therapy for depression.* American Psychological Association.

Greene, J. C. (2007). *Mixed methods in social inquiry* John Wiley & Sons.

Grillo, C. M., Sanislow, C. A., Skodol, A. E., Gunderson, J. G., Stout, R. L., Shea, M. T., . . . McGlashan, T. H. (2003). Do eating disorders co-occur with personality disorders? comparison groups matter. *International Journal of Eating Disorders, 33*(2), 155-164.

Grilo, 1. (2001). A comparison of different methods for assessing the features of eating disorders in patients with binge eating disorder. *Journal of Consulting and Clinical Psychology, 69*(2), 317.

Grilo, C. M., White, M. A., Gueorguieva, R., Wilson, G. T., & Masheb, R. M. (2013). Predictive significance of the overvaluation of shape/weight in obese patients with binge eating disorder: Findings from a randomized controlled trial with 12-month follow-up.*Psychological Medicine, 43*(06), 1335-1344.

Grilo, C. M., Pagano, M. E., Skodol, A. E., Sanislow, C. A., McGlashan, T. H., Gunderson, J. G., & Stout, R. L. (2007). Natural course of bulimia nervosa and of eating disorder not otherwise specified: 5-year prospective study of remissions, relapses, and the effects of personality disorder psychopathology. *Journal of Clinical Psychiatry, 68*(5), 738-746.

Grilo, C. M., Crosby, R. D., Wilson, G. T., & Masheb, R. M. (2012). 12-month follow-up of fluoxetine and cognitive behavioral therapy for binge eating disorder. *Journal of Consulting and Clinical Psychology.*

Grilo, C. M., Hrabosky, J. I., White, M. A., Allison, K. C., Stunkard, A. J., & Masheb, R. M. (2008). Overvaluation of shape and weight in binge eating disorder and overweight controls: Refinement of a diagnostic construct. *Journal of Abnormal Psychology, 117*(2), 414-419.

Grilo, C. M., Masheb, R. M., Wilson, G. T., Gueorguieva, R., & White, M. A. (2011). Cognitive–behavioral therapy, behavioral weight loss, and sequential treatment for obese patients with binge-eating disorder: A randomized controlled trial. *Journal of Consulting and Clinical Psychology, 79*(5), 675-685.

Grilo, C. M., Sanislow, C. A., Shea, M. T., Skodol, A. E., Stout, R. L., Pagano, M. E., . . . McGlashan, T. H. (2003a). The natural course of bulimia nervosa and eating disorder not otherwise specified is not influenced by personality disorders. *International Journal of Eating Disorders, 34*(3), 319-330.

Grilo, C. M., White, M. A., & Masheb, R. M. (2009). DSM-IV psychiatric disorder comorbidity and its correlates in binge eating disorder.*International Journal of Eating Disorders, 42*(3), 228-234.

Grilo, C. M., & Masheb, R. M. (2005). A randomized controlled comparison of guided self-help cognitive behavioral therapy and behavioral weight loss for binge eating disorder. *Behaviour Research and Therapy, 43*(11), 1509-1525.

Grilo, C. M., Masheb, R. M., & Salant, S. L. (2005). Cognitive behavioral therapy guided self-help and orlistat for the treatment of binge eating disorder: A randomized, double-blind, placebo-controlled trial. *Biological Psychiatry, 57*(10), 1193-1201.

Grilo, C. M., Masheb, R. M., & Wilson, G. T. (2001a). A comparison of different methods for assessing the features of eating disorders in patients with binge eating disorder. *Journal of Consulting and Clinical Psychology, 69*(2), 317.

Grilo, C. M., Masheb, R. M., & Wilson, G. T. (2001b). Subtyping binge eating disorder. *Journal of Consulting and Clinical Psychology, 69*(6), 1066.

Grilo, C. M., Masheb, R. M., & Wilson, G. T. (2005). Efficacy of cognitive behavioral therapy and fluoxetine for the treatment of binge eating disorder: A randomized double-blind placebo-controlled comparison. *Biological Psychiatry, 57*(3), 301-309.

Grilo, C. M., Sanislow, C. A., Shea, M. T., Skodol, A. E., Stout, R. L., Pagano, M. E., . . . McGlashan, T. H. (2003b). The natural course of bulimia nervosa and eating disorder not otherwise specified is not influenced by personality disorders. *International Journal of Eating Disorders, 34*(3), 319-330.

Grilo, C. M., White, M. A., Barnes, R. D., & Masheb, R. M. (2013). Psychiatric disorder co-morbidity and correlates in an ethnically diverse sample of obese patients with binge eating disorder in primary care settings. *Comprehensive Psychiatry, 54*(3), 209-216.

Groleau, P., Steiger, H., Bruce, K., Israel, M., Sycz, L., Ouellette, A., & Badawi, G. (2012). Childhood emotional abuse and eating symptoms in bulimic disorders: An examination of possible mediating variables. *International Journal of Eating Disorders, 45*(3), 326-332.

Gross, J., Rosen, J. C., Leitenberg, H., & Willmuth, M. E. (1986). Validity of the eating attitudes test and the eating disorders inventory in bulimia nervosa. *Journal of Consulting and Clinical Psychology, 54*(6), 875-876.

Grour, M. W., Thomas, S. P., & Shoffner, D. (1992). Adolescent stress and coping: A longitudinal study. *Research in Nursing & Health, 15*(3), 209-217.

Grover, M., Williams, C., Eisler, I., Fairbairn, P., McCloskey, C., Smith, G., . . . Schmidt, U. (2011). An off-line pilot evaluation of a web-based systemic cognitive-behavioral intervention for carers of people with anorexia nervosa. *International Journal of Eating Disorders, 44*(8), 708-715.

Grunwald, M., & Wesemann, D. (2006). Individual use of online-consulting for persons affected with eating disorders and their relatives—evaluation of an online consulting service. *European Eating Disorders Review, 14*(4), 218-225.

Guardiola-wanden-berghe, R., Sanz-valero, J., & Wanden-berghe, C. (2010). Eating disorders blogs: Testing the quality of information on the internet. *Eating Disorders, 18*(2), 148-152.

Guba, E. G. (1981). Criteria for assessing the trustworthiness of naturalistic inquiries. *Educational Technology Research and Development, 29*(2), 75-91.

Guba, E. G., & Lincoln, Y. S. (1994). Competing paradigms in qualitative research. *Handbook of Qualitative Research, 2*(163-194), 105.

Guerdjikova, A. I., & McElroy, S. L. (2009). Binge eating disorder pharmacotherapy clinical trails—who is left out? *European Eating Disorders Review, 17*(2), 101-108.

Guidano, V. F., Liotti, G., & Mahoney, M. J. (1983). *Cognitive processes and emotional disorders: A structural approach to psychotherapy* Guilford Press New York.

Guillaume, S., Sang, C. N. T., Jaussent, I., Raingeard, I., Bringer, J., Jollant, F., & Courtet, P. (2010). Is decision making really impaired in eating disorders? *Neuropsychology, 24*(6), 808-812.

Guillemin, M., & Gillam, L. (2004). Ethics, reflexivity, and “ethically important moments” in research. *Qualitative Inquiry, 10*(2), 261-280.

Guinzbourg, M. (2011). Eating disorders–A current concern: Similarities and differences among the anorexia, bulimia, and EDNOS categories. *Rorschachiana, 32*(1), 27-45.

Gull, W. W. (1874). Anorexia nervosa. *Transactions of the Clinical Society of London, 7*, 22-28.

Gunderson, J. G., & Gabbard, G. O. (1999). Making the case for psychoanalytic therapies in the current psychiatric environment. *Journal of the American Psychoanalytic Association,*

Gupta, S., Zachary Rosenthal, M., Mancini, A. D., Cheavens, J. S., & Lynch, T. R. (2008). Emotion regulation skills mediate the effects of shame on eating disorder symptoms in women. *Eating Disorders, 16*(5), 405-417.

Gurney, V. W., & Halmi, K. A. (2001). Developing an eating disorder curriculum for primary care providers. *Eating Disorders, 9*(2), 97-107.

Gusella, J., Casey, S., Schurter, M., & Andersen, A. E. (2002). How I practice. *Eating Disorders, 10*(4), 339.

Gustafsson, S. A., Edlund, B., Davén, J., Kjellin, L., & Norring, C. (2010). Perceived expectations in daily life among adolescent girls suffering from an eating disorder: A phenomenographic study. *Eating Disorders, 18*(1), 25-42.

Gustafsson, S. A., Edlund, B., Kjellin, L., & Norring, C. (2009). Risk and protective factors for disturbed eating in adolescent girls – aspects of perfectionism and attitudes to eating and weight. *European Eating Disorders Review, 17*(5), 380-389.

Haaland, A. T., Vogel, P. A., Launes, G., Haaland, V. Ø, Hansen, B., Solem, S., & Himle, J. A. (2011). The role of early maladaptive schemas in predicting exposure and response prevention outcome for obsessive-compulsive disorder. *Behaviour Research and Therapy, 49*(11), 781-788.

Hackmann, A., Bennett-Levy, J., & Holmes, E. A. (2011). *Oxford guide to imagery in cognitive therapy*. Oxford university press.

Haeyen, S. (2019). Strengthening the healthy adult self in art therapy using schema therapy as a positive psychological intervention for people diagnosed with personality disorders. *Frontiers in Psychology, 10*, 644.

Hahusseau, S., & Pélissolo, A. (2006). Behavior and cognitive therapies focused on The Young Personality Disorders Schemas: a pilot study of 14 cases. *L'encephale*, *32*(3 Pt 1), 298-304.

Halcomb, E. J., & Davidson, P. M. (2006). Is verbatim transcription of interview data always necessary?. *Applied nursing research*, *19*(1), 38-42.

Hales, C. N., & Barker, D. J. (2001). The thrifty phenotype hypothesis. *British Medical Bulletin*, *60*(1), 5-20.

Halmi, K. A. (2000). Eating disorders. *Women and Health*, 1032-1041.

Harper, G. (1983). Varieties of parenting failure in anorexia nervosa: Protection and parentectomy, revisited. *Journal of the American Academy of Child Psychiatry, 22*(2), 134-139.

Harper, K., Richter, N. L., & Gorey, K. M. (2009). Group work with female survivors of childhood sexual abuse: Evidence of poorer outcomes among those with eating disorders. *Eating Behaviors, 10*(1), 45-48.

Harris, R. (2009). *ACT with love: Stop struggling, reconcile differences, and strengthen your relationship with acceptance and commitment* New Harbinger Publications.

Harris, R. (2019). *ACT made simple: An easy-to-read primer on acceptance and commitment therapy* New Harbinger Publications.

Harrison, A., Sullivan, S., Tchanturia, K., & Treasure, J. (2010). Emotional functioning in eating disorders: Attentional bias, emotion recognition and emotion regulation. *Psychological Medicine, 40*(11), 1887-1897.

Harrison, A., Sullivan, S., Tchanturia, K., & Treasure, J. (2009). Emotion recognition and regulation in anorexia nervosa. *Clinical Psychology & Psychotherapy, 16*(4), 348-356.

Hart, L. M., Jorm, A. F., Paxton, S. J., Kelly, C. M., & Kitchener, B. A. (2009). First aid for eating disorders. *Eating Disorders, 17*(5), 357-384.

Hart, L. M., Cornell, C., Damiano, S. R., & Paxton, S. J. (2015). Parents and prevention: A systematic review of interventions involving parents that aim to prevent body dissatisfaction or eating disorders. *International Journal of Eating Disorders, 48*(2), 157-169.

Hartmann, A., Orlinsky, D., Weber, S., Sandholz, A., & Zeeck, A. (2010). Session and intersession experience related to treatment outcome in bulimia nervosa. *Psychotherapy: Theory, Research, Practice, Training, 47*(3), 355-370.

Hartmann, A., Zeeck, A., & Barrett, M. S. (2010). Interpersonal problems in eating disorders. *International Journal of Eating Disorders, 43*(7), 619-627.

Hartos, J. L., & Power, T. G. (1997). Mothers' awareness of their early adolescents' stressors relation between awareness and adolescent adjustment. *The Journal of Early Adolescence, 17*(4), 371-389.

Hartt, J., & Waller, G. (2002). Child abuse, dissociation, and core beliefs in bulimic disorders. *Child Abuse & Neglect, 26*(9), 923-938.

Harvey, S. M., & Spigner, C. (1995). Factors associated with sexual behavior among adolescents: A multivariate analysis. *Adolescence, 30*(118), 253.

Hasenboehler, K., Munsch, S., Meyer, A. H., Kappler, C., & Vögele, C. (2009). Family structure, body mass index, and eating behavior. *International Journal of Eating Disorders, 42*(4), 332-338.

Haslam, M., Arcelus, J., Farrow, C., & Meyer, C. (2012). Attitudes towards emotional expression mediate the relationship between childhood invalidation and adult eating concern. *European Eating Disorders Review, 20*(6), 510-514.

Haslam, M., Meyer, C., & Waller, G. (2011). Do eating attitudes predict early change in eating behaviors among women with bulimic disorders who are treated with cognitive behavioral therapy? *International Journal of Eating Disorders, 44*(8), 741-744.

Haslam, M., Mountford, V., Meyer, C., & Waller, G. (2008). Invalidating childhood environments in anorexia and bulimia nervosa. *Eating Behaviors, 9*(3), 313-318.

Hasler, G., Delsignore, A., Milos, G., Buddeberg, C., & Schnyder, U. (2004). Application of Prochaska's transtheoretical model of change to patients with eating disorders. *Journal of Psychosomatic Research, 57*(1), 67-72.

Hasler, G., Lissek, S., Ajdacic, V., Milos, G., Gamma, A., Eich, D., . . . Angst, J. (2005). Major depression predicts an increase in Long-Term body weight variability in young adults. *Obesity Research, 13*(11), 1991-1998.

Hatch, A., Madden, S., Kohn, M., Clarke, S., Touyz, S., & Williams, L. M. (2010). Anorexia nervosa: Towards an integrative neuroscience model. *European Eating Disorders Review, 18*(3), 165-179.

Hatcher, R. (1999). Therapists' views of treatment alliance and collaboration in therapy. *Psychotherapy Research, 9*(4), 405-423.

Haudek, C., Rorty, M., & Henker, B. (1999). The role of ethnicity and parental bonding in the eating and weight concerns of Asian-American and caucasian college women. *International Journal of Eating Disorders, 25*(4), 425-433.

Haworth-Hoeppner, S. (2000). The critical shapes of body image: The role of culture and family in the production of eating disorders. *Journal of Marriage and Family, 62*(1), 212-227.

Hay, P. (2013). A systematic review of evidence for psychological treatments in eating disorders: 2005-2012. *International Journal of Eating Disorders, 46*(5), 462-469.

Hay, P. J., Claudino, A. M., Touyz, S., & Abd Elbaky, G. (2015). Individual psychological therapy in the outpatient treatment of adults with anorexia nervosa. *The Cochrane Library,*

Hay, P. P., Bacaltchuk, J., Stefano, S., & Kashyap, P. (2009). Psychological treatments for bulimia nervosa and binging. *The Cochrane Library,*

Hayaki, J. (2009). Negative reinforcement eating expectancies, emotion dysregulation, and symptoms of bulimia nervosa. *International Journal of Eating Disorders, 42*(6), 552-556.

Hayaki, J., Friedman, M. A., & Brownell, K. D. (2002). Shame and severity of bulimic symptoms. *Eating Behaviors, 3*(1), 73-83.

Haynos, A. F., & Fruzzetti, A. E. (2011). Anorexia nervosa as a disorder of emotion dysregulation: Evidence and treatment implications.*Clinical Psychology: Science and Practice, 18*(3), 183-202.

Heath, G., & Startup, H. (2020). 11 creative methods with coping modes and chair work. *Creative Methods in Schema Therapy: Advances and Innovation in Clinical Practice,*

Heatherton, T. F., & Baumeister, R. F. (1991). Binge eating as escape from self-awareness. *Psychological Bulletin, 110*(1), 86.

Heatherton, T. F., & Polivy, J. (1992). Chronic dieting and eating disorders: A spiral model.

Hebebrand, J., & Bulik, C. M. (2011). Critical appraisal of the provisional DSM-5 criteria for anorexia nervosa and an alternative proposal. *International Journal of Eating Disorders, 44*(8), 665-678.

Heckwolf, J. I., Bergland, M. C., & Mouratidis, M. (2014). Coordinating principles of art therapy and DBT. *The Arts in Psychotherapy, 41*(4), 329-335.

Heilemann, M. V., Pieters, H. C., Kehoe, P., & Yang, Q. (2011). Schema therapy, motivational interviewing, and collaborative-mapping as treatment for depression among low income, second generation latinas. *Journal of Behavior Therapy and Experimental Psychiatry, 42*(4), 473-480.

Helverskov, J. L., Clausen, L., Mors, O., Frydenberg, M., Thomsen, P. H., & Rokkedal, K. (2010). Trans-diagnostic outcome of eating disorders: A 30-month follow-up study of 629 patients. *European Eating Disorders Review, 18*(6), 453-463.

Henderson, M., & Freeman, C. P. (1987). A self-rating scale for bulimia. the 'BITE'. *The British Journal of Psychiatry : The Journal of Mental Science, 150*, 18-24.

Hepworth, N. S. (2011). A mindful eating group as an adjunct to individual treatment for eating disorders: A pilot study. *Eating Disorders, 19*(1), 6-16.

Hermans, H. J. (1988). On the integration of nomothetic and idiographic research methods in the study of personal meaning. *Journal of Personality, 56*(4), 785-812.

Herrin, M. (2009). Body image, eating disorders, and obesity in youth: Assessment, prevention, and treatment. *Eating Disorders, 17*(5), 450-451.

Herron, W. G. (1991). Review of 'psychodynamic treatment of anorexia and bulimia'. *Psychotherapy: Theory, Research, Practice, Training, 28*(3), 523-524.

Herzog, D. B., Dorer, D. J., Keel, P. K., Selwyn, S. E., Ekeblad, E. R., Flores, A. T., . . . Keller, M. B. (1999). Recovery and relapse in anorexia and bulimia nervosa: A 7.5-year follow-up study. *Journal of the American Academy of Child & Adolescent Psychiatry, 38*(7), 829-837.

Herzog, D. B., Keller, M. B., Sacks, N. R., Yeh, C. J., & LAVORI, P. W. (1992). Psychiatric comorbidity in treatment-seeking anorexics and bulimics. *Journal of the American Academy of Child & Adolescent Psychiatry, 31*(5), 810-818.

Herzog, D. B., Keller, M. B., Lavori, P. W., Kenny, G. M., & Sacks, N. R. (1992). The prevalence of personality disorders in 210 women with eating disorders. *Journal of Clinical Psychiatry,*

Hesse-Biber, S., Leavy, P., Quinn, C. E., & Zoino, J. (2006). The mass marketing of disordered eating and eating disorders: The social psychology of women, thinness and culture. Paper presented at the *Women's Studies International Forum, , 29*(2) 208-224.

Hetherington, M. M., Altemus, M., Nelson, M. L., Bernat, A. S., & Gold, P. W. (1994). Eating behavior in bulimia nervosa: Multiple meal analyses. *The American Journal of Clinical Nutrition, 60*(6), 864-873.

Hewitt JK. 1997. Behavior genetics and eating disorders. *Psychopharmacology. Bull.* 33:355– 358.

Higbed, L., & Fox, J. R. (2010). Illness perceptions in anorexia nervosa: A qualitative investigation. *British Journal of Clinical Psychology, 49*(3), 307-325.

Hilbert, A., Hildebrandt, T., Agras, W. S., Wilfley, D. E., & Wilson, G. T. (2015). Rapid response in psychological treatments for binge eating disorder. *Journal of Consulting and Clinical Psychology, 83*(3), 649.

Hilbert, A., Pike, K. M., Goldschmidt, A. B., Wilfley, D. E., Fairburn, C. G., Dohm, F., . . . Weissman, R. S. (2014). Risk factors across the eating disorders. *Psychiatry Research, 220*(1), 500-506.

Hildebrandt, T. (2010). The clinician's guide to collaborative caring in eating disorders: The new maudsley method. *Eating Disorders, 18*(5), 452-455.

Hildebrandt, T., Bacow, T., Markella, M., & Loeb, K. L. (2012). Anxiety in anorexia nervosa and its management using family-based treatment. *European Eating Disorders Review, 20*(1), e1-e16.

Hill, A. B. (1965). The environment and disease: Association or causation? *Proceeding of the Royal Society of Medicine, 58*, 295-300.

Hill, A. J., & Franklin, J. A. (1998). Mothers, daughters and dieting: Investigating the transmission of weight control. *British Journal of Clinical Psychology, 37*(1), 3-13.

Hill, D. M., Craighead, L. W., & Safer, D. L. (2011). Appetite-focused dialectical behavior therapy for the treatment of binge eating with purging: A preliminary trial. *International Journal of Eating Disorders, 44*(3), 249-261.

Hill, J., Fonagy, P., Safier, E., & Sargent, J. (2004). The ecology of attachment in the family. *Family Process, 42*(2), 205-221.

Hill, L. S., Reid, F., Morgan, J. F., & Lacey, J. H. (2010). SCOFF, the development of an eating disorder screening questionnaire. *International Journal of Eating Disorders, 43*(4), 344-351.

Hilliard, R. B. (1993). Single-case methodology in psychotherapy process and outcome research. *Journal of Consulting and Clinical Psychology, 61*(3), 373.

Hindell, A. (2009). Personality disorders and eating disorders: Exploring the frontier. *Eating Disorders, 17*(1), 93-94.

Hinrichsen, H. & Waller, G. (2006). The treatment of avoidant personality disorder. In Sansone, R.A. & Levitt, J.L. (Ed.), *Personality disorders and eating disorders: Exploring the frontier* (pp. 213-230). New York: Routledge.

Hinrichsen, H., Garry, J., & Waller, G. (2006). Development and preliminary validation of the testable assumptions Questionnaire—Eating disorders (TAQ-ED). *Eating Behaviors, 7*(3), 275-281.

Hinrichsen, H., Sheffield, A., & Waller, G. (2007). The role of parenting experiences in the development of social anxiety and agoraphobia in the eating disorders. *Eating Behaviors, 8*(3), 285-290.

Hinrichsen, H., Waller, G., & van Gerko, K. (2004). Social anxiety and agoraphobia in the eating disorders: Associations with eating attitudes and behaviours. *Eating Behaviors, 5*(4), 285-290.

Hinrichsen, H., Wright, F., Waller, G., & Meyer, C. (2003). Social anxiety and coping strategies in the eating disorders. *Eating Behaviors, 4*(2), 117-126.

Hirsch, M. (1994). The body as a transitional object. *Psychotherapy and Psychosomatics, 62*(1-2), 78-81.

Hirschfeld, R. M., Williams, J. B., Spitzer, R. L., Calabrese, J. R., Flynn, L., Keck Jr, P. E., . . . Rapport, D. J. (2000). Development and validation of a screening instrument for bipolar spectrum disorder: The mood disorder questionnaire. *American Journal of Psychiatry, 157*(11), 1873-1875.

Hodes, M., Timimi, S., & Robinson, P. (1997). Children of mothers with eating disorders: A preliminary study. *European Eating Disorders Review, 5*(1), 11-24.

Hodge, L., & Simpson, S. (2016). Speaking the unspeakable: Artistic expression in eating disorder research and schema therapy. *The Arts in Psychotherapy, 50*, 1-8.

Hodgins, D., Diskin, K. M., Arkowitz, H., Westra, H. A., Miller, W. R., & Rollnick, S. (2008). Motivational interviewing in the treatment of problem and pathological gambling. *Motivational Interviewing in the Treatment of Psychological Problems,* , 225-248.

Hoek, H. W. (2016). Review of the worldwide epidemiology of eating disorders. *Current Opinion in Psychiatry, 29*(6), 336-339.

Hoffart, A. (2012). The case formulation process in schema therapy of chronic axis I disorder (affective/anxiety disorder). *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice,* , 67-80.

Hoffart, A., Lysebo, H., Sommerfeldt, B., & Rø, Ø. (2010). Change processes in residential cognitive therapy for bulimia nervosa. *European Eating Disorders Review, 18*(5), 367-375.

Hoffart, A., & Sexton, H. (2002). The role of optimism in the process of schema-focused cognitive therapy of personality problems. *Behaviour Research and Therapy, 40*(6), 611-623.

Hoffart, A., Sexton, H., Hedley, L. M., Wang, C. E., Holthe, H., Haugum, J. A., Holte, A. (2005). The structure of maladaptive schemas: A confirmatory factor analysis and a psychometric evaluation of factor-derived scales. *Cognitive Therapy and Research, 29*(6), 627-644.

Hoffmann, J. P., Cerbone, F. G., & Su, S. S. (2000). A growth curve analysis of stress and adolescent drug use. *Substance use & Misuse, 35*(5), 687-716.

Hoiles, K. J., Egan, S. J., & Kane, R. T. (2012). The validity of the transdiagnostic cognitive behavioural model of eating disorders in predicting dietary restraint. *Eating Behaviors, 13*(2), 123-126.

Hollon, S. D. (2006). Cognitive Therapy in the Treatment and Prevention of Depression. In T. E. Joiner, J. S. Brown, & J. Kistner (Eds.), *The interpersonal, cognitive, and social nature of depression* (pp. 133–151). Lawrence Erlbaum Associates Publishers.

Holloway, I. (1997). *Basic concepts for qualitative research* Wiley-Blackwell.

Holm-Denoma, J., Scaringi, V., Gordon, K. H., Van Orden, K. A., & Joiner Jr., T. E. (2009). Eating disorder symptoms among undergraduate varsity athletes, club athletes, independent exercisers, and non-exercisers. *International Journal of Eating Disorders, 42*(1), 47-53.

Holmes, E. A., Lang, T. J., & Deeprose, C. (2009). Mental imagery and emotion in treatment across disorders: Using the example of depression. *Cognitive Behaviour Therapy, 38*(S1), 21-28.

Holmes, E. A., & Mathews, A. (2005). Mental imagery and emotion: A special relationship? *Emotion, 5*(4), 489.

Holmes, E. A., & Mathews, A. (2010). Mental imagery in emotion and emotional disorders. *Clinical Psychology Review, 30*(3), 349-362.

Holmes, E. A., Mathews, A., Dalgleish, T., & Mackintosh, B. (2006). Positive interpretation training: Effects of mental imagery versus verbal training on positive mood. *Behavior Therapy, 37*(3), 237-247.

Holmes, J. (1993). John bowlby and attachment theory. London (routledge) 1993.

Holmgren, S., Humble, K., Norring, C., Roos, B., Rosmark, B., & Sohlberg, S. (1983). The anorectic bulimic conflict. an alternative diagnostic approach to anorexia nervosa and bulimia. *International Journal of Eating Disorders, 2*(2), 3-14.

Holmqvist, K., & Frisén, A. (2010). Body dissatisfaction across cultures: Findings and research problems. *European Eating Disorders Review, 18*(2), 133-146.

Holstein, B. E. (1990). The use of focusing in combination with a cognitive-behavioral weight loss program. *Unpublished Doctoral Research, the Illinois School of Professional Psychology, Chicago,*

Holtkamp, K., Herpertz-Dahlmann, B., Mika, C., Heer, M., Heussen, N., Fichter, M., . . . Schweiger, U. (2003). Elevated physical activity and low leptin levels co-occur in patients with anorexia nervosa. *The Journal of Clinical Endocrinology & Metabolism, 88*(11), 5169-5174.

Holtkamp, K., Herpertz-Dahlmann, B., Vloet, T., & Hagenah, U. (2005). Group psychoeducation for parents of adolescents with eating disorders: The aachen program. *Eating Disorders, 13*(4), 381-390.

Holub, S. C., Haney, A. M., & Roelse, H. (2012). Deconstructing the concept of the healthy eater self-schematic: Relations to dietary intake, weight and eating cognitions. *Eating Behaviors, 13*(2), 106-111.

Honey, A., Boughtwood, D., Clarke, S., Halse, C., Kohn, M., & Madden, S. (2008). Support for parents of children with anorexia: What parents want. *Eating Disorders, 16*(1), 40-51.

Honey, A., Clarke, S., Halse, C., Kohn, M., & Madden, S. (2006). The influence of siblings on the experience of anorexia nervosa for adolescent girls. *European Eating Disorders Review, 14*(5), 315-322.

Honey, A., & Halse, C. (2005). Parents dealing with anorexia nervosa: Actions and meanings. *Eating Disorders, 13*(4), 353-367.

Hong, J. P., Samuels, J., Joseph Bienvenu, O., Hsu, F. C., Eaton, W. W., Costa, P. T., & Nestadt, G. (2005). The longitudinal relationship between personality disorder dimensions and global functioning in a community-residing population. *Psychological Medicine, 35*(6), 891-896.

Horney, K. (1950). *Neurosis and human growth: The struggle towards self-realization* WW Norton, Incorporated.

Hornyak, L. M., & Baker, E. K. (1989). *Experiential therapies for eating disorders* Guilford Press.

Horvath, A. O. (1994). Research on the alliance. *The Working Alliance: Theory, Research, and Practice,* , 259-286.

Horvath, A. O., & Greenberg, L. S. (1989). Development and validation of the working alliance inventory. *Journal of Counseling Psychology, 36*(2), 223.

Hoshmand, L. T., & Polkinghorne, D. E. (1992). Redefining the science-practice relationship and professional training. *American Psychologist, 47*(1), 55.

Hoste, R. R., & le Grange, D. (2008). Expressed emotion among white and ethnic minority families of adolescents with bulimia nervosa.*European Eating Disorders Review, 16*(5), 395-400.

Houghton, C. E., Casey, D., Shaw, D., & Murphy, K. (2010). Ethical challenges in qualitative research: Examples from practice. *Nurse Researcher, 18*(1), 15-25.

House, J., Eisler, I., Simic, M., & Micali, N. (2008). Diagnosing eating disorders in adolescents: A comparison of the eating disorder examination and the development and well-being assessment. *International Journal of Eating Disorders, 41*(6), 535-541.

Howard, M. S., & Medway, F. J. (2004). Adolescents' attachment and coping with stress. *Psychology in the Schools, 41*(3), 391-402.

Hsu, L. G. (1996). Epidemiology of the eating disorders. *Psychiatric Clinics of North America, 19*(4), 681-700.

Hudson, J. I., Lalonde, J. K., Coit, C. E., Tsuang, M. T., McElroy, S. L., Crow, S. J., . . . Pope, H. G.,Jr. (2010). Longitudinal study of the diagnosis of components of the metabolic syndrome in individuals with binge-eating disorder. *The American Journal of Clinical Nutrition, 91*(6), 1568-1573.

Hudson, J. I., Hiripi, E., Pope Jr., H. G., & Kessler, R. C. (2007). The prevalence and correlates of eating disorders in the national comorbidity survey replication. *Biological Psychiatry, 61*(3), 348-358.

Hudson, J. I., & Pope Jr., H. G. (2007). Genetic epidemiology of eating disorders and co-occurring conditions: The role of endophenotypes. *International Journal of Eating Disorders, 40*, S76-S78.

Hughes, J. M. (1990). *Reshaping the psychoanalytic domain: The work of Melanie Klein, WRD Fairbairn, and DW winnicott* Univ of California Press.

Hughes, M. L., Hamill, M., van Gerko, K., Lockwood, R., & Waller, G. (2006). The relationship between different levels of cognition and behavioural symptoms in the eating disorders. *Eating Behaviors, 7*(2), 125-133.

Huibers, M. (2011). CS05-02 - schema therapy for chronic depression. *European Psychiatry, 26, Supplement 1*(0), 1783.

Huline-Dickens, S. (2000). Anorexia nervosa: Some connections with the religious attitude. *Psychology and Psychotherapy: Theory, Research and Practice, 73*(1), 67-76.

Humphrey, L. L. (1986). Structural analysis of parent–child relationships in eating disorders. *Journal of Abnormal Psychology, 95*(4), 395-402.

Humphrey, L. L. (1989). Observed family interactions among subtypes of eating disorders using structural analysis of social behavior.*Journal of Consulting and Clinical Psychology, 57*(2), 206-214.

Humphrey, L. L., & Stern, S. (1988). Object relations and the family system in bulimia: A theoretical integration. *Journal of Marital and Family Therapy, 14*(4), 337-350.

Huon, G., & Brown, L. (1986). Evaluating a group treatment for bulimia. *Anorexia Nervosa and Bulimic Disorders*, 479-483.

Hulsbergen, M., Smeets, E., Loeb, E., Lindenborn, A., Wagenaar, K., Van Herksen, T., van Sprang, I. (2015). *Schematherapie en de gezonde volwassene: Positieve technieken uit de praktijk* Springer.

Ismail, K., Thomas, S. M., Maissi, E., Chalder, T., Schmidt, U., Bartlett, J., Treasure, J. (2008). Motivational enhancement therapy with and without cognitive behavior therapy to treat type 1 DiabetesA randomized trial. *Annals of Internal Medicine, 149*(10), 708-719.

Isomaa, R., Isomaa, A., Marttunen, M., Kaltiala-Heino, R., & Björkqvist, K. (2009). The prevalence, incidence and development of eating disorders in finnish adolescents—a two-step 3-year follow-up study. *European Eating Disorders Review, 17*(3), 199-207.

Iwakabe, S., & Gazzola, N. (2009). From single-case studies to practice-based knowledge: Aggregating and synthesizing case studies.*Psychotherapy Research, 19*(4-5), 601-611.

J.Y. (2003). Integrative group treatment for bulimia nervosa (book). *Eating Disorders Review, 14*(1), 5.

Jackson, M. R. (2015). Resistance to qual/quant parity: Why the “paradigm” discussion can’t be avoided. *Qualitative Psychology, 2*(2), 181.

Jacob, G., van Genderen, H., & Seebauer, L. (2014). Promoting your healthy adult mode. *Breaking Negative Thinking Patterns: A Schema Therapy Self-Help and Support Book, A Schema Therapy Self-Help and Support Book,* , 165-174.

Jacobi, C., Hayward, C., de Zwaan, M., Kraemer, H. C., & Agras, W. S. (2004). Coming to terms with risk factors for eating disorders: Application of risk terminology and suggestions for a general taxonomy. *Psychological Bulletin, 130*(1), 19.

Jacobson, N. S., & Revenstorf, D. (1988). Statistics for assessing the clinical significance of psychotherapy techniques: Issues, problems, and new developments. *Behavioral Assessment,*

Jacobs-Pilipski, M. J., Winzelberg, A., Wilfley, D. E., Bryson, S. W., & Taylor, C. B. (2005). Spirituality among young women at risk for eating disorders. *Eating Behaviors, 6*(4), 293-300.

Jahromi, F. G., Naziri, G., & Barzegar, M. (2012). The relationship between socially prescribed perfectionism and depression: The mediating role of maladaptive cognitive schemas. *Procedia - Social and Behavioral Sciences, 32*(0), 141-147.

Jaite, C., Schneider, N., Hilbert, A., Pfeiffer, E., Lehmkuhl, U., & Salbach-Andrae, H. (2012). Etiological role of childhood emotional trauma and neglect in adolescent anorexia nervosa: A cross-sectional questionnaire analysis. *Psychopathology, 45*(1), 61-66.

Jakes, S. C., & Rhodes, J. E. (2003). The effect of different components of psychological therapy on people with delusions: Five experimental single cases. *Clinical Psychology & Psychotherapy, 10*(5), 302-315.

Janbozorgi, M. (2011). The effect of parenting style and early maladaptive schemas on children's self-esteem. *Journal of Behavioral Sciences, 5*(2), 165-172.

Jänsch, C., Harmer, C., & Cooper, M. J. (2009). Emotional processing in women with anorexia nervosa and in healthy volunteers. *Eating Behaviors, 10*(3), 184-191.

Janzen, B. L., Kelly, I. W., & Saklofske, D. H. (1992). Bulimic symptomatology and coping in a nonclinical sample. *Perceptual and Motor Skills, 75*(2), 395-399.

Jenkins, G. (2009). Investigation of schema modes in the eating disordered population.

Jenkins, P. E., & O'Connor, H. (2012). Discerning thoughts from feelings: The cognitive-affective division in eating disorders. *Eating Disorders, 20*(2), 144-158.

Johnson, J. G., Spitzer, R. L., & Williams, J. (2001). Health problems, impairment and illnesses associated with bulimia nervosa and binge eating disorder among primary care and obstetric gynaecology patients. *Psychological Medicine, 31*(08), 1455-1466.

Johnson, J. G., Cohen, P., Kasen, S., & Brook, J. S. (2002). Eating disorders during adolescence and the risk for physical and mental disorders during early adulthood. *Archives of General Psychiatry*, *59*(6), 545.

Johnson, J. G., Cohen, P., Kasen, S., & Brook, J. S. (2014). Childhood adversities associated with risk for eating disorders or weight problems during adolescence or early adulthood. *American Journal of Psychiatry,*

Johnson, R. B., & Onwuegbuzie, A. J. (2004). Mixed methods research: A research paradigm whose time has come. *Educational Researcher, 33*(7), 14-26.

Johnson, R. B., Onwuegbuzie, A. J., & Turner, L. A. (2007). Toward a definition of mixed methods research. *Journal of Mixed Methods Research, 1*(2), 112-133.

Johnson, W. G., Roberson-Nay, R., Rohan, K. J., & Torgrud, L. (2003). An experimental investigation of DSM-IV binge-eating criteria. *Eating Behaviors, 4*(3), 295-303.

Johnston, C., Dorahy, M. J., Courtney, D., Bayles, T., & O'Kane, M. (2009). Dysfunctional schema modes, childhood trauma and dissociation in borderline personality disorder. *Journal of Behavior Therapy and Experimental Psychiatry, 40*(2), 248-255.

Joiner, T. E., & Coyne, J. C. (1999). *The interactional nature of depression: Advances in interpersonal approaches.* American Psychological Association.

Jones, A., Evans, M., Bamford, B., & Ford, H. (2008). Exploring quality of life for eating-disordered patients. *European Eating Disorders Review, 16*(4), 276-286.

Jones, C., Harris, G., & Leung, N. (2005a). Parental rearing behaviours and eating disorders: The moderating role of core beliefs. *Eating Behaviors, 6*(4), 355-364.

Jones, C., Harris, G., & Leung, N. (2005b). Core beliefs and eating disorder recovery. *European Eating Disorders Review, 13*(4), 237-244.

Jones, C., Leung, N., & Harris, G. (2007). Dysfunctional core beliefs in eating disorders: A review. *Journal of Cognitive Psychotherapy, 21*(2), 156-171.

Jones, C. J., Leung, N., & Harris, G. (2006). Father-daughter relationship and eating psychopathology: The mediating role of core beliefs. *British Journal of Clinical Psychology, 45*(3), 319-330.

Jones, E. E. (1993). Introduction to special section: Single-case research in psychotherapy. *Journal of Consulting and Clinical Psychology, 61*(3), 371.

Jones, E. E., Ghannam, J., Nigg, J. T., & Dyer, J. F. (1993). A paradigm for single-case research: The time series study of a long-term psychotherapy for depression. *Journal of Consulting and Clinical Psychology, 61*(3), 381.

Joos, A. A. B., Cabrillac, E., Hartmann, A., Wirsching, M., & Zeeck, A. (2009). Emotional perception in eating disorders. *International Journal of Eating Disorders, 42*(4), 318-325.

Jordan, P. J., Redding, C. A., Troop, N. A., Treasure, J., & Serpell, L. (2003). Developing a stage of change measure for assessing recovery from anorexia nervosa. *Eating Behaviors, 3*(4), 365-385.

Jorgensen, R. S., & Dusek, J. B. (1990). Adolescent adjustment and coping strategies. *Journal of Personality, 58*(3), 503-513.

Kaeding, A., Sougleris, C., Reid, C., van Vreeswijk, M. F., Hayes, C., Dorrian, J., & Simpson, S. (2017). Professional burnout, early maladaptive schemas, and physical health in clinical and counselling psychology trainees. *Journal of Clinical Psychology, 73*(12), 1782-1796.

Kalarchian, M. A., & Marcus, M. D. (2003). Management of the bariatric surgery patient: Is there a role for the cognitive behavior therapist? *Cognitive and Behavioral Practice, 10*(2), 112-119.

Kalarchian, M. A., Wilson, G. T., Brolin, R. E., & Bradley, L. (1998). Binge eating in bariatric surgery patients. *International Journal of Eating Disorders, 23*(1), 89-92.

Kantrowitz, J. L. (2006). Writing about patients: Responsibilities, risks, and ramifications.

Kaplan, A. S., & Woodside, D. B. (1987). Biological aspects of anorexia nervosa and bulimia nervosa. *Journal of Consulting and Clinical Psychology, 55*(5), 645-653.

Karukivi, M., Hautala, L., Korpelainen, J., Haapasalo-pesu, K., Liuksila, P., Joukamaa, M., & Saarijärvi, S. (2010). Alexithymia and eating disorder symptoms in adolescents. *Eating Disorders, 18*(3), 226-238.

Kass, A. E., Patmore, J. M., & Wilfley, D. E. (2015). Interpersonal psychotherapy in the treatment of eating disorders. *The Wiley Handbook of Eating Disorders,* , 859-872.

Katarzyna Kucharska-Pietura, A., Vasilis Nikolaou, A., Marek Masiak, A., & Treasure, J. (2004). The recognition of emotion in the faces and voice of anorexia nervosa. *International Journal of Eating Disorders, 35*(1), 42-47.

Katterman, S. N., & Klump, K. L. (2010). Stigmatization of eating disorders: A controlled study of the effects of the television show starved. *Eating Disorders, 18*(2), 153-164.

Katzman, D. K. (2005). Medical complications in adolescents with anorexia nervosa: A review of the literature. *International Journal of Eating Disorders, 37*, 52-59.

Katzman, M. A., & Lee, S. (1997). Beyond body image: The integration of feminist and transcultural theories in the understanding of self-starvation. *International Journal of Eating Disorders, 22*(4), 385-394.

Kauser, F. (2008). Grainne smith (2007) families, carers and professionals: Building constructive conversations john wiley and sons, Ltd: Chichester, West Sussex,. *European Eating Disorders Review, 16*(3), 242.

Kaye, W. H., Frank, G. K., Bailer, U. F., & Henry, S. E. (2005). Neurobiology of anorexia nervosa: Clinical implications of alterations of the function of serotonin and other neuronal systems. *International Journal of Eating Disorders, 37*, 15-19.

Kaye, W. H., Bulik, C. M., Thornton, L., Barbarich, N., & Masters, K. (2004). Comorbidity of anxiety disorders with anorexia and bulimia nervosa. *American Journal of Psychiatry, 161*(12), 2215-2221.

Kaye, W. H., Bulik, C. M., Thornton, L., Barbarich, N., Masters, K., & Price Foundation Collaborative Group. (2014). Comorbidity of anxiety disorders with anorexia and bulimia nervosa. *American Journal of Psychiatry,* 161(12), 2215-2221.

Kaye, W. H., Fudge, J. L., & Paulus, M. (2009). New insights into symptoms and neurocircuit function of anorexia nervosa. *Nature Reviews Neuroscience, 10*(8), 573-584.

Kaye, W., Gendall, K., & Strober, M. (2001). Nutrition, serotonin and behavior in anorexia and bulimia nervosa.Nestle Nutritional Workshop Clinical Performance Programme (Vol.5, pp.153-165)

Kazdin, A. E. (1981). Drawing valid inferences from case studies. *Journal of Consulting and Clinical Psychology, 49*(2), 183.

Kearney-Cooke, A. (1989). Reclaiming the body: Using guided imagery in the treatment of body image disturbances among bulimic women. *Experiential Therapies for Eating Disorders,* , 11-33.

Keel, P. K., & Mitchell, J. E. (1997). Outcome in bulimia nervosa. *The American Journal of Psychiatry,*

Keel, P. K. (2007). Purging disorder: Subthreshold variant or full-threshold eating disorder? *International Journal of Eating Disorders, 40*, S89-S94.

Keel, P. K., & Brown, T. A. (2010). Update on course and outcome in eating disorders. *International Journal of Eating Disorders, 43*(3), 195-204.

Keel, P. K., Brown, T. A., Holm-Denoma, J., & Bodell, L. P. (2011). Comparison of DSM-IV versus proposed DSM-5 diagnostic criteria for eating disorders: Reduction of eating disorder not otherwise specified and validity. *International Journal of Eating Disorders, 44*(6), 553-560.

Keel, P. K., Gravener, J. A., Joiner Jr., T. E., & Haedt, A. A. (2010). Twenty-year follow-up of bulimia nervosa and related eating disorders not otherwise specified. *International Journal of Eating Disorders, 43*(6), 492-497.

Keel, P. K., & Klump, K. L. (2003). Are eating disorders culture-bound syndromes? implications for conceptualizing their etiology. *Psychological Bulletin, 129*(5), 747-769.

Keel, P. K., & Striegel-Moore, R. (2009). The validity and clinical utility of purging disorder. *International Journal of Eating Disorders, 42*(8), 706-719.

Keel, P. K., & Forney, K. J. (2013). Psychosocial risk factors for eating disorders. *International Journal of Eating Disorders, 46*(5), 433-439.

Keery, H., Van den Berg, P., & Thompson, J. K. (2004). An evaluation of the tripartite influence model of body dissatisfaction and eating disturbance with adolescent girls. *Body Image, 1*(3), 237-251.

Kehagias, I., Karamanakos, S. N., Argentou, M., & Kalfarentzos, F. (2011). Randomized clinical trial of laparoscopic roux-en-Y gastric bypass versus laparoscopic sleeve gastrectomy for the management of patients with BMI< 50 kg/m2. *Obesity Surgery, 21*(11), 1650-1656.

Kietel, M. A., Parisi, M., Whitney, J. L., & Stack, L. F. (2010). Salient stressors for mothers of children and adolescents with anorexia nervosa. *Eating Disorders, 18*(5), 435-444.

Keith, L., Gillanders, D., & Simpson, S. (2009). An exploration of the main sources of shame in an eating-disordered population. *Clinical Psychology & Psychotherapy, 16*(4), 317-327.

Kellogg, S. (2004). Dialogical encounters: Contemporary perspectives on" chairwork" in psychotherapy. *Psychotherapy: Theory, Research, Practice, Training, 41*(3), 310.

Kellogg, S. (2012). On speaking one's mind: Using chairwork dialogues in schema therapy. *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research and Practice,* , 197.

Kellogg, S (2019, December 11). Transformational chairwork & the four dialogues [Webinar]. International Society for Schema Therapy. https://schematherapysociety.org/Transformation-Chairwork-and-the-Four-Dialogues-Webinar

Kellogg, S. H., & Young, J. E. (2006). Schema therapy for borderline personality disorder. *Journal of Clinical Psychology, 62*(4), 445-458.

Kelly, J. T., Patten, S., & Mitchell, J. E. (1985). Adolescent behaviors and attitudes toward weight. *Anorexia Nervosa and Bulimia,* , 191-204.

Kelly, N. R., Lydecker, J. A., & Mazzeo, S. E. (2012). Positive cognitive coping strategies and binge eating in college women. *Eating Behaviors, 13*(3), 289-292.

Kemps, E., Tiggemann, M., Wade, T., Ben-Tovim, D., & Breyer, R. (2006). Selective working memory deficits in anorexia nervosa. *European Eating Disorders Review, 14*(2), 97-103.

Kendler, K. S., MacLean, C., Neale, M., Kessler, R., Heath, A., & Eaves, L. (1991). The genetic epidemiology of bulimia nervosa. *Am J Psychiatry, 148*(12), 1627-1637.

Kendrick, M. L., Clark, M. M., Collazo-Clavell, M. L., Mai, J. L., Grant, J. E., Neseth, M. A., & Sarr, M. G. (2007). Chapter 51 - multidisciplinary team in a bariatric surgery program. In Henry Buchwald A2M.D. A2Ph.D. A2George S.M. Cowan A2Jr. A2M.D., & Walter J. Pories, M. D. (Eds.), *Surgical management of obesity* (pp. 425-431). Philadelphia: W.B. Saunders.

Kennedy, M. A., Ip, K., Samra, J., & Gorzalka, B. B. (2007). The role of childhood emotional abuse in disordered eating. *Journal of Emotional Abuse, 7*(1), 17-36.

Kennedy-Moore, E., & Watson, J. C. (1999). Expressing emotion. *New York: Guilford,*

Kent, A., & Waller, G. (2000). Childhood emotional abuse and eating psychopathology. *Clinical Psychology Review, 20*(7), 887-903.

Kent, A., Waller, G., & Dagnan, D. (1999). A greater role of emotional than physical or sexual abuse in predicting disordered eating attitudes: The role of mediating variables. *International Journal of Eating Disorders, 25*(2), 159-167.

Kernberg, O., F. (1995). Technical approach to eating disorders in patients with borderline personality organization. *Annual of Psychoanalysis, 23*, 33-48.

Keski-Rahkonen, A., Hoek, H. W., Susser, E. S., Linna, M. S., Sihvola, E., Raevuori, A., . . . Rissanen, A. (2007). Epidemiology and course of anorexia nervosa in the community. *American Journal of Psychiatry, 164*(8), 1259-1265.

Kessler, R. C., Berglund, P. A., Chiu, W. T., Deitz, A. C., Hudson, J. I., Shahly, V., . . . Benjet, C. (2013). The prevalence and correlates of binge eating disorder in the world health organization world mental health surveys. *Biological Psychiatry, 73*(9), 904-914.

Key, A., O'Brien, A., Gordon, I., Christie, D., & Lask, B. (2006). Assessment of neurobiology in adults with anorexia nervosa. *European Eating Disorders Review, 14*(5), 308-314.

Keys, A., Brožek, J., Henschel, A., Mickelsen, O., & Taylor, H. L. (1950). The biology of human starvation.(2 vols).

Kiang, L., & Harter, S. (2006). Sociocultural values of appearance and attachment processes: An integrated model of eating disorder symptomatology. *Eating Behaviors, 7*(2), 134-151.

Kielhofner, G. (1982). Qualitative research: Part one paradigmatic grounds and issues of reliability and validity. *The Occupational Therapy Journal of Research, 2*(2), 67-79.

Kiesler, D. J. (1982). Interpersonal theory for personality and psychotherapy. *Handbook of Interpersonal Psychotherapy, 101*, 3-24.

Kiesler, D. J. (1997). Contemporary interpersonal theory and research: Personality, psychopathology, and psychotherapy. *The Journal of Psychotherapy Practice and Research, 6*(4), 339.

Killick, S., & Allen, C. (1997). 'Shifting the balance'—motivational interviewing to help behaviour change in people with bulimia nervosa.*European Eating Disorders Review, 5*(1), 33-41.

Kirby, J. S., Fischer, M. S., Raney, T. J., Baucom, D. H., & Bulik, C. M. (2016). Couple-based interventions in the treatment of adult anorexia nervosa: A brief case example of UCAN. *Psychotherapy, 53*(2), 241.

Kivlighan, D. M., & Shaughnessy, P. (1995). Analysis of the development of the working alliance using hierarchical linear modeling.*Journal of Counseling Psychology, 42*(3), 338-349.

Klaczynski, P. A., Goold, K. W., & Mudry, J. J. (2004). Culture, obesity stereotypes, self-esteem, and the "thin ideal": A social identity perspective. *Journal of Youth and Adolescence, 33*(4), 307-317.

Klein, M. H., Mathieu-Coughlan, P., & Kiesler, D. J. (1986). The experiencing scales. *The psychotherapeutic process: A research handbook*, *21*, 71.

Klein, J. D., Postle, C. K., Kreipe, R. E., Smith, S. M., McIntosh, S., Spada, J., & Ossip-Klein, D. (2006). Do physicians discuss needed diet and nutrition health topics with adolescents? *Journal of Adolescent Health, 38*(5), 608. e1-608. e6.

Klerman, G. L., Weissman, M. M., Rounsaville, B. J., & Chevron, E. S. (1984). Interpersonal psychotherapy of depression. Basic books. *New York.*

Kluck, A. S. (2010). Family influence on disordered eating: The role of body image dissatisfaction. *Body Image, 7*(1), 8-14.

Kluck, A. S. (2008). Family factors in the development of disordered eating: Integrating dynamic and behavioral explanations. *Eating Behaviors, 9*(4), 471-483.

Klump, K. L. (2013). Puberty as a critical risk period for eating disorders: A review of human and animal studies. *Hormones and Behavior, 64*(2), 399-410.

Klump, K. L., Bulik, C. M., Kaye, W. H., Treasure, J., & Tyson, E. (2009). Academy for eating disorders position paper: Eating disorders are serious mental illnesses. *International Journal of Eating Disorders, 42*(2), 97-103.

Klump, K. L., & Gobrogge, K. L. (2005). A review and primer of molecular genetic studies of anorexia nervosa. *International Journal of Eating Disorders, 37*, 43-48.

Klump, K. L., Miller, K. B., Keel, P. K., McGue, M., & Iacono, W. G. (2001). Genetic and environmental influences on anorexia nervosa syndromes in a population–based twin sample. *Psychological Medicine, 31*(04), 737-740.

Klumpner, G. H., & Frank, A. (1991). On methods of reporting clinical material. *Journal of the American Psychoanalytic Association, 39*(2), 537-551.

Knowles, L., Anokhina, A., & Serpell, L. (2013). Motivational interventions in the eating disorders: What is the evidence? *International Journal of Eating Disorders, 46*(2), 97-107.

Kobak, R., & Ferenz-Gillies, R. (1995). Emotion regulation and depressive symptoms during adolescence: A functionalist perspective.*Development and Psychopathology, 7*(01), 183-192.

Kog, E., & Vandereycken, W. (1989). Family interaction in eating disorder patients and normal controls. *International Journal of Eating Disorders, 8*(1), 11-23.

Köhler, S., Guhn, A., Betzler, F., Stiglmayr, C., Brakemeier, E., & Sterzer, P. (2017). Therapeutic self-disclosure within dbt, schema therapy, and CBASP: Opportunities and challenges. *Frontiers in Psychology, 8*, 2073.

Kohut, H. (1971). The analysis of the self. New York: Int. Routledge.

Kohut, H. (1977). The restoration of the self. New York (international universities press) 1977.

Kohut, H. (1984). How does analysis cure?(edited by A. Goldberg with the collaboration of PE Stepansky).

Kong, S., & Bernstein, K. (2009). Childhood trauma as a predictor of eating psychopathology and its mediating variables in patients with eating disorders. *Journal of Clinical Nursing, 18*(13), 1897-1907.

Kopelman, P. G. (2000). Obesity as a medical problem. *Nature, 404*(6778), 635-643.

Kordy, H., Haug, S., & Percevic, R. (2006). Patients differ—a plea for individually tailored service allocation. *European Eating Disorders Review, 14*(1), 1-7.

Kortegaard, L. S., Hoerder, K., Joergensen, J., Gillberg, C., & Kyvik, K. O. (2001). A preliminary population-based twin study of self-reported eating disorder. *Psychological Medicine, 31*(02), 361-365.

Koski, J. P. (2014). 'I'm just a walking eating disorder': The mobilisation and construction of a collective illness identity in eating disorder support groups. *Sociology of Health & Illness, 36*(1), 75-90.

Koss, M. P., & Butcher, J. N. (1986). Research on brief psychotherapy. in S.L. Garfield & A.E. Bergin (eds.), handbook of psychotherapy and behavior change, pp. 627-670.

Kosslyn, S. M., Ganis, G., & Thompson, W. L. (2001). Neural foundations of imagery. *Nature Reviews Neuroscience, 2*(9), 635-642.

Kottler, J. A. (1992). *Compassionate therapy: Working with difficult clients.* Jossey-Bass.

Kozlowska, K., & Hanney, L. (2002). The network perspective: An integration of attachment and family systems theories. *Family Process, 41*(3), 285-312.

Kramer, U., & Stiles, W. B. (2015). The responsiveness problem in psychotherapy: A review of proposed solutions. *Clinical Psychology: Science and Practice, 22*(3), 277-295.

Krefting, L. (1991). Rigor in qualitative research: The assessment of trustworthiness. *American Journal of Occupational Therapy, 45*(3), 214-222.

Kreitler, S., & Chemerinski, A. (1988). The cognitive orientation of obesity. *International Journal of Obesity, 12*(5), 403-415.

Kreitler, S., & Kreitler, H. (2013). *The cognitive foundations of personality traits* Springer Science & Business Media.

Kristeller, J. L., & Wollever, R. Q. (2011). Mindfulness-based eating awareness training for treating binge eating disorder: The conceptual foundation. *Eating Disorders, 19*(1), 49-61.

Kristeller, J. L., Baer, R. A., & Quillian-Wolever, R. (2006). Mindfulness-based approaches to eating disorders. *Mindfulness-Based Treatment Approaches: Clinician's Guide to Evidence Base and Applications,* , 75-91.

Kruger, H. S., Puoane, T., Senekal, M., & Van der Merwe, M. (2005). Obesity in south africa: Challenges for government and health professionals. *Public Health Nutrition, 8*(05), 491-500.

Kruseman, M., Leimgruber, A., Zumbach, F., & Golay, A. (2010). Dietary, weight, and psychological changes among patients with obesity, 8 years after gastric bypass. *Journal of the American Dietetic Association, 110*(4), 527-534.

Kübler-Ross, E. (2009). *On death and dying: What the dying have to teach doctors, nurses, clergy and their own families* Taylor & Francis.

Kuyken, W., Padesky, C. A., & Dudley, R. (2009). Collaborative case conceptualization. *Working Effectively with Clients in Cognitive-Behavioral Therapy,*

Lackstrom, J. (2000). Eating disorders and marital relationships (book). *Eating Disorders, 8*(1), 87.

Lafrance Robinson, A., Kosmerly, S., Mansfield-Green, S., & Lafrance, G. (2014). Disordered eating behaviours in an undergraduate sample: Associations among gender, body mass index, and difficulties in emotion regulation. *Canadian Journal of Behavioural Science/Revue Canadienne Des Sciences Du Comportement, 46*(3), 320.

Lambert, M. J. (2013). *Bergin and garfield's handbook of psychotherapy and behavior change* John Wiley & Sons.

Lampard, A. M., Byrne, S. M., McLean, N., & Fursland, A. (2011). Avoidance of affect in the eating disorders. *Eating Behaviors, 12*(1), 90-93.

Lampard, A. M., Byrne, S. M., McLean, N., & Fursland, A. (2012). The eating disorder inventory-2 perfectionism scale: Factor structure and associations with dietary restraint and weight and shape concern in eating disorders. *Eating Behaviors, 13*(1), 49-53.

Lampard, A. M., Tasca, G. A., Balfour, L., & Bissada, H. (2013). An evaluation of the transdiagnostic cognitive-behavioural model of eating disorders. *European Eating Disorders Review, 21*(2), 99-107.

Langroudi, M. S., Bahramizadeh, H., & Mehri, Y. (2011). Schema therapy and family systems theory: The relationship between early maladaptive schemas and differentiation of self. *Procedia - Social and Behavioral Sciences, 30*(0), 634-638.

Larkin, M., & Thompson, A. R. (2012). Interpretative phenomenological analysis in mental health and psychotherapy research. *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners,* , 99-116.

Larsson, C. L., & Johansson, G. K. (2002). Dietary intake and nutritional status of young vegans and omnivores in Sweden. *The American journal of clinical nutrition*, *76*(1), 100-106.

Lasater, L. M., & Mehler, P. S. (2001). Medical complications of bulimia nervosa. *Eating Behaviors, 2*(3), 279-292.

Lask, B., Geller, J., & Srikameswaran, S. (2007). Motivational approaches. *Eating Disorders in Childhood and Adolescence,* , 177-198.

Lask, B., & Frampton, I. (2009). Anorexia nervosa—irony, misnomer and paradox. *European Eating Disorders Review, 17*(3), 165-168.

Latner, J. D., & Wilson, G. T. (2000). Cognitive-behavioral therapy and nutritional counseling in the treatment of bulimia nervosa and binge eating. *Eating Behaviors, 1*(1), 3-21.

Latner, J. D., & Wilson, G. T. (2002). Self-monitoring and the assessment of binge eating. *Behavior Therapy, 33*(3), 465-477.

Latzer, Y., Hochdorf, Z., Bachar, E., & Canetti, L. (2002). Attachment style and family functioning as discriminating factors in eating disorders. *Contemporary Family Therapy: An International Journal, 24*(4), 581.

Latzer, Y., Lavee, Y., & Gal, S. (2009). Marital and parent–child relationships in families with daughters who have eating disorders. *Journal of Family Issues,*

Lavender, A., & Schmidt, U. (2006). Cognitive-behavioural case formulation in complex eating disorders. In N. Tarrier (Ed.), *Case formulation in cognitive behaviour therapy: The treatment of challenging and complex cases* (pp. 238-262). New York: Routledge.

Lavender, J. M., Jardin, B. F., & Anderson, D. A. (2009). Bulimic symptoms in undergraduate men and women: Contributions of mindfulness and thought suppression. *Eating Behaviors, 10*(4), 228-231.

Lavender, J. M., Wonderlich, S. A., Engel, S. G., Gordon, K. H., Kaye, W. H., & Mitchell, J. E. (2015). Dimensions of emotion dysregulation in anorexia nervosa and bulimia nervosa: A conceptual review of the empirical literature. *Clinical Psychology Review, 40*, 111-122.

Lawrence, M. (1979). Anorexia nervosa—The control paradox. *Women's Studies International Quarterly, 2*(1), 93-101.

Lawson, R., Waller, G., & Lockwood, R. (2007). Cognitive content and process in eating-disordered patients with obsessive–compulsive features. *Eating Behaviors, 8*(3), 305-310.

Layden, M. A., Newman, C. F., Freeman, A., & Morse, S. B. (1993). *Cognitive therapy of borderline personality disorder.* Allyn & Bacon.

Lazar, S. G. (2010). *Psychotherapy is worth it: A comprehensive review of its cost-effectiveness* American Psychiatric Pub.

Lazarevic, D., Hough, M., & Brockman, R. (2013). *The relationship between the healthy adult schemas mode and psychological flexibility*. Master's thesis, University of Western Sydney

Lazarus, A. A. (1985). *Casebook of multimodal therapy*. New York: The Guilford Press.

Lazarus, A. A., & Messer, S. B. (1991). Does chaos prevail? an exchange on technical eclecticism and assimilative integration. *Journal of Psychotherapy Integration, 1*(2), 143.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping* Springer publishing company.

Leahy, R. L. (2003). Cognitive therapy techniques. New York: Guilford. Rev. Clin. Psychol, 2011, 351-381.

Leahy, R. L. (2007). Emotional schemas and resistance to change in anxiety disorders. *Cognitive and Behavioral Practice, 14*(1), 36-45. doi:10.1016/j.cbpra.2006.08.001

Leaman, D. R. (1978). Confrontation in counseling. *The Personnel and Guidance Journal, 56*(10), 630-633.

Leary, M. R., Schreindorfer, L. S., & Haupt, A. L. (1995). The role of low self-esteem in emotional and behavioral problems: Why is low self-esteem dysfunctional? *Journal of Social and Clinical Psychology, 14*(3), 297-314.

LeBel, J. L., Lu, J., & Dubé, L. (2008). Weakened biological signals: Highly-developed eating schemas amongst women are associated with maladaptive patterns of comfort food consumption. *Physiology & Behavior, 94*(3), 384-392.

Ledoux, T., Winterowd, C., Richardson, T., & Clark, J. D. (2010). Relationship of negative self-schemas and attachment styles with appearance schemas. *Body Image, 7*(3), 213-217.

Le Grange, D. (1999). Family therapy for adolescent anorexia nervosa. *Journal of Clinical Psychology, 55*, 727-740.

le Grange, D. (2006). How enthusiastic should we be about family-based treatment for adolescent anorexia nervosa? *European Eating Disorders Review, 14*(6), 373-375.

Le Grange, D. (2016). Anorexia nervosa in adults: The urgent need for novel outpatient treatments that work. *Psychotherapy, 53*(2), 251.

Le Grange, D., Binford, R., & Loeb, K. L. (2005). Manualized family-based treatment for anorexia nervosa: A case series. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(1), 41-46.

le Grange, D., Crosby, R. D., Rathouz, P. J., & Leventhal, B. L. (2007). A randomized controlled comparison of family-based treatment and supportive psychotherapy for adolescent bulimia nervosa. *Archives of General Psychiatry, 64*(9), 1049-1056.

le Grange, D., Doyle, P., Crosby, R. D., & Chen, E. (2008). Early response to treatment in adolescent bulimia nervosa. *International Journal of Eating Disorders, 41*(8), 755-757.

le Grange, D., & Eisler, I. (2009). Family interventions in adolescent anorexia nervosa. *Child and Adolescent Psychiatric Clinics of North America, 18*(1), 159-173.

le Grange, D., & Lock, J. (2005). The dearth of psychological treatment studies for anorexia nervosa. *International Journal of Eating Disorders, 37*(2), 79-91.

Le Grange, D., Lock, J., Agras, W. S., Moye, A., Bryson, S. W., Jo, B., & Kraemer, H. C. (2012). Moderators and mediators of remission in family-based treatment and adolescent focused therapy for anorexia nervosa. *Behaviour Research and Therapy, 50*(2), 85-92.

Le Grange, D., Lock, J., Loeb, K., & Nicholls, D. (2010). Academy for eating disorders position paper: The role of the family in eating disorders. *International Journal of Eating Disorders, 43*(1), 1-5.

Le Grange, D., Louw, J., Breen, A., & Katzman, M. A. (2004). The meaning of 'Self-starvation' in impoverished black adolescents in south africa. *Culture, Medicine & Psychiatry, 28*(4), 439-461.

Le Grange, D., Binford, R., & Loeb, K. L. (2005). Manualized family-based treatment for anorexia nervosa: A case series. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(1), 41-46.

Le Grange, D., Telch, C. F., & Tibbs, J. (1998). Eating attitudes and behaviors in 1,435 south African caucasian and non-caucasian college students. *The American Journal of Psychiatry, 155*(2), 250-254.

Leichner, P., Hall, D., & Calderon, R. (2005). Meal support training for friends and families of patients with eating disorders. *Eating Disorders, 13*(4), 407-411.

Leichsenring, F. (2004). Randomized controlled versus naturalistic studies: A new research agenda. *Bulletin of the Menninger Clinic, 68*(2), 137.

Leichsenring, F., & Klein, S. (2014). Evidence for psychodynamic psychotherapy in specific mental disorders: A systematic review. *Psychoanalytic Psychotherapy, 28*(1), 4-32.

Leichsenring, F., Masuhr, O., Jaeger, U., Dally, A., & Streeck, U. (2010). The effectiveness of psychoanalytic-interactional psychotherapy in borderline personality disorder. *Bulletin of the Menninger Clinic, 74*(3), 206-218.

Lent, M. R., & Swencionis, C. (2012). Addictive personality and maladaptive eating behaviors in adults seeking bariatric surgery. *Eating Behaviors, 13*(1), 67-70.

Leonard, D., & Mehler, P. S. (2001). Medical issues in the patient with anorexia nervosa. *Eating Behaviors, 2*(4), 293-305.

Lethbridge, J., Watson, H. J., Egan, S. J., Street, H., & Nathan, P. R. (2011). The role of perfectionism, dichotomous thinking, shape and weight overvaluation, and conditional goal setting in eating disorders. *Eating Behaviors, 12*(3), 200-206.

Leung, F., Geller, J., & Katzman, M. (1996). Issues and concerns associated with different risk models for eating disorders. *International Journal of Eating Disorders, 19*(3), 249-256.

Leung, N., Waller, G., & Thomas, G. (1999). Core beliefs in anorexic and bulimic women. *The Journal of Nervous and Mental Disease, 187*(12), 736-741.

Leung, N., & Price, E. (2007). Core beliefs in dieters and eating disordered women. *Eating Behaviors, 8*(1), 65-72.

Leung, N., Thomas, G., & Waller, G. (2000). The relationship between parental bonding and core beliefs in anorexic and bulimic women. *British Journal of Clinical Psychology*, *39*(2), 205-213.

Leung, N., Waller, G., & Thomas, G. (1999b). Group cognitive-behavioural therapy for anorexia nervosa: A case for treatment? *European Eating Disorders Review, 7*(5), 351-361.

Leung, N., Waller, G., & Thomas, G. (2000). Outcome of group cognitive-behavior therapy for bulimia nervosa: The role of core beliefs. *Behaviour Research and Therapy, 38*(2), 145-156.

Levenkron, S. (1982). *Treating and overcoming anorexia nervosa* Scribner.

Levine, M. P., Smolak, L., Moodey, A. F., Shuman, M. D., & Hessen, L. D. (1994). Normative developmental challenges and dieting and eating disturbances in middle school girls. *International Journal of Eating Disorders, 15*(1), 11-20.

Levine, M. (1974). Scientific method and the adversary model: Some preliminary thoughts. *American Psychologist, 29*(9), 661.

Levine, M. (1980). Investigative reporting as a research method: An analysis of Bernstein and Woodward's all the president's men. *American Psychologist, 35*(7), 626.

Levine, P. A. (2015). *Trauma and memory: Brain and body in a search for the living past: A practical guide for understanding and working with traumatic memory* North Atlantic Books.

Levitt, D. H. (2003). Drive for thinness and fear of fat: Separate yet related constructs? *Eating Disorders, 11*(3), 221-234.

Levitt, D. H. (2008). Participation in athletic activities and eating disordered behavior. *Eating Disorders, 16*(5), 393-404.

Levitt, J. L. (2005). A therapeutic approach to treating the eating disorder/borderline personality disorder patient. *Eating Disorders, 13*(1), 109-121.

Levy, R. K. (1997). The transtheoretical model of change: An application to bulimia nervosa. *Psychotherapy: Theory, Research, Practice, Training, 34*(3), 278-285.

Lewinsohn, P. M., Hops, H., Roberts, R. E., Seeley, J. R., & Andrews, J. A. (1993). Adolescent psychopathology: I. prevalence and incidence of depression and other DSM-III—R disorders in high school students. *Journal of Abnormal Psychology, 102*(1), 133.

Licinio, J., Wong, M., & Gold, P. W. (1996). The hypothalamic-pituitary-adrenal axis in anorexia nervosa. *Psychiatry Research, 62*(1), 75-83.

Liddle, H. A. (1999). Theory development in a family-based therapy for adolescent drug abuse. *Journal of Clinical Child Psychology, 28*(4), 521-532.

Lier, H. Ø, Biringer, E., Stubhaug, B., & Tangen, T. (2012). The impact of preoperative counseling on postoperative treatment adherence in bariatric surgery patients: A randomized controlled trial. *Patient Education and Counseling, 87*(3), 336-342.

Likierman, M. (1997). On rejection: Adolescent girls and anorexia. *Journal of Child Psychotherapy, 23*(1), 61-80.

Lilenfeld, L. R., Wonderlich, S., Riso, L. P., Crosby, R., & Mitchell, J. (2006). Eating disorders and personality: A methodological and empirical review. *Clinical Psychology Review, 26*(3), 299-320.

Lincoln, Y. S., & Guba, E. G. (1999). Naturalistic inquiry. 1985, Beverly Hills.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry* Sage.

Lindberg, L., & Hjern, A. (2003). Risk factors for anorexia nervosa: A national cohort study. *International Journal of Eating Disorders, 34*(4), 397-408.

Lindeman, M., Stark, K., & Latvala, K. (2000). Vegetarianism and eating-disordered thinking. *Eating Disorders, 8*(2), 157.

Linehan, M. M. (1993). *Skills training manual for treating borderline personality disorder.* Guilford Press.

Linehan, M. M., & Chen, E. Y. (2005). Dialectical behavior therapy for eating disorders. *Encyclopedia of cognitive behavior therapy* (pp. 168-171) Springer.

Linehan, M. M., Comtois, K. A., Murray, A. M., Brown, M. Z., Gallop, R. J., Heard, H. L, Lindenboim, N. (2006). Two-year randomized controlled trial and follow-up of dialectical behavior therapy vs therapy by experts for suicidal behaviors and borderline personality disorder. *Archives of General Psychiatry, 63*(7), 757-766.

Linville, D., Benton, A., O'Neil, M., & Sturm, K. (2010). Medical providers' screening, training and intervention practices for eating disorders. *Eating Disorders, 18*(2), 110-131. doi:10.1080/10640260903585532

Liotti, G., Pasquini, P., & Cirrincione, R. (2000). Predictive factors for borderline personality disorder: Patients' early traumatic experiences and losses suffered by the attachment figure. *Acta Psychiatrica Scandinavica, 102*(4), 282-289.

Littell, J. H., & Girvin, H. (2002). Stages of change. A critique. *Behavior Modification, 26*(2), 223-273.

Littrell, J. (1998). Is the reexperience of painful emotion therapeutic? *Clinical Psychology Review, 18*(1), 71-102.

Livesley, W. J., & Jackson, D. (2009). Manual for the dimensional assessment of personality pathology—basic questionnaire. *Port Huron, MI: Sigma,*

Livesley, W. J. (1998). Suggestions for a framework for an empirically based classification of personality disorder. *Canadian Journal of Psychiatry, 43*(2), 137-147.

Livesley, W. J. (2003). Diagnostic dilemmas in classifying personality disorder. In K. A. Phillips, M. B. First & H. A. Pincus (Eds.), *Advancing DSM: Dilemmas in psychiatric diagnosis.* (pp. 153-189). Washington, DC: American Psychiatric Association.

Livesley, W. J., Jang, K. L., & Thordarson, D. S. (2005). Etiological relationships between eating disorder symptoms and dimensions of personality disorder. *Eating Disorders, 13*(1), 23-35.

Lo, A. L., Hsu, L. K. G., & Vandereycke, W. (2012). Extreme fasting among daoist priestesses of the tang dynasty: An old chinese variant of anorexia nervosa? *History of Psychiatry,* (3), 342-348.

Lobbestael, J., van Vreeswijk, M., & Arntz, A. (2007). Shedding light on schema modes: A clarification of the mode concept and its current research status. *Netherlands Journal of Psychology, 63*(3), 69-78.

Lobbestael, J., Arntz, A., & Vreeswijk, M. (2006). Schema mode Inventory–Revised. Paper presented at the *First Conference of the International Association of Schema Therapy, Stockholm,*

Lobbestael, J., Arntz, A., & Bernstein, D. P. (2010). Disentangling the relationship between different types of childhood maltreatment and personality disorders. *Journal of Personality Disorders, 24*(3), 285-295.

Lobbestael, J., Arntz, A., Löbbes, A., & Cima, M. (2009). A comparative study of patients and therapists' reports of schema modes.*Journal of Behavior Therapy and Experimental Psychiatry, 40*(4), 571-579.

Lobbestael, J., Arntz, A., & Sieswerda, S. (2005). Schema modes and childhood abuse in borderline and antisocial personality disorders. *Journal of Behavior Therapy and Experimental Psychiatry, 36*(3), 240-253.

Lobbestael, J., Van Vreeswijk, M. F., & Arntz, A. (2008). An empirical test of schema mode conceptualizations in personality disorders.*Behaviour Research and Therapy, 46*(7), 854-860.

Lobbestael, J., van Vreeswijk, M., Spinhoven, P., Schouten, E., & Arntz, A. (2010). Reliability and validity of the short schema mode inventory (SMI). *Behavioural and Cognitive Psychotherapy, 38*(04), 437-458.

Lobera, I. J., Estébanez, S., Fernández, M. J. S., Bautista, E. Á, & Garrido, O. (2009). Coping strategies in eating disorders. *European Eating Disorders Review, 17*(3), 220-226.

Lock, A., Epston, D., & Maisel, R. (2004). Countering that which is called anorexia. *Narrative Inquiry, 14*(2), 275-301.

Lock, J., Le Grange, D., Agras, W. S., & Dare, C. (2001). Treatment manual for anorexia nervosa: A family-based approach. New York.

Lock, J., Agras, W. S., Bryson, S., & Kraemer, H. C. (2005). A comparison of short-and long-term family therapy for adolescent anorexia nervosa. *Journal of the American Academy of Child & Adolescent Psychiatry, 44*(7), 632-639.

Lock, J., Couturier, J., & Agras, W. S. (2006). Comparison of long-term outcomes in adolescents with anorexia nervosa treated with family therapy. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*(6), 666-672.

Lock, J., Couturier, J., & Agras, W. S. (2008). Costs of remission and recovery using family therapy for adolescent anorexia nervosa: A descriptive report. *Eating Disorders, 16*(4), 322-330.

Lock, J., & le Grange, D. (2005). Family-based treatment of eating disorders. *International Journal of Eating Disorders, 37*, 64-67. doi:10.1002/eat.20122

Lock, J., & Le Grange, D. (2015). *Treatment manual for anorexia nervosa: A family-based approach* Guilford Publications.

Lock, J., le GRANGE, D., Forsberg, S., & Hewell, K. (2006). Is family therapy useful for treating children with anorexia nervosa? results of a case series. *Journal of the American Academy of Child & Adolescent Psychiatry, 45*(11), 1323-1328.

Lockwood, G., & Perris, P. (2012). Emotional needs. *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice,* , 41.

Lockwood, G., & Samson, R. (2020). 4 understanding and meeting core emotional needs. *Creative Methods in Schema Therapy: Advances and Innovation in Clinical Practice,*

Loeb, C. (2012). Doing what works: An integrative system for the treatment of eating disorders from diagnosis to recovery. *Eating Disorders, 20*(2), 173-174.

Loeb, K. L., Le Grange, D., & Lock, J. (2005). Family-based treatment for the prevention of anorexia nervosa. *Unpublished Manual.Mount Sinai School of Medicine,*

Loeb, K. L., Lock, J., Greif, R., & le Grange, D. (2010). Transdiagnostic theory and application of family-based treatment for youth with eating disorders. *Cognitive and Behavioral Practice,*

Lohr, L. B., Teglasi, H., & French, M. (2004). Schemas and temperament as risk factors for emotional disability. *Personality and Individual Differences, 36*(7), 1637-1654

Loth, K. A., Neumark-Sztainer, D., & Croll, J. K. (2009). Informing family approaches to eating disorder prevention: Perspectives of those who have been there. *International Journal of Eating Disorders, 42*(2), 146-152.

Loudon, I. (1984). The disease called chlorosis. *Psychological Medicine, 14*, 27-36.

Louis, J. P., Wood, A. M., & Lockwood, G. (2020). Development and validation of the positive parenting schema inventory (PPSI) to complement the young parenting inventory (YPI) for schema therapy (ST). *Assessment, 27*(4), 766-786.

Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: Comparison of the depression anxiety stress scales (DASS) with the beck depression and anxiety inventories. *Behaviour Research and Therapy, 33*(3), 335-343.

Lowe, M. R., Bunnell, D. W., Neeren, A. M., Chernyak, Y., & Greberman, L. (2011). Evaluating the real-world effectiveness of cognitive-behavior therapy efficacy research on eating disorders: A case study from a community-based clinical setting. *International Journal of Eating Disorders, 44*(1), 9-18.

Lowe, M. R., Davis, W. N., Annunziato, R. A., & Lucks, D. L. (2003). Inpatient treatment for eating disorders: Outcome at discharge and 3-month follow-up. *Eating Behaviors, 4*(4), 385-397.

Luborsky, L. (1984). Principles of psychoanalytic psychotherapy: A manual for supportive-expressive treatment.

Luce, K. H., Crowther, J. H., & Pole, M. (2008). Eating disorder examination questionnaire (EDE-Q): Norms for undergraduate women. *International Journal of Eating Disorders, 41*(3), 273-276.

Luce, K. H., Engler, P. A., & Crowther, J. H. (2007). Eating disorders and alcohol use: Group differences in consumption rates and drinking motives. *Eating Behaviors, 8*(2), 177-184.

Luce, K. H., & Crowther, J. H. (1999). The reliability of the eating disorder examination—Self-report questionnaire version (EDE-Q). *International Journal of Eating Disorders, 25*(3), 349-351.

Luck, A., Waller, G., Meyer, C., Ussher, M., & Lacey, H. (2005). The role of schema processes in the eating disorders. *Cognitive Therapy & Research, 29*(6), 717-732.

Lundahl, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: Twenty-five years of empirical studies. *Research on Social Work Practice,*

Mabe, A. G., Forney, K. J., & Keel, P. K. (2014). Do you “like” my photo? Facebook use maintains eating disorder risk. *International Journal of Eating Disorders, 47*(5), 516-523.

Macdonald, P., Hibbs, R., Cornfield, F., & Treasure, J. (2012). The use of motivational interviewing in eating disorders: A systematic review. *Psychiatry Research, 200*(1), 1-11.

Macdonald, P., Hibbs, R., Rhind, C., Harrison, A., Goddard, E., Raenker, S., . . . Treasure, J. (2014). Disseminating skills to carers of people with eating disorders: An examination of treatment fidelity in lay and professional carer coaches. *Health Psychology and Behavioral Medicine: An Open Access Journal, 2*(1), 555-564.

Macdonald, P., & Treasure, J. (2015). Motivational interviewing and readiness for change. *The Wiley Handbook of Eating Disorders*, 873-885.

Mace, C. J. (2001). Cognitive and interpersonal therapy: Psychiatric aspects. In Editors-in-Chief: Neil J. Smelser, & Paul B. Baltes (Eds.), *International encyclopedia of the social & behavioral sciences* (pp. 2075-2080). Oxford: Pergamon.

Machado, B. C., Gonçalves, S. F., Martins, C., Hoek, H. W., & Machado, P. P. (2014). Risk factors and antecedent life events in the development of anorexia nervosa: A Portuguese Case-Control study. *European Eating Disorders Review, 22*(4), 243-251.

Mack, J. E. (1975). Borderline states: An historical perspective. *Borderline States in Psychiatry*, 1-27.

Mackewn, J. (1997). *Developing gestalt counselling* Sage.

MacLaren, V. V., & Best, L. A. (2009). Female students' disordered eating and the big five personality facets. *Eating Behaviors, 10*(3), 192-195.

MacLean, L. M., Meyer, M., & Estable, A. (2004). Improving accuracy of transcripts in qualitative research. *Qualitative Health Research, 14*(1), 113-123.

Madden, S.Biopsychiatric theories of eating disorders. *The Wiley Handbook of Eating Disorders,* , 209-221.

Mahler, M. S., Pine, F., & Bergman, A. (1975). The psychological birth of the human infant New York: Int.

Mahler, M. S., Pine, F., & Bergman, A. (2000). *The psychological birth of the human infant: Symbiosis and individuation* Basic Books.

Mahon, J., Bradley, S. N., Harvey, P. K., Winston, A. P., & Palmer, R. L. (2001). Childhood trauma has dose-effect relationship with dropping out from psychotherapeutic treatment for bulimia nervosa: A replication. *International Journal of Eating Disorders, 30*(2), 138-148.

Mahoney, M. J. (1993). Introduction to special section: Theoretical developments in the cognitive psychotherapies. *Journal of Consulting and Clinical Psychology, 61*(2), 187.

Mahony, P. (1986). *Freud and the rat man* Yale UP.

Mahrer, A. R. (1996). *The complete guide to experiential psychotherapy.* John Wiley & Sons.

Main, M., Kaplan, N., & Cassidy, J. (1985). Security in infancy, childhood, and adulthood: A move to the level of representation. *Monographs of the Society for Research in Child Development,* , 66-104.

Main, M., & Solomon, J. (1990). Procedures for identifying infants as disorganized/disoriented during the Ainsworth strange situation. *Attachment in the Preschool Years: Theory, Research, and Intervention, 1*, 121-160.

Maisel, R. L., Epston, D., & Borden, A. (2004). *Biting the hand that starves you: Inspiring resistance to anorexia/bulimia* WW Norton & Company.

Malan, D. H. (2012). *Toward the validation of dynamic psychotherapy: A replication* Springer Science & Business Media.

Malchiodi, C. A., & Rozum, A. L. (2012). Cognitive-behavioral and mind–body approaches. *Handbook of Art Therapy,* , 89-103.

Malin, A. J., & Pos, A. E. (2015). The impact of early empathy on alliance building, emotional processing, and outcome during experiential treatment of depression. *Psychotherapy Research, 25*(4), 445-459.

Mallorquí-Bagué, N., Vintró-Alcaraz, C., Sánchez, I., Riesco, N., Agüera, Z., Granero, R., . . . Fernández-Aranda, F. (2018). Emotion regulation as a transdiagnostic feature among eating disorders: Cross-sectional and longitudinal approach. *European Eating Disorders Review, 26*(1), 53-61.

Manjrekar, E., Schoenleber, M., & Mu, W. (2013). Shame aversion and maladaptive eating-related attitudes and behaviors. *Eating Behaviors, 14*(4), 456-459.

Maples, J., Collins, B., Miller, J. D., Fischer, S., & Seibert, A. (2011). Differences between grandiose and vulnerable narcissism and bulimic symptoms in young women. *Eating Behaviors, 12*(1), 83-85.

Marcus, M. D., McCabe, E. B., & Levine, M. D. (1999). Dialectical behavior therapy (DBT) in the treatment of eating disorders. Paper presented at the *4th London International Conference on Eating Disorders, London,*

Marcus, M. D., & Kalarchian, M. A. (2003). Binge eating in children and adolescents. *International Journal of Eating Disorders, 34*, S47-S57. doi:10.1002/eat.10205

Marrone, S., Mitchell, J. E., Crosby, R., Wonderlich, S., & Jollie-Trottier, T. (2009). Predictors of response to cognitive behavioral treatment for bulimia nervosa delivered via telemedicine versus face-to-face. *International Journal of Eating Disorders, 42*(3), 222-227.

Marsden, P. (1997). Demeter and persephone: Fears of cannibalistic engulfment in bulimia. *British Journal of Psychotherapy, 13*(3), 318-326.

Marshall, C., & Rossman, G. B. (2014). *Designing qualitative research* Sage publications.

Marshall, R. D., Spitzer, R. L., Vaughan, S. C., Vaughan, R., Mellman, L. A., MacKinnon, R. A., & Roose, S. P. (2001). Assessing the subjective experience of being a participant in psychiatric research. *American Journal of Psychiatry, 158*(2), 319-321.

Martinez, E., Castro, J., Bigorra, A., Morer, A., Calvo, R., Vila, M., . . . Rieger, E. (2007). Assessing motivation to change in bulimia nervosa: The bulimia nervosa stages of change questionnaire. *European Eating Disorders Review, 15*(1), 13-23.

Marx, R. D., & Griffith, R. M. (2001). There seems to be a growing interest today in religiously based diet Programs—What's going on? *Eating Disorders, 9*(2), 185-187.

Marx, R., McCabe, E. B., & Marcus, M. D. (2002). Questions & answers. *Eating Disorders, 10*(4), 335.

Masley, S. A., Gillanders, D. T., Simpson, S. G., & Taylor, M. A. (2012). A systematic review of the evidence base for schema therapy. *Cognitive Behaviour Therapy, 41*(3), 185-202.

Masson, P. C., & Sheeshka, J. D. (2009). Clinicians' perspectives on the premature termination of treatment in patients with eating disorders. *Eating Disorders, 17*(2), 109-125.

Masuda, A., & Wendell, J. W. (2010). Mindfulness mediates the relation between disordered eating-related cognitions and psychological distress. *Eating Behaviors, 11*(4), 293-296.

Mathes, W. F., Brownley, K. A., Mo, X., & Bulik, C. M. (2009). The biology of binge eating. *Appetite, 52*(3), 545-553.

Matsunaga, H., Kaye, W. H., McConaha, C., Plotnicov, K., Pollice, C., & Rao, R. (2000). Personality disorders among subjects recovered from eating disorders. *International Journal of Eating Disorders, 27*(3), 353-357.

Matthews, A., & Lynn, S. J. (2008). Subclinical bulimia vs. depression in an interpersonal context. *Eating Behaviors, 9*(4), 509-512.

Matusek, J. A., & Wright, M. O. (2010). Ethical dilemmas in treating clients with eating disorders: A review and application of an integrative ethical decision-making model. *European Eating Disorders Review, 18*(6), 434-452.

Maurer, O., & Rafaeli, E. (2020). 8 current life imagery. *Creative Methods in Schema Therapy: Advances and Innovation in Clinical Practice,*

Maxwell, H., Tasca, G. A., Ritchie, K., Balfour, L., & Bissada, H. (2014). Change in attachment insecurity is related to improved outcomes 1-year post group therapy in women with binge eating disorder. *Psychotherapy, 51*(1), 57-65.

Maxwell, J. A. (2004). Using qualitative methods for causal explanation. *Field Methods, 16*(3), 243-264.

Maxwell, J. A. (2012). The importance of qualitative research for causal explanation in education. *Qualitative Inquiry, 18*(8), 655-661.

Mayer, B., Bos, A. E. R., Muris, P., Huijding, J., & Vlielander, M. (2008). Does disgust enhance eating disorder symptoms? *Eating Behaviors, 9*(1), 124-127.

Mayhew, R., & Edelmann, R. J. (1989). Self-esteem, irrational beliefs and coping strategies in relation to eating problems in a non-clinical population. *Personality and Individual Differences, 10*(5), 581-584.

Mazzeo, S. E., & Bulik, C. M. (2009). Environmental and genetic risk factors for eating disorders: What the clinician needs to know.*Child and Adolescent Psychiatric Clinics of North America, 18*(1), 67-82.

Mazzeo, S. E., Saunders, R., & Mitchell, K. S. (2006). Gender and binge eating among bariatric surgery candidates. *Eating Behaviors, 7*(1), 47-52.

Mazzeo, S. E., & Espelage, D. L. (2002). Association between childhood physical and emotional abuse and disordered eating behaviors in female undergraduates: An investigation of the mediating role of alexithymia and depression. *Journal of Counseling Psychology, 49*(1), 86.

Mazzeo, S. E., Zucker, N. L., Gerke, C. K., Mitchell, K. S., & Bulik, C. M. (2005). Parenting concerns of women with histories of eating disorders. *International Journal of Eating Disorders, 37*(S1), S77-S79.

Mazzeo, S. E., Saunders, R., & Mitchell, K. S. (2005). Binge eating among African American and caucasian bariatric surgery candidates. *Eating Behaviors, 6*(3), 189-196.

Mellor-Clark, J. (1998). CORE system information management handbook. *CoreSystem Group, Leeds,*

McAlpine, D. E., Frisch, M. J., Rome, E. S., Clark, M. M., Signore, C., Lindroos, A. K., & Allison, K. C. (2010). Bariatric surgery: A primer for eating disorder professionals. *European Eating Disorders Review, 18*(4), 304-317.

McClelland, L., & Crisp, A. (2001). Anorexia nervosa and social class. *International Journal of Eating Disorders, 29*(2), 150-156.

McCrae, R. R., & Costa, P. T. (2003). *Personality in adulthood: A five-factor theory perspective* Guilford Press.

McCreary, D. R., & Sasse, D. K. (2002). Gender differences in high school students' dieting behavior and their correlates. *International Journal of Men's Health, 1*(2)

McDowell, B. D., Moser, D. J., Ferneyhough, K., Bowers, W. A., Andersen, A. E., & Paulsen, J. S. (2003). Cognitive impairment in anorexia nervosa is not due to depressed mood. *International Journal of Eating Disorders, 33*(3), 351-355.

McFarlane, T. L., MacDonald, D. E., Royal, S., & Olmstead, M. P. (2013). Rapid and slow responders to eating disorder treatment: A comparison on clinically relevant variables. *International Journal of Eating Disorders, 46*(6), 563-566.

McFillin, R. K., Cahn, S. C., Burks, V. S., Levine, M. P., Loney, S. L., & Levine, R. L. (2012). Social information-processing and coping in adolescent females diagnosed with an eating disorder: Toward a greater understanding of control. *Eating Disorders, 20*(1), 42-59.

McGee, B. J., Hewitt, P. L., Sherry, S. B., Parkin, M., & Flett, G. L. (2005). Perfectionistic self-presentation, body image, and eating disorder symptoms. *Body Image, 2*(1), 29-40.

McGinn, L. K., Young, J. E., & Sanderson, W. C. (1995). When and how to do longer term therapy… without feeling guilty. *Cognitive and Behavioral Practice, 2*(1), 187-212.

McIntosh, V. V., Bulik, C. M., McKenzie, J. M., Luty, S. E., & Jordan, J. (2000). Interpersonal psychotherapy for anorexia nervosa. *International Journal of Eating Disorders, 27*(2), 125-139.

McIntosh, V. V., Jordan, J., Carter, F. A., Luty, S. E., McKenzie, J. M., Bulik, C. M., . . . Joyce, P. R. (2005). Three psychotherapies for anorexia nervosa: A randomized, controlled trial. *American Journal of Psychiatry, 162*(4), 741-747.

McIntosh, V. V., Jordan, J., Carter, J. D., Frampton, C. M., McKenzie, J. M., Latner, J. D., & Joyce, P. R. (2016). Psychotherapy for transdiagnostic binge eating: A randomized controlled trial of cognitive-behavioural therapy, appetite-focused cognitive-behavioural therapy, and schema therapy. *Psychiatry Research, 240*, 412-420.

McKnight, R. F., & Park, R. J. (2010). Atypical antipsychotics and anorexia nervosa: A review. *European Eating Disorders Review, 18*(1), 10-21.

McLean, S. A., Paxton, S. J., & Wertheim, E. H. (2010). Factors associated with body dissatisfaction and disordered eating in women in midlife. *International Journal of Eating Disorders, 43*(6), 527-536.

McLeod, J. (2010). *Case study research in counselling and psychotherapy* Sage Publications.

McLeod, J. (2014). *Doing research in counselling and psychotherapy* Sage.

McLeod, J., & Balamoutsou, S. (2001). A method for qualitative narrative analysis of psychotherapy transcripts. *Psychological Test and Assessment Modeling, 43*(3), 128.

McNair, R., Taft, A., & Hegarty, K. (2008). Using reflexivity to enhance in-depth interviewing skills for the clinician researcher. *BMC Medical Research Methodology, 8*(1), 1.

McNicholas, F., Lydon, A., Lennon, R., & Dooley, B. (2009). Eating concerns and media influences in an irish adolescent context. *European Eating Disorders Review, 17*(3), 208-213.

McVey, G., Gusella, J., Tweed, S., & Ferrari, M. (2009). A controlled evaluation of web-based training for teachers and public health practitioners on the prevention of eating disorders. *Eating Disorders, 17*(1), 1-26.

Meads, C., Gold, L., & Burls, A. (2001). How effective is outpatient care compared to inpatient care for the treatment of anorexia nervosa? A systematic review. *European Eating Disorders Review, 9*(4), 229-241.

Mehler, P. S. (2011). Medical complications of bulimia nervosa and their treatments. *International Journal of Eating Disorders, 44*(2), 95-104.

Mehler, P. S., Cleary, B. S., & Gauianil, J. L. (2011). Osteoporosis in anorexia nervosa. *Eating Disorders, 19*(2), 194-202.

Mehler, P. S., & MacKenzie, T. D. (2009). Treatment of osteopenia and osteoporosis in anorexia nervosa: A systematic review of the literature. *International Journal of Eating Disorders, 42*(3), 195-201.

Melrose, S. (2009). Naturalistic generalization.

Merriam, S. B. (1998). *Qualitative research and case study applications in education. revised and expanded from" case study research in education.".* ERIC.

Merrill, K. A., & Strauman, T. J. (2004). The role of personality in cognitive-behavioral therapies. *Behavior Therapy, 35*(1), 131-146.

Messer, S. B. (2007). Psychoanalytic case studies and the pragmatic case study method. *Pragmatic Case Studies in Psychotherapy, 3*(1)

Messman-Moore, T. L., & Garrigus, A. S. (2007). The association of child abuse and eating disorder symptomatology: The importance of multiple forms of abuse and revictimization. *Journal of Aggression, Maltreatment & Trauma, 14*(3), 51-72.

Meyer, C., & Gillings, K. (2004). Parental bonding and bulimic psychopathology: The mediating role of mistrust/abuse beliefs. *International Journal of Eating Disorders, 35*(2), 229-233.

Meyer, C., Leung, N., Barry, L., & De Feo, D. (2010). Emotion and eating psychopathology: Links with attitudes toward emotional expression among young women. *International Journal of Eating Disorders, 43*(2), 187-189.

Meyer, C., Taranis, L., & Touyz, S. (2008). Excessive exercise in the eating disorders: A need for less activity from patients and more from researchers.. *European Eating Disorders Review, 16*(2), 81-83.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook* Sage.

Miller, F. G., Rosenstein, D. L., & DeRenzo, E. G. (1998). Professional integrity in clinical research. *Jama, 280*(16), 1449-1454.

Miller, J. L., Schmidt, L. A., Vaillancourt, T., McDougall, P., & Laliberte, M. (2006). Neuroticism and introversion: A risky combination for disordered eating among a non-clinical sample of undergraduate women. *Eating Behaviors, 7*(1), 69-78.

Miller, J. L., Vaillancourt, T., & Hanna, S. E. (2009). The measurement of “eating-disorder-thoughts” and “eating-disorder-behaviors”: Implications for assessment and detection of eating disorders in epidemiological studies. *Eating Behaviors, 10*(2), 89-96.

Miller, T., Birch, M., Mauthner, M., & Jessop, J. (2012). *Ethics in qualitative research* Sage.

Miller, W. (2002). S Miller W, Rollnick, S. Motivational Interviewing: Preparing people for change.

Miller, W. R. (1995). *Motivational enhancement therapy manual: A clinical research guide for therapists treating individuals with alcohol abuse and dependence* DIANE Publishing.

Miller, W. R., Benefield, R. G., & Tonigan, J. S. (1993). Enhancing motivation for change in problem drinking: A controlled comparison of two therapist styles. *Journal of Consulting and Clinical Psychology, 61*(3), 455.

Miller, W. R., & Rollnick, S. (2012). *Motivational interviewing: Helping people change* Guilford press.

Miller, W. R., & Rollnick, S. (2013). Motivational interviewing: Helping people change. New York. *NY: Guilford,*

Miller, W. R., & Rollnick, S. (2002). Motivational interviewing: Preparing people for change Guilford. *New York,*

Miller, W. R., Zweben, A., DiClemente, C. C., & Rychtarik, R. G. (1992). Motivational enhancement therapy manual: A clinical research guide for therapists and individuals with alcohol abuse and dependence. *Adm,* , 92-1894.

Miller, W. Y. R.S.(1991): Motivational interviewing: Preparing people to change addictive behavior.

Millon, T., & Davis, R. O. (1996). *Disorders of personality: DSM-IV and beyond* John Wiley & Sons.

Milos, G. F., Baur, V., Muehlebach, S., & Spindler, A. (2013). Axis-I comorbidity is linked to prospective instability of diagnoses within eating disorders. *BMC Psychiatry, 13*, 295-295.

Milos, G. F., Spindler, A. M., Buddeberg, C., & Crameri, A. (2003). Axes I and II comorbidity and treatment experiences in eating disorder subjects. *Psychotherapy and Psychosomatics, 72*(5), 276-285.

Milos, G., Spindler, A., Schnyder, U., & Fairburn, C. G. (2005). Instability of eating disorder diagnoses: Prospective study. *The British Journal of Psychiatry : The Journal of Mental Science, 187*, 573-578.

Milos, G., Spindler, A., Hepp, U., & Schnyder, U. (2004). Suicide attempts and suicidal ideation: Links with psychiatric comorbidity in eating disorder subjects. *General Hospital Psychiatry, 26*(2), 129-135.

Milos, G., Spindler, A., & Schnyder, U. (2004). Psychiatric comorbidity and eating disorder inventory (EDI) profiles in eating disorder patients. *Canadian Journal of Psychiatry, 49*(3), 179-184.

Minuchin, S., Rosman, B., & Baker, L. (1978). Psychomatic families.

Minuchin, S., Baker, L., Rosman, B. L., Liebman, R., Milman, L., & Todd, T. C. (1975). A conceptual model of psychosomatic illness in children: Family organization and family therapy. *Archives of General Psychiatry, 32*(8), 1031-1038.

Minuchin, S., Rosman, B. L., Baker, L., & Minuchin, S. (2009). *Psychosomatic families: Anorexia nervosa in context* Harvard University Press.

Mitchell, J. E., Crosby, R. D., Wonderlich, S. A., Hill, L., le Grange, D., Powers, P., & Eddy, K. (2007). Latent profile analysis of a cohort of patients with eating disorders not otherwise specified. *International Journal of Eating Disorders, 40*, S95-S98.

Mitchell, J. E., & Eckert, E. D. (1987). Scope and significance of eating disorders. *Journal of Consulting and Clinical Psychology, 55*(5), 628-634.

Mitchell, J. E., Halmi, K., Wilson, G. T., Agras, W. S., Kraemer, H., Crow, S., & Strober, M. (2002a). A randomized secondary treatment study of women with bulimia nervosa who fail to respond to CBT. *International Journal of Eating Disorders, 32*(3), 271-281.

Mitchell, J. E., & Peterson, C. B. (2005). *Assessment of eating disorders* Guilford Press.

Mitchell, K. S., Mazzeo, S. E., Schlesinger, M. R., Brewerton, T. D., & Smith, B. N. (2012). Comorbidity of partial and subthreshold PTSD among men and women with eating disorders in the national comorbidity survey-replication study. *International Journal of Eating Disorders, 45*(3), 307-315.

Mobbs, O., Van der Linden, M., d'Acremont, M., & Perroud, A. (2008). Cognitive deficits and biases for food and body in bulimia: Investigation using an affective shifting task. *Eating Behaviors, 9*(4), 455-461.

Mogul, S. L. (1980). Asceticism in adolescence and anorexia nervosa. *Psychoanalytic Study of the Child, 35*, 155-178.

Mohr, H. M., Zimmermann, J., Röder, C., Lenz, C., Overbeck, G., & Grabhorn, R. (2010). Separating two components of body image in anorexia nervosa using fMRI. *Psychological Medicine, 40*(9), 1519.

Moldovan, A. R., & David, D. (2011). Effect of obesity treatments on eating behavior: Psychosocial interventions versus surgical interventions. A systematic review. *Eating Behaviors, 12*(3), 161-167.

Moll, S. (2012). Navigating political minefields: Partnerships in organizational case study research. *Work, 43*(1), 5-12.

Mond, J. M., Hay, P. J., Rodgers, B., & Owen, C. (2007). Recurrent binge eating with and without the “undue influence of weight or shape on self-evaluation”: Implications for the diagnosis of binge eating disorder. *Behaviour Research and Therapy, 45*(5), 929-938.

Mond, J. M., Hay, P. J., Rodgers, B., Owen, C., & Beumont, P. J. V. (2004). Temporal stability of the eating disorder examination questionnaire. *International Journal of Eating Disorders, 36*(2), 195-203.

Mond, J. M., & Calogero, R. M. (2009). Excessive exercise in eating disorder patients and in healthy women. *Australian and New Zealand Journal of Psychiatry, 43*(3), 227-234.

Mond, J. M., Hay, P. J., Rodgers, B., Owen, C., & Beumont, P. J. (2004). Validity of the eating disorder examination questionnaire (EDE-Q) in screening for eating disorders in community samples. *Behaviour Research and Therapy, 42*(5), 551-567.

Mond, J., Myers, T. C., Crosby, R., Hay, P., & Mitchell, J. (2008). ‘Excessive exercise’ and eating-disordered behaviour in young adult women: Further evidence from a primary care sample. *European Eating Disorders Review, 16*(3), 215-221.

Monro, F. J., & Huon, G. F. (2006). Media-portrayed idealized images, selfobjectification, and eating behavior. *Eating Behaviors, 7*(4), 375-383.

Montag, C., Haase, L., Seidel, D., Bayerl, M., Gallinat, J., Herrmann, U., & Dannecker, K. (2014). A pilot RCT of psychodynamic group art therapy for patients in acute psychotic episodes: Feasibility, impact on symptoms and mentalising capacity. *Plus One, 9*(11), e112348.

Monteleone, P., Tortorella, A., Martiadis, V., Serritella, C., Fuschino, A., & Maj, M. (2004). Opposite changes in the serum brain-derived neurotrophic factor in anorexia nervosa and obesity. *Psychosomatic Medicine, 66*(5), 744-748.

Monti, D. A., Peterson, C., Kunkel, E. J. S., Hauck, W. W., Pequignot, E., Rhodes, L., & Brainard, G. C. (2006). A randomized, controlled trial of mindfulness-based art therapy (MBAT) for women with cancer. *Psycho-Oncology, 15*(5), 363-373.

Moore, K. (2006). Petrucelli, J. & Stuart, C. (eds.) (2001). hungers and compulsions the psychodynamic treatment of eating disorders & addictions. Jason Aronson inc.: London, pp. 392, ISBN 0-765-70318-1. *European Eating Disorders Review, 14*(1), 66.

Moradi, B., Dirks, D., & Matteson, A. V. (2005). Roles of sexual objectification experiences and internalization of standards of beauty in eating disorder symptomatology: A test and extension of objectification theory. *Journal of Counseling Psychology, 52*(3), 420.

Moras, K., Telfer, L. A., & Barlow, D. H. (1993). Efficacy and specific effects data on new treatments: A case study strategy with mixed anxiety-depression. *Journal of Consulting and Clinical Psychology, 61*(3), 412.

Moreno, J. L. (1987). *The essential Moreno: Writings on psychodrama, group method, and spontaneity* Springer Publishing Company.

Moreno, J. L., & Moreno, Z. T. (1959). Psychodrama, vol. I. *Beacon House, New York.*

Morina, N., Lancee, J., & Arntz, A. (2017). Imagery rescripting as a clinical intervention for aversive memories: A meta-analysis. *Journal of Behavior Therapy and Experimental Psychiatry, 55*, 6-15.

Morris, F. J. (2014). Should art be integrated into cognitive behavioral therapy for anxiety disorders? *The Arts in Psychotherapy, 41*(4), 343-352.

Morris, J. (2008). Herzog, D., Franko, D., Cable, P. (2007) unlocking the mysteries of eating disorders: A life saving guide to your child's treatment and recovery (Harvard medical school guides) McGraw-hill contemporary, USA, pp. 304, ISBN-10:..*European Eating Disorders Review, 16*(3), 244. doi:10.1002/erv.862

Morris, R., Bramham, J., Smith, E., & Tchanturia, K. (2014). Empathy and social functioning in anorexia nervosa before and after recovery. *Cognitive Neuropsychiatry, 19*(1), 47-57.

Morrison, N. (2000). Schema-focused cognitive therapy for complex long-standing problems: A single case study. *Behavioural and Cognitive Psychotherapy, 28*(03), 269-283.

Morrow, S. L. (2005). Quality and trustworthiness in qualitative research in counseling psychology. *Journal of Counseling Psychology, 52*(2), 250.

Mosby, I. (2013). *Mosby's dictionary of medicine, nursing & health professions* Elsevier Health Sciences.

Moser, D. J., Benjamin, M. L., Bayless, J. D., McDowell, B. D., Paulsen, J. S., Bowers, W. A., . . . Andersen, A. E. (2003). Neuropsychological functioning pretreatment and posttreatment in an inpatient eating disorders program. *International Journal of Eating Disorders, 33*(1), 64-70.

Mosley, P. E. (2009). Bigorexia: Bodybuilding and muscle dysmorphia. *European Eating Disorders Review, 17*(3), 191-198.

Mountford, V., Corstorphine, E., Tomlinson, S., & Waller, G. (2007). Development of a measure to assess invalidating childhood environments in the eating disorders. *Eating Behaviors, 8*(1), 48-58.

Mountford, V., & Waller, G. (2006). Using imagery in cognitive-behavioral treatment for eating disorders: Tackling the restrictive mode.*International Journal of Eating Disorders, 39*(7), 533-543.

Mountford, V., Waller, G., Watson, D., & Scragg, P. (2004). An experimental analysis of the role of schema compensation in anorexia nervosa. *Eating Behaviors, 5*(3), 223-230.

Moyers, T. B., Miller, W. R., & Hendrickson, S. M. (2005). How does motivational interviewing work? therapist interpersonal skill predicts client involvement within motivational interviewing sessions. *Journal of Consulting and Clinical Psychology, 73*(4), 590.

Munder, T., Wilmers, F., Leonhart, R., Linster, H. W., & Barth, J. (2010). Working alliance Inventory-Short revised (WAI-SR): Psychometric properties in outpatients and inpatients. *Clinical Psychology & Psychotherapy, 17*(3), 231-239.

Munro, C., Burdon-Cooper, C., Allott, C., & Hannon, J. (2014, June). Preliminary outcomes from the use of schema therapy in a community treatment team for patients with severe anorexia nervosa. *Paper presented at the International Society of Schema Therapy conference.* Turkey: Istanbul.

Munro, C., Randell, L., and Lawrie, S. M. (2017) An Integrative Bio-Psycho-Social Theory of Anorexia Nervosa. *Clin. Psychol. Psychotherapy.*, 24: 1– 21.

Munro, C., Thomson, V., Corr, J., Randell, L., Davies, J. E., Gittoes, C., . . . Freeman, C. P. (2014). A new service model for the treatment of severe anorexia nervosa in the community: The anorexia nervosa intensive treatment team. *Psychiatric Bulletin, 38*(5), 220-225.

Munsch, S., Meyer, A. H., Quartier, V., & Wilhelm, F. H. (2012). Binge eating in binge eating disorder: A breakdown of emotion regulatory process? *Psychiatry Research, 195*(3), 118-124.

Murray, C., & Waller, G. (2002). Reported sexual abuse and bulimic psychopathology among nonclinical women: The meditating role of shame. *International Journal of Eating Disorders, 32*(2), 186-191.

Murray, S. B., & Le Grange, D. (2014). Family therapy for adolescent eating disorders: An update. *Current Psychiatry Reports, 16*(5), 1-7.

Myers, T. C., Swan-Kremeier, L., Wonderlich, S., Lancaster, K., & Mitchell, J. E. (2004). The use of alternative delivery systems and new technologies in the treatment of patients with eating disorders. *International Journal of Eating Disorders, 36*(2), 123-143.

Nadort, M., Arntz, A., Smit, J. H., Giesen-Bloo, J., Eikelenboom, M., Spinhoven, P., . . . van Dyck, R. (2009). Implementation of outpatient schema therapy for borderline personality disorder with versus without crisis support by the therapist outside office hours: A randomized trial. *Behaviour Research and Therapy, 47*(11), 961-973.

Nakazato, M., Hashimoto, K., Yoshimura, K., Hashimoto, T., Shimizu, E., & Iyo, M. (2006). No change between the serum brain-derived neurotrophic factor in female patients with anorexia nervosa before and after partial weight recovery. *Progress in Neuro-Psychopharmacology and Biological Psychiatry, 30*(6), 1117-1121.

Napel-Schutz, M. C., Abma, T. A., Bamelis, L., & Arntz, A. (2011). Personality disorder patients' perspectives on the introduction of imagery within schema therapy: A qualitative study of patients' experiences. *Cognitive and Behavioral Practice, 18*(4), 482-490.

Nathan, P. E., & Gorman, J. M. (2002). A guide lo treatments that work. 2nd Ed. *New York: Oxford.*

National Institute for Clinical Excellence, & National Institute for Clinical Excellence. (2004). Eating disorders: Core interventions in the treatment and management of anorexia nervosa, bulimia nervosa and related eating disorders. *Clinical Guideline, 9*

Neimeyer, R. A. (1993). An appraisal of constructivist psychotherapies. *Journal of Consulting and Clinical Psychology, 61*(2), 221.

Nesci, J., Redston, S., Newton, R., Snell, M., Kaplan, , A., & Cleeve, S. (2014) Perceived parenting of inpatients with anorexia nervosa: implications for schema therapy and practice. Conference presentation at the International Society of Schema Therapy (ISST) Conference (June, 2014). Istanbul, Turkey.

Neumark-Sztainer, D., Story, M., Hannan, P. J., Beuhring, T., & Resnick, M. D. (2000). Disordered eating among adolescents: Associations with sexual/physical abuse and other familial/psychosocial factors. *International Journal of Eating Disorders, 28*(3), 249-258.

Neumark-Sztainer, D., Eisenberg, M. E., Fulkerson, J. A., Story, M., & Larson, N. I. (2008). Family meals and disordered eating in adolescents: Longitudinal findings from project EAT. *Archives of Pediatrics & Adolescent Medicine, 162*(1), 17-22.

Nevis, E. C. (2014). *Gestalt therapy: Perspectives and applications* CRC Press.

Nevonen, L., & Broberg, A. G. (2006). A comparison of sequenced individual and group psychotherapy for patients with bulimia nervosa. *International Journal of Eating Disorders, 39*(2), 117-127.

Newton, M., Boblin, S., Brown, B., & Ciliska, D. (2006). Understanding intimacy for women with anorexia nervosa: A phenomenological approach. *European Eating Disorders Review, 14*(1), 43-53. doi:10.1002/erv.669

Ng, F., Trauer, T., Dodd, S., Callaly, T., Campbell, S., & Berk, M. (2007). The validity of the 21-item version of the depression anxiety stress scales as a routine clinical outcome measure. *Acta Neuropsychiatrica, 19*(5), 304-310.

Nguyen-Rodriguez, S., Unger, J. B., & Spruijt-Metz, D. (2009). Psychological determinants of emotional eating in adolescence. *Eating Disorders, 17*(3), 211-224. doi:10.1080/10640260902848543

Nicholls, D., & Arcelus, J. (2010). Making eating disorders classification work in ICD-11. *European Eating Disorders Review, 18*(4), 247-250.

Nicolosi, G. (2006). Biotechnologies, alimentary fears and the orthorexic society. *Tailoring Biotechnologies, 2*(3), 37-56.

Nielsen, K. (2015). 'Fake It'til You Make It'' Why Community College Students' Aspirations ''Hold Steady'. *Sociology of Education*, *88*(4), 265-283.

Nielsen, S. (1990). The epidemiology of anorexia nervosa in denmark from 1973 to 1987: A nationwide register study of psychiatric admission. *Acta Psychiatrica Scandinavica, 81*(6), 507-514.

Nielsen, S. (2002). Eating disorders in females with type 1 diabetes: an update of a meta-analysis. *European Eating Disorders Review: The Professional Journal of the Eating Disorders Association*, *10*(4), 241-254.

Nightingale, D., & Cromby, J. (1999). *Social constructionist psychology: A critical analysis of theory and practice* McGraw-Hill Education (UK).

Nilsson, K., Sundbom, E., & Hägglöf, B. (2008). A longitudinal study of perfectionism in adolescent onset anorexia nervosa-restricting type. *European Eating Disorders Review, 16*(5), 386-394.

Noor, K. B. M. (2008). Case study: A strategic research methodology. *American Journal of Applied Sciences, 5*(11), 1602-1604.

Noordenbos, G., Aliakbari, N., & Campbell, R. (2014). The relationship among critical inner voices, low self-esteem, and self-criticism in eating disorders. *Eating Disorders, 22*(4), 337-351.

Noordenbos, G., & Van Duyn, C. (2009). Do lessons about eating disorders by ex-patients contribute to early recognition? *Eating Disorders, 17*(5), 435-444.

Norcross, J. C. (2011). Psychotherapy relationships that works: Evidence-based responsiveness. Oxford University Press.

Norcross, J. C. (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients.* Oxford University Press.

Norcross, J. C., Beutler, L. E., & Levant, R. F. (2006). *Evidence-based practices in mental health: Debate and dialogue on the fundamental questions.* American Psychological Association.

Nordahl, H. M., & Nysæter, T. E. (2005). Schema therapy for patients with borderline personality disorder: A single case series. *Journal of Behavior Therapy and Experimental Psychiatry, 36*(3), 254-264.

Nordbø, R. H. S., Gulliksen, K. S., Espeset, E. M. S., Skårderud, F., Geller, J., & Holte, A. (2008). Expanding the concept of motivation to change: The content of patients' wish to recover from anorexia nervosa. *International Journal of Eating Disorders, 41*(7), 635-642.

Nordmann, J. E., & Herbert, J. D. (1996). Cognitive therapy for personality disorders: A schema-focused approach: (Revised edition). by J. E. young, sarasota, FL: Professional resource press, 1994. 104 pp. $11.95. *Clinical Psychology Review, 16*(1), 78-79.

Norris, M. L., Apsimon, M., Harrison, M., Obeid, N., Buchholz, A., Henderson, K. A., & Spettigue, W. (2012). An examination of medical and psychological morbidity in adolescent males with eating disorders. *Eating Disorders, 20*(5), 405-415.

Norris, M. L., Spettigue, W., Buchholz, A., Henderson, K. A., & Obeid, N. (2010). Factors influencing research drug trials in adolescents with anorexia nervosa. *Eating Disorders, 18*(3), 210-217.

Norwood, S. J., Bowker, A., Buchholz, A., Henderson, K. A., Goldfield, G., & Flament, M. F. (2011). Self-silencing and anger regulation as predictors of disordered eating among adolescent females. *Eating Behaviors, 12*(2), 112-118. doi:10.1016/j.eatbeh.2011.01.009

Nunn, K., Frampton, I., Gordon, I., & Lask, B. (2008). The fault is not in her parents but in her insula—A neurobiological hypothesis of anorexia nervosa. *European Eating Disorders Review, 16*(5), 355-360. doi:10.1002/erv.890

O'Brien, E. M., Dalrymple, K., Hrabosky, J., Chelminski, I., Young, D., & Zimmerman, M. (2012). Insomnia is associated with impaired quality of life among bariatric surgery candidates. *Obesity Research & Clinical Practice, 6*(2), e91-e102. doi:10.1016/j.orcp.2011.06.001

Oakley, A. (1981). Interviewing women: A contradiction in terms. *Doing Feminist Research, 30*(6), 1.

O'Brien, K. M., & Vincent, N. K. (2003). Psychiatric comorbidity in anorexia and bulimia nervosa: Nature, prevalence, and causal relationships. *Clinical Psychology Review, 23*(1), 57-74.

O'Connor, M., Simmons, T., & Cooper, M. (2003). Assumptions and beliefs, dieting, and predictors of eating disorder-related symptoms in young women and young men. *Eating Behaviors, 4*(1), 1-6.

O'Dea, J. (2000). School-based interventions to prevent eating problems: First do no harm. *Eating Disorders, 8*(2), 123.

O'Dea, J. A., & Abraham, S. (2000). Improving the body image, eating attitudes, and behaviors of young male and female adolescents: A new educational approach that focuses on self-esteem. *International Journal of Eating Disorders, 28*(1), 43-57.

Ogden, J. E. (2000). The role of the mother-daughter relationship in explaining weight concern. *International Journal of Eating Disorders,*

Ogden, J., & Steward, J. (2000). The role of the mother-daughter relationship in explaining weight concern. *International Journal of Eating Disorders*, *28*(1), 78-83.

Ogle, J. P., & Damhorst, M. L. (2000). Dieting among adolescent girls and their mothers: An interpretive study. *Family and Consumer Sciences Research Journal, 28*(4), 428-462.

Ogles, B. M., Lunnen, K. M., & Bonesteel, K. (2001). Clinical significance: History, application, and current practice. *Clinical Psychology Review, 21*(3), 421-446.

Ohanian, V. (2002). Imagery rescripting within cognitive behavior therapy for bulimia nervosa: An illustrative case report. *International Journal of Eating Disorders, 31*(3), 352-357.

O'Kearney, R. (1996). Attachment disruption in anorexia nervosa and bulimia nervosa: A review of theory and empirical research. *International Journal of Eating Disorders, 20*(2), 115-127.

O'Kearney, R. (1998). Attachment disruption in anorexia nervosa and bulimia nervosa: A review of theory and empirical research. *International Journal of Eating Disorders, 20*(2), 115-127.

O'Kearney, R., Gertler, R., Conti, J., & Duff, M. (1995). Disturbances of weight control behaviours and psychological functioning in individuals presenting to an outpatient eating disorder unit: A descriptive study. *European Eating Disorders Review*, *3*(2), 80-92.

Okon, D. M., Greene, A. L., & Smith, J. E. (2003). Family interactions predict intraindividual symptom variation for adolescents with bulimia. *International Journal of Eating Disorders, 34*(4), 450-457.

Oldershaw, A., Lavender, T., Sallis, H., Stahl, D., & Schmidt, U. (2015a). Emotion generation and regulation in anorexia nervosa: A systematic review and meta-analysis of self-report data. *Clinical Psychology Review, 39*, 83-95.

Oldershaw, A., Startup, H., & Lavender, T. (2019). Anorexia nervosa and a lost emotional self: A psychological formulation of the development, maintenance, and treatment of anorexia nervosa. *Frontiers in Psychology, 10*, 219.

Openshaw, C., & Waller, G. (2005). Psychometric properties of the stirling eating disorder scales with bulimia nervosa patients. *Eating Behaviors, 6*(2), 165-168.

Orbach, S. (1998). *Fat is a feminist issue: The anti-diet guide for women fat is a feminist* Random House.

Orchard, R. (2003). With you, not against you: Applying motivational interviewing to occupational therapy in anorexia nervosa. *The British Journal of Occupational Therapy, 66*(7), 325-327.

O'Riordan, S. S., & Zamboanga, B. L. (2008). Aspects of the media and their relevance to bulimic attitudes and tendencies among female college students. *Eating Behaviors, 9*(2), 247-250. doi:10.1016/j.eatbeh.2007.03.004

Orue, I., & Calvete, E. (2012). O-43 - early maladaptive schemas and social anxiety in adolescents: The mediating role of automatic thoughts. *European Psychiatry, 27, Supplement 1*(0), 1.

Orzolek-Kronner, C. (2002). The effect of attachment theory in the development of eating disorders: Can symptoms be proximity-seeking? *Child & Adolescent Social Work Journal, 19*(6), 421-435.

O'Shaughnessy, R., & Dallos, R. (2009). Attachment research and eating disorders: A review of the literature. *Clinical Child Psychology and Psychiatry, 14*(4), 559-574.

Ouwens, M. A., Van Strien, T., Van Leeuwe, J., & Van der Staak, C. (2009). The dual pathway model of overeating. replication and extension with actual food consumption. *Appetite, 52*(1), 234-237.

Pace, C. S., Cavanna, D., Guiducci, V., & Bizzi, F. (2015). When parenting fails: Alexithymia and attachment states of mind in mothers of female patients with eating disorders. *Frontiers in Psychology, 6*, 1145.

Paivio, S. C., & Greenberg, L. S. (1995). Resolving" unfinished business": Efficacy of experiential therapy using empty-chair dialogue.*Journal of Consulting and Clinical Psychology, 63*(3), 419.

Palazzoli, M. S. (1974). *Self-starvation: From the intrapsychic to the transpersonal approach to anorexia nervosa.(trans A. pomerans).*Chaucer.

Paley, V., & Rabinor, J. R. (2000). Hatching a new identity: Transforming the anorexic patient and the therapist. *Eating Disorders, 8*(1), 67.

Pallister, E., & Waller, G. (2008). Anxiety in the eating disorders: Understanding the overlap. *Clinical Psychology Review, 28*(3), 366-386.

Palmer, B. (2006a). Where have all the straightforward patients gone? *European Eating Disorders Review, 14*(1), 68.

Palmer, B. (2006b). Wound up? *European Eating Disorders Review, 14*(2), 137.

Palmer, B. (2009). One to watch? *European Eating Disorders Review, 17*(4), 326.

Palmer, B. (2010). Getting better? *European Eating Disorders Review, 18*(4), 339.

Palmer, R. L., Oppenheimer, R., & Marshall, P. D. (1988). Eating-disorded patients remember their parents: A study using the parental-bonding instrument. *International Journal of Eating Disorders, 7*(1), 101-106.

Palmer, R. L., Birchall, H., Damani, S., Gatward, N., McGrain, L., & Parker, L. (2003). A dialectical behavior therapy program for people with an eating disorder and borderline personality disorder--description and outcome. *International Journal of Eating Disorders, 33*(3), 281-286.

Parkitny, L., & McAuley, J. (2010). The depression anxiety stress scale (DASS). *Journal of Physiotherapy, 56*(3), 204.

Parry, G., Shapiro, D. A., & Firth, J. (1986). The case of the anxious executive: A study from the research clinic. *Psychology and Psychotherapy: Theory, Research and Practice, 59*(3), 221-223.

Parry-Jones, B. (1991). Historical terminology of eating disorders. *Psychological Medicine, 21*(01), 21-28.

Passi, V. A., Bryson, S. W., & Lock, J. (2003). Assessment of eating disorders in adolescents with anorexia nervosa: Self-report questionnaire versus interview. *International Journal of Eating Disorders, 33*(1), 45-54.

Patel, P., Wheatcroft, R., Park, R. J., & Stein, A. (2002). The children of mothers with eating disorders. *Clinical Child and Family Psychology Review, 5*(1), 1-19.

Patterson, R. E., Wang, K. T., & Slaney, R. B. (2012). Multidimensional perfectionism, depression and relational health in women with eating disturbances. *Eating Behaviors, 13*(3), 226-232.

Patton, G. C., Selzer, R., Coffey, C., Carlin, J. B., & Wolfe, R. (1999). Onset of adolescent eating disorders: Population based cohort study over 3 years. *BMJ (Clinical Research Ed.), 318*(7186), 765-768.

Patton, M. Q. (1999). Enhancing the quality and credibility of qualitative analysis. *Health services research*, *34*(5 Pt 2), 1189.

Patton, M. Q. (2002). Learning in the Field: An Introduction to Qualitative Research, edited by Gretchen B. Rossman and Sharon F. Rallis. Sage, Beverley Hills, 1998.

Paul, T., Schroeter, K., Dahme, B., & Nutzinger, D. O. (2014). Self-injurious behavior in women with eating disorders. *American Journal of Psychiatry,*

Paulson-Karlsson, G., Engstrom, I., & Nevonen, L. (2009). A pilot study of a family-based treatment for adolescent anorexia nervosa: 18- and 36-month follow-ups. *Eating Disorders, 17*(1), 72-88.

Pauwels, E., Claes, L., Smits, D., Dierckx, E., Muehlenkamp, J. J., Peuskens, H., & Vandereycken, W. (2013). Validation and reliability of the young schema questionnaire in a flemish inpatient eating disorder and alcohol and substance use disorder sample. *Cognitive Therapy and Research, 37*(3), 647-656.

Pawlow, L. A., O'Neil, P. M., White, M. A., & Byrne, T. K. (2005). Findings and outcomes of psychological evaluations of gastric bypass applicants. *Surgery for Obesity and Related Diseases, 1*(6), 523-527.

Paxton, S. J. (1991). Body image satisfaction, dieting beliefs, and weight loss behaviors in adolescent girls and boys. *Journal of youth and adolescence*, *20*(3), 361–379.

Paxton, S. J., Schutz, H. K., Wertheim, E. H., & Muir, S. L. (1999). Friendship clique and peer influences on body image concerns, dietary restraint, extreme weight-loss behaviors, and binge eating in adolescent girls. *Journal of Abnormal Psychology, 108*(2), 255.

Peak, N. J., Mizes, J. S., & Guillard Jr., R. P. (2012). Investigating the use of the mizes anorectic cognitions questionnaire in a community sample of racially diverse high school males and females. *Eating Behaviors, 13*(2), 94-99.

Peat, C., Mitchell, J. E., Hoek, H. W., & Wonderlich, S. A. (2009). Validity and utility of subtyping anorexia nervosa. *International Journal of Eating Disorders, 42*(7), 590-594.

Pellegrino, E. D. (1992). Beneficence, scientific autonomy, and self-interest: Ethical dilemmas in clinical research. *Cambridge Quarterly of Healthcare Ethics, 1*(04), 361-369.

Pendleton, V. R., Goodrick, G. K., Poston, W. S. C., Reeves, R. S., & Foreyt, J. P. (2002). Exercise augments the effects of cognitive-behavioral therapy in the treatment of binge eating. *International Journal of Eating Disorders, 31*(2), 172-184.

Perez, M., Hernandez, A., Clarke, A., & Joiner Jr., T. E. (2007). Analysis of bulimic symptomatology across age and geographic locations. *Eating Behaviors, 8*(1), 136-142.

Perez, M., Joiner, T. E., & Lewinsohn, P. M. (2004). Is major depressive disorder or dysthymia more strongly associated with bulimia nervosa? *International Journal of Eating Disorders, 36*(1), 55-61.

Perkins, S., Winn, S., Murray, J., Murphy, R., & Schmidt, U. (2004). A qualitative study of the experience of caring for a person with bulimia nervosa. part 1: The emotional impact of caring. *International Journal of Eating Disorders, 36*(3), 256-268.

Perls, F. S. (1969a). Ego, hunger and aggression: The beginning of gestalt therapy.

Perls, F. S. (1969b). Gestalt therapy verbatim.

Perls, F. (1973). *The gestalt approach & eye witness to therapy.* Science & Behavior Books.

Perls, F., Hefferline, G., & Goodman, P. (1951). Gestalt therapy. *New York,* Souvenir Press.

Perri, M. G. (1989). Review of 'experiential therapies for eating disorders'. *Psychology of Addictive Behaviors, 3*(3), 151-153.

Perris, C. (1999). A conceptualization of personality-related disorders of interpersonal behaviour with implications for treatment. *Clinical Psychology & Psychotherapy, 6*(4), 239-260.

Perry, C. (1998). Processes of a case study methodology for postgraduate research in marketing. *European Journal of Marketing, 32*(9/10), 785-802.

Perry, J. A., Silvera, D. H., Neilands, T. B., Rosenvinge, J. H., & Hanssen, T. (2008). A study of the relationship between parental bonding, self-concept and eating disturbances in Norwegian and American college populations. *Eating Behaviors, 9*(1), 13-24.

Perry, L., Morgan, J., Reid, F., Brunton, J., O'Brien, A., Luck, A., & Lacey, H. (2002). Screening for symptoms of eating disorders: Reliability of the SCOFF screening tool with written compared to oral delivery. *International Journal of Eating Disorders, 32*(4), 466-472.

Persons, J. B., & Tompkins, M. A. (1997). Cognitive-behavioral case formulation. *Handbook of Psychotherapy Case Formulation,* , 314-339.

Peshkin, M. M. (1966). The emotional aspects of allergy in children. *Journal of Asthma Research, 3*(4), 265-277.

Petermann, F., & Müller, J. M. (2001). Clinical psychology and evidence-based practice: A practical approach to treatment planning and evaluation.

Peterson, C. B., Crosby, R. D., Wonderlich, S. A., Joiner, T., Crow, S. J., Mitchell, J. E., Le Grange, D. (2007). Psychometric properties of the eating disorder examination-questionnaire: Factor structure and internal consistency. *International Journal of Eating Disorders, 40*(4), 386-389.

Peterson, C., Miller, K., Crow, S., Thuras, P., & Mitchell, J. (2005). Subtypes of binge eating disorder based on psychiatric history. *International Journal of Eating Disorders*, *38*(3), 273-276.

Peterson, C. (2015). “Walkabout: Looking in, looking out”: A mindfulness-based art therapy program. *Art Therapy, 32*(2), 78-82.

Peterson, D. R. (1991). Connection and disconnection of research and practice in the education of professional psychologists. *American Psychologist, 46*(4), 422.

Peterson, D. R. (2006). Connection and disconnection of research and practice in the education of professional psychologists. *Training and Education in Professional Psychology,* (1), 47.

Petronis, A. (2010). Epigenetics as a unifying principle in the aetiology of complex traits and diseases. *Nature, 465*(7299), 721-727.

Petty, L. C., Rosen, E. F., & Michaels, S. (2000). Nineteen eating disorder scales: Comparison by focus, ease, response format, and readability. *Eating Disorders, 8*(4), 311.

Phillips, A. (1988). Winnicott Cambridge. *MA: Harvard UP,*

Phillips, R., Stewart, S. M., Presnell, K., Simmons, A., Kennard, B. D., Liss, D., & Setliff, S. (2010). Psychological variables impacting weight gain rapidity in adolescents hospitalized for eating disorders. *European Eating Disorders Review, 18*(5), 376-384.

Piaget, J. (1955). The construction of reality in the child. *Journal of Consulting Psychology, 19*(1), 77.

Piaget, J., Cook, M., & Norton, W. W. (1952). *The origins of intelligence in children* International Universities Press New York.

Pietkiewicz, I., & Smith, J. A. (2014). A practical guide to using interpretative phenomenological analysis in qualitative research psychology. *Psychological Journal, 20*(1), 7-14.

Pike, K. M. (2005). Assessment of anorexia nervosa. *International Journal of Eating Disorders, 37*, 22-25. doi:10.1002/eat.20111

Pike, K. M. (2009). Half full or half empty?: Commentary on maintenance treatment for anorexia nervosa by jacqueline C. carter et al.*International Journal of Eating Disorders, 42*(3), 208-209.

Pike, K. M., Dunne, P. E., & Grant, A. (2015). Disorders in Asian societies. *The Wiley Handbook of Eating Disorders,* , 64.

Piran, N. (2010). A feminist perspective on risk factor research and on the prevention of eating disorders. *Eating Disorders, 18*(3), 183-198.

Polasky, L. J., & Holahan, C. K. (1998). Maternal self-discrepancies, inter-role conflict, and negative affect among married professional women with children. *Journal of Family Psychology, 12*(3), 388.

Polivy, J., & Herman, C. P. (2002). Causes of eating disorders. *Annual Review of Psychology, 53*(1), 187-213.

Pompili, M., Girardi, P., Tatarelli, G., Ruberto, A., & Tatarelli, R. (2006). Suicide and attempted suicide in eating disorders, obesity and weight–image concern. *Eating Behaviors, 7*(4), 384-394.

Ponterotto, J. G., Kuriakose, G., & Granovskaya, Y. (2008). Counselling and psychotherapy. *The Sage Handbook of Qualitative Research in Psychology,* , 455-471.

Pope, H. G. J., Lalonde, J. K., Pindyck, L. J., Walsh, T., Bulik, C. M., Crow, S. J., . . . Hudson, J. I. (2006). Binge eating disorder: A stable syndrome. *The American Journal of Psychiatry, 163*(12), 2181-2183.

Popkin, B. M. (1994). The nutrition transition in low-income countries: An emerging crisis. *Nutrition Reviews, 52*(9), 285-298.

Pos, A. E., Greenberg, L. S., Goldman, R. N., & Korman, L. M. (2003). Emotional processing during experiential treatment of depression. *Journal of Consulting and Clinical Psychology, 71*(6), 1007.

Posavac, S. S., & Posavac, H. D. (2002). Predictors of women's concern with body weight: The roles of perceived self-media ideal discrepancies and self-esteem. *Eating Disorders, 10*(2), 153-160.

Poulsen, S., Lunn, S., Daniel, S. I., Folke, S., Mathiesen, B. B., Katznelson, H., & Fairburn, C. G. (2014). A randomized controlled trial of psychoanalytic psychotherapy or cognitive-behavioral therapy for bulimia nervosa. *American Journal of Psychiatry,*

Poulsen, S., Lunn, S., & Sandros, C. (2010). Client experience of psychodynamic psychotherapy for bulimia nervosa: An interview study. *Psychotherapy: Theory, Research, Practice, Training, 47*(4), 469-483. doi:10.1037/a0021178

Poursharifi, H., Bidadian, M., Bahramizadeh, H., & Salehinezhad, M. A. (2011). The relationship between early maladaptive schemas and aspects of identity in obesity. *Procedia - Social and Behavioral Sciences, 30*(0), 517-523.

Powers, P. S., Rosemurgy, A. S., Coovert, D. L., & Boyd, F. R. (1988). Psychosocial sequelae of bariatric surgery: A pilot study. *Psychosomatics, 29*(3), 283-288.

Presnell, K., Bearman, S. K., & Stice, E. (2004). Risk factors for body dissatisfaction in adolescent boys and girls: A prospective study.*International Journal of Eating Disorders, 36*(4), 389-401.

Prestano, C., Lo Coco, G., Gullo, S., & Lo Verso, G. (2008). Group analytic therapy for eating disorders: Preliminary results in a single-group study. *European Eating Disorders Review, 16*(4), 302-310.

Preti, A., de Girolamo, G., Vilagut, G., Alonso, J., de Graaf, R., Bruffaerts, R., . . . Morosini, P. (2009). The epidemiology of eating disorders in six european countries: Results of the ESEMeD-WMH project. *Journal of Psychiatric Research, 43*(14), 1125-1132.

Pretorius, N., Rowlands, L., Ringwood, S., & Schmidt, U. (2010). Young people's perceptions of and reasons for accessing a web-based cognitive behavioural intervention for bulimia nervosa. *European Eating Disorders Review, 18*(3), 197-206.

Price-Evans, K., & Treasure, J. (2011). The use of motivational interviewing in anorexia nervosa. *Child and Adolescent Mental Health, 16*(2), 65-70.

Pringle, A., Harmer, C. J., & Cooper, M. J. (2011). Biases in emotional processing are associated with vulnerability to eating disorders over time. *Eating Behaviors, 12*(1), 56-59.

Probst, M., Pieters, G., & Vanderlinden, J. (2008). Evaluation of body experience questionnaires in eating disorders in female patients (AN/BN) and nonclinical participants. *International Journal of Eating Disorders, 41*(7), 657-

Prochaska, J. O., & DiClementi, C. C. (1984). The transpersonal approach: Crossing the traditional boundaries of therapy. *Homewood, Ill: Dow-Jones/Irwin,*

Prochaska, J. O., Redding, C. A., Evers, K. E., Glanz, K., Lewis, F. M., & Rimer, B. K. (2002). Health behavior and health education: Theory, research, and practice. *The Transtheoretical Model and Stages of Change,* , 60-84.

Prochaska, J. O., & DiClemente, C. C. (1982). Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research & Practice, 19*(3), 276.

Prochaska, J. O., DiClemente, C. C., & Norcross, J. C. (1992). In search of how people change: Applications to addictive behaviors. *American Psychologist, 47*(9), 1102.

Prochaska, J. O., DiClemente, C. C., Velicer, W. F., & Rossi, J. S. (1993). Standardized, individualized, interactive, and personalized self-help programs for smoking cessation. *Health Psychology, 12*(5), 399.

Proctor, C., Tweed, R., & Morris, D. (2016a). The Rogerian fully functioning person: A positive psychology perspective. *Journal of Humanistic Psychology, 56*(5), 503-529.

Procter, H. G. (1981). Family construct psychology: An approach to understanding and treating families. *Developments in Family Therapy,* , 350-366.

Procter, H. (1985). 16 a construct approach to family therapy and systems intervention.

Proulx, K. (2008). Experiences of women with bulimia nervosa in a mindfulness-based eating disorder treatment group. *Eating Disorders, 16*(1), 52-72.

Prozan, C. (1987). An integration of feminist and psychoanalytic theory. *Women & Therapy*, *6*(1-2), 59-71

Pugh, M. (2015). A narrative review of schemas and schema therapy outcomes in the eating disorders. *Clinical Psychology Review, 39*, 30-41.

Pugh, M. (2016). The internal 'anorexic voice': A feature or fallacy of eating disorders? *Advances in Eating Disorders, 4*(1), 75-83.

Pugh, M. (2019). *Cognitive behavioural chairwork: Distinctive features* Routledge.

Pugh, Matthew, and Caroline Salter. "Motivational chairwork: A novel method for enhancing motivation and resolving ambivalence in eating disorders." In Workshop presented at the London Eating Disorders Conference, London, March. 2017.

Pugh, M., & Rae, S. (2019). Chairwork in schema therapy: Applications and considerations in the treatment of eating disorders. In Schema Therapy for Eating Disorders (pp. 102-120). Routledge.

Pugh, M., & Waller, G. (2016). The anorexic voice and severity of eating pathology in anorexia nervosa. *International Journal of Eating Disorders, 49*(6), 622-625.

Pugh, M., & Waller, G. (2017). Understanding the 'anorexic voice' in anorexia nervosa. *Clinical Psychology & Psychotherapy, 24*(3), 670-676.

Quiles Marcos, Y., Cantero, T., Pagán Acosta, G., & Romero Escobar, C. (2009). Personality disorders in patients with eating disorders. Paper presented at the *Anales De Psiquiatria, , 25*(2) 64-69.

Raabe, S., Ehring, T., Marquenie, L., Arntz, A., & Kindt, M. (2018). Imagery rescripting versus STAIR plus imagery rescripting for PTSD related to childhood abuse: A randomized controlled trial.

Rabinor, J. R. (2001). The therapist's voice. *Eating Disorders, 9*(4), 377-381.

Rabinor, J. R. (2009). A meditation on life, love and being a therapist: It's not what I expected. *Eating Disorders, 17*(3), 267-272.

Rabinor, J. R., & Botwin, S. (2001). The therapist's voice & A warrior prevails. *Eating Disorders, 9*(2), 177-183.

Rafaeli, E., Bernstein, D. P., & Young, J. E. (2010). *Schema therapy: Distinctive features* Taylor & Francis.

Ragin, C. C. (2009). Reflections on casing and case-oriented research. *The Sage Handbook of Case-Based Methods, ,* 522-534.

Raich, R. M., Portell, M., & Peláez-Fernández, M. A. (2010). Evaluation of a school-based programme of universal eating disorders prevention: Is it more effective in girls at risk? *European Eating Disorders Review, 18*(1), 49-57.

Raich, R. M., Sánchez-Carracedo, D., López-Guimerà, G., Portell, M., Moncada, A., & Fauquet, J. (2008). A controlled assessment of school-based preventive programs for reducing eating disorder risk factors in adolescent spanish girls. *Eating Disorders, 16*(3), 255-272.

Ram, A., Stein, D., Sofer, S., & Kreitler, S. (2008). Bulimia nervosa and substance use disorder: Similarities and differences. *Eating Disorders, 16*(3), 224-240.

Ramacciotti, D. A., Sorbello, M., Pazzagli, A., Vismara, L., Mancone, A., & Pallanti, S. (2001). Attachment processes in eating disorders.*Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity, 6*(3), 166-170.

Rance, N. M., Moller, N. P., & Douglas, B. A. (2010). Eating disorder counsellors with eating disorder histories: A story of being 'normal'. *Eating Disorders, 18*(5), 377-392.

Rangel, C., Dukeshire, S., & MacDonald, L. (2012). Diet and anxiety. an exploration into the orthorexic society. *Appetite, 58*(1), 124-132.

Ransom, D. C., La Guardia, J. G., Woody, E. Z., & Boyd, J. L. (2010). Interpersonal interactions on online forums addressing eating concerns. *International Journal of Eating Disorders, 43*(2), 161-170.

Ratto, C. L., & Capitano, D. L. (1999). New directions for cognitive therapy: A schema-focused approach. *Cognitive and Behavioral Practice, 6*(1), 68-73.

Rawal, A., Enayati, J., Williams, J., & Park, R. J. (2009). A mindful approach to eating disorders. *Healthcare Counselling and Psychotherapy Journal, 9*(4), 16-20.

Reagan, P., & Hersch, J. (2005). Influence of race, gender, and socioeconomic status on binge eating frequency in a population-based sample. *International Journal of Eating Disorders, 38*(3), 252-256.

Reas, D. L., Øverås, M., & Rø, Ø. (2012). Norms for the eating disorder examination questionnaire (EDE-Q) among high school and university men. *Eating Disorders, 20*(5), 437-443.

Reba-Harrelson, L., Von Holle, A., Thornton, L. M., Klump, K. L., Berrettini, W. H., Brandt, H., . . . Bulik, C. M. (2008). Features associated with diet pill use in individuals with eating disorders. *Eating Behaviors, 9*(1), 73-81.

Redgrave, G. W., Coughlin, J. W., Heinberg, L. J., & Guarda, A. S. (2007). First-degree relative history of alcoholism in eating disorder inpatients: Relationship to eating and substance use psychopathology. *Eating Behaviors, 8*(1), 15-22.

Regier, D. A. (2007). Classifying eating disorders in DSM-V: New nosological perspectives. *International Journal of Eating Disorders, 40*, S8-S9.

Reinharz, S., & Davidman, L. (1992). *Feminist methods in social research.* Oxford University Press.

Remond, A., Hough, M., & Brockman, R (2013) *The relationship between self-compassion and schema modes*. Master's thesis, University of Western Sydney.

Renner, F., Lobbestael, J., Peeters, F., Arntz, A., & Huibers, M. (2012). Early maladaptive schemas in depressed patients: Stability and relation with depressive symptoms over the course of treatment. *Journal of Affective Disorders, 136*(3), 581-590.

Rennie, D. L. (2007). Methodical hermeneutics and humanistic psychology. *The Humanistic Psychologist, 35*(1), 1-14.

Reyes-Rodriguez, M. L., Von Holle, A., Ulman, T. F., Thornton, L. M., Klump, K. L., Brandt, H., . . . Bulik, C. M. (2011). Posttraumatic stress disorder in anorexia nervosa. *Psychosomatic Medicine, 73*(6), 491-497.

Reynolds Jr, D. J., & Stiles, W. B. (2007). Online data collection for psychotherapy process research. *CyberPsychology & Behavior, 10*(1), 92-99.

Reynolds JR, D. J., Stiles, W. B., & Grohol, J. M. (2006). An investigation of session impact and alliance in internet based psychotherapy: Preliminary results. *Counselling and Psychotherapy Research, 6*(3), 164-168.

Rezaei, F., Haidaripoor, S., & Ghadami, N. (2012). P-81 - early maladaptive schemas in addicts and their association with personality disorders. *European Psychiatry, 27, Supplement 1*(0), 1.

Rezaei, F., & Shams Alizadeh, N. (2011). P01-93 - early maladaptive schemas in methamphetamine and opioid addicts. *European Psychiatry, 26, Supplement 1*(0), 93.

Rhéaume, J., Freeston, M. H., Ladouceur, R., Bouchard, C., Gallant, L., Talbot, F., & Vallières, A. (2000). Functional and dysfunctional perfectionists: Are they different on compulsive-like behaviors? *Behaviour Research and Therapy, 38*(2), 119-128.

Ricca, V., Mannucci, E., Mezzani, B., Moretti, S., Di Bernardo, M., Bertelli, M., . . . Faravelli, C. (2001). Fluoxetine and fluvoxamine combined with individual cognitive-behaviour therapy in binge eating disorder: A one-year follow-up study. *Psychotherapy and Psychosomatics, 70*(6), 298-306.

Rice, L. N., & Greenberg, L. S. (1984). Patterns of change.

Richards, L. K., Shingleton, R. M., Goldman, R., Siegel, D., & Thompson-Brenner, H. (2016). Integrative dynamic therapy for bulimia nervosa: An evidence-based case study. *Psychotherapy, 53*(2), 195.

Richards, P. S., Baldwin, B. M., Frost, H. A., Clark-Sly, J., Berrett, M. E., & Hardman, R. K. (2000). What works for treating eating disorders? conclusions of 28 outcome reviews. *Eating Disorders, 8*(3), 189.

Ridolfi, D. R., & Vander Wal, J. S. (2008). Eating disorders awareness week: The effectiveness of a one-time body image dissatisfaction prevention session. *Eating Disorders, 16*(5), 428-443.

Rieger, E., & Touyz, S. (2006). An investigation of the factorial structure of motivation to recover in anorexia nervosa using the anorexia nervosa stages of change questionnaire. *European Eating Disorders Review, 14*(4), 269-275.

Rieger, E., Touyz, S. W., & Beumont, P. J. (2002). The anorexia nervosa stages of change questionnaire (ANSOCQ): Information regarding its psychometric properties. *International Journal of Eating Disorders, 32*(1), 24-38.

Rieger, E., Touyz, S., Schotte, D., Beumont, P., Russell, J., Clarke, S., . . . Griffiths, R. (2000). Development of an instrument to assess readiness to recover in anorexia nervosa. *International Journal of Eating Disorders, 28*(4), 387-396.

Rieger, E., Van Buren, D. J., Bishop, M., Tanofsky-Kraff, M., Welch, R., & Wilfley, D. E. (2010). An eating disorder-specific model of interpersonal psychotherapy (IPT-ED): Causal pathways and treatment implications. *Clinical Psychology Review, 30*(4), 400-410.

Rijkeboer, M. M., van den Bergh, H., & van den Bout, J. (2005). Stability and discriminative power of the young schema-questionnaire in a dutch clinical versus non-clinical population. *Journal of Behavior Therapy and Experimental Psychiatry, 36*(2), 129-144.

Ringer, F., & Crittenden, P. M. (2007). Eating disorders and attachment: The effects of hidden family processes on eating disorders. *European Eating Disorders Review, 15*(2), 119-130.

Ringham, R., Levine, M., Kalarchian, M., & Marcus, M. (2008). Temperament, mood, dietary restraint, and bulimic symptomatology in college women. *Eating Behaviors, 9*(3), 336-342.

Riso, L. P., Maddux, R. E., & Santorelli, N. T. (2007). Early maladaptive schemas in chronic depression. In L. P. Riso, P. L. du Toit, D. J. Stein & J. E. Young (Eds.), *Cognitive schemas and core beliefs in psychological problems: A scientist-practitioner guide* (pp. 41-58). Washington, DC: American Psychological Association.

Ritchie, J., Lewis, J., Nicholls, C. M., & Ormston, R. (2013). *Qualitative research practice: A guide for social science students and researchers* Sage.

Ritvo, S. (1984). The image and uses of the body in psychic conflict: With special reference to eating disorders in adolescence. *The Psychoanalytic Study of the Child,*

Rø, Ø, Reas, D. L., & Rosenvinge, J. (2012). The impact of age and BMI on eating disorder examination questionnaire (EDE-Q) scores in a community sample. *Eating Behaviors, 13*(2), 158-161.

Roberts, A., & Good, E. (2010). Media images and female body dissatisfaction: The moderating effects of the five-factor traits. *Eating Behaviors, 11*(4), 211-216.

Roberts, L. W. (2002). Ethics and mental illness research. *Psychiatric Clinics of North America, 25*(3), A525-A545.

Robinson, A. L., Dolhanty, J., & Greenberg, L. (2015). Emotion-Focused family therapy for eating disorders in children and adolescents.*Clinical Psychology & Psychotherapy, 22*(1), 75-82.

Robinson, A.Integrative response therapy for binge eating disorder. *Cognitive and Behavioral Practice,* (0)

Robinson, G. (1972). The story of parentectomy. *Journal of Asthma Research, 9*(4), 199-205.

Robinson, P., Barrett, B., Bateman, A., Hakeem, A., Hellier, J., Lemonsky, F., Fonagy, P. (2014). Study protocol for a randomized controlled trial of mentalization based therapy against specialist supportive clinical management in patients with both eating disorders and symptoms of borderline personality disorder. *BMC Psychiatry, 14*(1), 51.

Robinson, P., & Serfaty, M. (2008). Getting better byte by byte: A pilot randomised controlled trial of email therapy for bulimia nervosa and binge eating disorder. *European Eating Disorders Review, 16*(2), 84-93. doi:10.1002/erv.818

Roche, A. E. (2010). From shock therapy to psychotherapy: The role of peter dally in the revolutions of anorexia nervosa treatment. *European Eating Disorders Review, 18*(2), 71-75.

Rockert, W., Kaplan, A. S., & Olmsted, M. P. (2007). Eating disorder not otherwise specified: The view from a tertiary care treatment center. *International Journal of Eating Disorders, 40*, S99-S103. doi:10.1002/eat.20482

Rodgers, R., & Chabrol, H. (2009). Parental attitudes, body image disturbance and disordered eating amongst adolescents and young adults: A review. *European Eating Disorders Review, 17*(2), 137-151. doi:10.1002/erv.907

Rodríguez-Cano, T., Beato-Fernández, L., & Llario, A. B. (2006). Body dissatisfaction as a predictor of self-reported suicide attempts in adolescents: A Spanish community prospective study. *Journal of Adolescent Health, 38*(6), 684-688.

Roediger, E. (2012). Why are mindfulness and acceptance central elements for therapeutic change in schema therapy too? *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice,* , 239-247.

Roediger, E., & Jacob, G. (2010). *Fortschritte der schematherapie: Konzepte und anwendungen* Hogrefe Verlag.

Roediger, E. (2012). Why are mindfulness and acceptance central elements for therapeutic change in schema therapy too? an integrative perspective. *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice,* , 239-247.

Roediger, E. (2020, February 5). Strengthening the Healthy Adult [Webinar]. International Society of Schema Therapy. https://schematherapysociety.org/Strengthening-the-Healthy-Adult-Webinar/

Roediger, E., & Archonti, C. (2019). Transference and therapist–client schema chemistry in the treatment of eating disorders. *Schema Therapy for Eating Disorders: Theory and Practice for Individual and Group Settings.*

Roediger, E., Stevens, B. A., & Brockman, R. (2018a). *Contextual schema therapy: An integrative approach to personality disorders, emotional dysregulation, and interpersonal functioning* New Harbinger Publications.

Rogers, C. R. (1962). The interpersonal relationship: The core of guidance. *Harvard educational review*.

Rogers, C. R. (1963). The concept of the fully functioning person. *Psychotherapy: Theory, Research & Practice*, *1*(1), 17.

Rogers, C. (2012). *Client centred therapy (new ed)* Hachette UK.

Rogers, C. R. (1951). *Client-centered therapy: Its current practice, implications, and theory, with chapters* Houghton Mifflin.

Rogers, P. J., & Smit, H. J. (2000). Food craving and food "Addiction": A critical review of the evidence from a biopsychosocial perspective. *Pharmacology Biochemistry and Behavior, 66*(1), 3-14.

Rohde, P., Stice, E., & Marti, C. N. (2015). Development and predictive effects of eating disorder risk factors during adolescence: Implications for prevention efforts. *International Journal of Eating Disorders, 48*(2), 187-198.

Rollnick, S., & Miller, W. R. (1995). What is motivational interviewing? *Behavioural and Cognitive Psychotherapy, 23*(04), 325-334.

Root, T. L., Pinheiro, A. P., Thornton, L., Strober, M., Fernandez-Aranda, F., Brandt, H., Bulik, C. M. (2010). Substance use disorders in women with anorexia nervosa. *International Journal of Eating Disorders, 43*(1), 14-21.

Roots, P., Hawker, J., & Gowers, S. (2006). The use of target weights in the inpatient treatment of adolescent anorexia nervosa. *European Eating Disorders Review, 14*(5), 323-328. doi:10.1002/erv.723

Rorty, M., Yager, J., & Rossotto, E. (1994). Childhood sexual, physical, and psychological abuse in bulimia nervosa. *The American Journal of Psychiatry, 151*(8), 1122-1126.

Rorty, M., Yager, J., Rossotto, E., & Buckwalter, G. (2000). Parental intrusiveness in adolescence recalled by women with a history of bulimia nervosa and comparison women. *International Journal of Eating Disorders, 28*(2), 202-208.

Rose, K. S., Cooper, M. J., & Turner, H. (2006). The eating disorder belief questionnaire: Psychometric properties in an adolescent sample. *Eating Behaviors, 7*(4), 410-418.

Rosen, B. (1979). A method of structured brief psychotherapy. *British Journal of Medical Psychology, 52*(2), 157-162.

Rosen, J. C., & Gross, J. (1987). Prevalence of weight reducing and weight gaining in adolescent girls and boys. *Health Psychology, 6*(2), 131.

Rosenbaum, P. R. (2002). Observational studies. *Observational studies* (pp. 1-17) Springer.

Rosval, L., Steiger, H., Bruce, K., Israël, M., Richardson, J., & Aubut, M. (2006). Impulsivity in women with eating disorders: Problem of response inhibition, planning, or attention? *International Journal of Eating Disorders, 39*(7), 590-593.

Roth, A., & Fonagy, P. (2013). *What works for whom?: A critical review of psychotherapy research* Guilford Publications.

Rowe, S. L., Jordan, J., McIntosh, V. V. W., Carter, F. A., Frampton, C., Bulik, C. M., & Joyce, P. R. (2010). Does avoidant personality disorder impact on the outcome of treatment for bulimia nervosa? *International Journal of Eating Disorders, 43*(5), 420-427.

Rubak, S., Sandbaek, A., Lauritzen, T., & Christensen, B. (2005). Motivational interviewing: A systematic review and meta-analysis. *The British Journal of General Practice : The Journal of the Royal College of General Practitioners, 55*(513), 305-312.

Rubinstein, T. B., McGinn, A. P., Wildman, R. P., & Wylie-Rosett, J. (2010). Disordered eating in adulthood is associated with reported weight loss attempts in childhood. *International Journal of Eating Disorders, 43*(7), 663-666.

Rudkin, L. (2009). ABC of eating disorders edited by morris jane (2008). wiley-blackwell: West Sussex (paperback), pp. 70, ISBN:978-0-7279-1843-7. *European Eating Disorders Review, 17*(3), 235.

Ruggiero, G. M., Levi, D., Ciuna, A., & Sassaroli, S. (2003). Stress situation reveals an association between perfectionism and drive for thinness. *International Journal of Eating Disorders, 34*(2), 220-226.

Runyan, W. M. (1982). *Life histories and psychobiography: Explorations in theory and method.* Oxford University Press.

Russell, G. (1979). Bulimia nervosa: An ominous variant of anorexia nervosa. *Psychological Medicine, 9*(03), 429-448.

Russell, G. (2010). Commentary. *European Eating Disorders Review, 18*(2), 76-77.

Russell, G. F., Szmukler, G. I., Dare, C., & Eisler, I. (1987). An evaluation of family therapy in anorexia nervosa and bulimia nervosa.*Archives of General Psychiatry, 44*(12), 1047-1056.

Russell, G., Treasure, J., & Eisler, I. (1998). Mothers with anorexia nervosa who underfeed their children: Their recognition and management. *Psychological Medicine, 28*(01), 93-108.

Russell, S., & Ryder, S. (2001). BRIDGE 2 (building the relationship between body image and disordered eating graph and explanation): Interventions and transitions. *Eating Disorders, 9*(1), 15-27.

Russell-Mayhew, S., von Ranson, K. M., & Masson, P. C. (2010). How does overeaters anonymous help its members? A qualitative analysis. *European Eating Disorders Review, 18*(1), 33-42.

Ryan, R. M., & Deci, E. L. (2017). *Self-determination theory: Basic psychological needs in motivation, development, and wellness* Guilford Publications.

Ryan, V., Malson, H., Clarke, S., Anderson, G., & Kohn, M. (2006). Discursive constructions of 'eating disorders nursing': An analysis of nurses' accounts of nursing eating disorder patients. *European Eating Disorders Review, 14*(2), 125-135.

Ryle, A., Poynton, A. M., & Brockman, B. J. (1990). *Cognitive-analytic therapy: Active participation in change: A new integration in brief psychotherapy.* John Wiley & Sons.

Sackett, D. L., Rosenberg, W. M., Gray, J. A., Haynes, R. B., & Richardson, W. S. (1996). Evidence based medicine: What it is and what it isn't. *BMJ (Clinical Research Ed.), 312*(7023), 71-72.

Sackett, D. L., & Oxman, A. D. (2003). HARLOT plc: An amalgamation of the world's two oldest professions. *British Medical Journal, 327*(7429), 1442.

Safer, D. L., Telch, C. F., & Agras, W. S. (2001a). Dialectical behavior therapy adapted for bulimia: A case report. *International Journal of Eating Disorders, 30*(1), 101-106.

Safran, J. D., Crocker, P., McMain, S., & Murray, P. (1990). Therapeutic alliance rupture as a therapy event for empirical investigation.*Psychotherapy: Theory, Research, Practice, Training, 27*(2), 154.

Safran, J. D., Greenberg, L. S., & Rice, L. N. (1988). Integrating psychotherapy research and practice: Modeling the change process. *Psychotherapy: Theory, Research, Practice, Training, 25*(1), 1.

Sales, B. D., & Folkman, S. E. (2000). *Ethics in research with human participants.* American Psychological Association.

Salkovskis, P. M. (2002). Empirically grounded clinical interventions: Cognitive-behavioural therapy progresses through a multi-dimensional approach to clinical science. *Behavioural and Cognitive Psychotherapy, 30*(01), 3-9.

Salkovskis, P. M., & Clark, D. M. (1991). Cognitive therapy for panic attacks. *Journal of Cognitive Psychotherapy, 5*(3), 215-226.

Sallas, A. A. (2013). Treatment of eating disorders: Winning the war without having to do battle. *Anorexia Nervosa and Bulimic Disorders: Current Perspectives, 19*, 445.

Sallet, P. C., de Alvarenga, P. G., Ferrão, Y., de Mathis, M. A., Torres, A. R., Marques, A., Fleitlich-Bilyk, B. (2010). Eating disorders in patients with obsessive–compulsive disorder: Prevalence and clinical correlates. *International Journal of Eating Disorders, 43*(4), 315-325.

Sanchez-Johnsen, J. A. P., & Cuellar, I. (2004). Culturally competent assessment and evaluation. *Cross-Cultural Psychotherapy: Toward a Critical Understanding of Diverse Clients,* , 37.

Sansone, R. A., Levitt, J. L., & Sansone, L. A. (2006). The prevalence of personality disorders in those with eating disorders. *Personality Disorders and Eating Disorders: Exploring the Frontier.Routledge,* , 23-39.

Sansone, R. A., Levitt, J. L., & Sansone, L. A. (2004). The prevalence of personality disorders among those with eating disorders. *Eating Disorders, 13*(1), 7-21.

Sansone, R. A., & Sansone, L. A. (2010). Personality disorders as risk factors for eating disorders clinical implications. *Nutrition in Clinical Practice, 25*(2), 116-121.

Sansone, R. A., & Sansone, L. A. (2011). Personality pathology and its influence on eating disorders. *Innovations in Clinical Neuroscience, 8*(3), 14.

Sansone, R. A., & Wiederman, M. W. (2012). Distancing oneself from god: Relationships with borderline personality symptomatology.

Sansone, R. A. (2001). Patient-to-patient E-mail: Support for clinical practices. *Eating Disorders, 9*(4), 373-375.

Sansone, R. A., Chu, J. W., & Wiederman, M. W. (2010). Borderline personality and weight divergence in adulthood. *Eating Behaviors, 11*(4), 309-311.

Sansone, R. A., & Levitt, J. L. (2002a). Searching for answers: Eating disorders and self-harm behavior. *Eating Disorders, 10*(3), 189-191.

Sansone, R. A., & Levitt, J. L. (2005a). Borderline personality and eating disorders. *Eating Disorders, 13*(1), 71-83.

Sansone, R. A., & Sansone, L. A. (2002). Assessment tools for self-harm behavior among those with eating disorders. *Eating Disorders, 10*(3), 193-203.

Sansone, R. A., Schumacher, D., Wiederman, M. W., & Routsong-Weichers, L. (2008). The prevalence of binge eating disorder and borderline personality symptomatology among gastric surgery patients. *Eating Behaviors, 9*(2), 197-202.

Sansone, R. A., Wiederman, M. W., & Sansone, L. A. (2000). The prevalence of borderline personality disorder among individuals with obesity: A critical review of the literature. *Eating Behaviors, 1*(1), 93-104.

Sansone, R. A., Wiederman, M. W., Schumacher, D. F., & Routsong-Weichers, L. (2008). The prevalence of self-harm behaviors among a sample of gastric surgery candidates. *Journal of Psychosomatic Research, 65*(5), 441-444.

Sansone, R. A., Levitt, J. L., & Sansone, L. A. (2004). The prevalence of personality disorders among those with eating disorders. *Eating Disorders, 13*(1), 7-21.

Santonastaso, P., Zanetti, T., Sala, A., Favaretto, G., Vidotto, G., & Favaro, A. (1996). Prevalence of eating disorders in Italy: A survey on a sample of 16-year-old female students. *Psychotherapy and Psychosomatics, 65*(3), 158-162.

Santonastaso, P., Bosello, R., Schiavone, P., Tenconi, E., Degortes, D., & Favaro, A. (2009). Typical and atypical restrictive anorexia nervosa: Weight history, body image, psychiatric symptoms, and response to outpatient treatment. *International Journal of Eating Disorders, 42*(5), 464-470.

Sarbin, T. R. (1986). *Narrative psychology: The storied nature of human conduct.* Praeger Publishers/Greenwood Publishing Group.

Sassaroli, S., Bertelli, S., Decoppi, M., Crosina, M., Milos, G., & Ruggiero, G. M. (2005). Worry and eating disorders: A psychopathological association. *Eating Behaviors, 6*(4), 301-307.

Satir, D. A., Thompson-Brenner, H., Boisseau, C. L., & Crisafulli, M. A. (2009). Countertransference reactions to adolescents with eating disorders: Relationships to clinician and patient factors. *International Journal of Eating Disorders, 42*(6), 511-521.

Scerri, C. S., Abela, A., & Vetere, A. (2012). Ethical dilemmas of a clinician/researcher interviewing women who have grown up in a family where there was domestic violence. *International Journal of Qualitative Methods, 11*(2), 102-131.

Schäfer, J. Ö, Naumann, E., Holmes, E. A., Tuschen-Caffier, B., & Samson, A. C. (2017). Emotion regulation strategies in depressive and anxiety symptoms in youth: A meta-analytic review. *Journal of Youth and Adolescence, 46*(2), 261-276.

Schaffner, A. D., & Buchanan, L. P. (2008). Integrating evidence-based treatments with individual needs in an outpatient facility for eating disorders. *Eating Disorders, 16*(5), 378-392.

Schelling, S., Munsch, S., Meyer, A. H., Newark, P., Biedert, E., & Margraf, J. (2009). Increasing the motivation for physical activity in obese patients. *International Journal of Eating Disorders, 42*(2), 130-138.

Schlup, B., Munsch, S., Meyer, A. H., Margraf, J., & Wilhelm, F. H. (2009). The efficacy of a short version of a cognitive-behavioral treatment followed by booster sessions for binge eating disorder. *Behaviour Research and Therapy, 47*(7), 628-635.

Schmidt, U., Lee, S., Beecham, J., Perkins, S., Treasure, J., Yi, I., . . . Keville, S. (2007). A randomized controlled trial of family therapy and cognitive behavior therapy guided self-care for adolescents with bulimia nervosa and related disorders. *American Journal of Psychiatry,*

Schmidt, U., Oldershaw, A., Jichi, F., Sternheim, L., Startup, H., McIntosh, V., . . . Treasure, J. (2012). Out-patient psychological therapies for adults with anorexia nervosa: Randomised controlled trial. *The British Journal of Psychiatry : The Journal of Mental Science, 201*(5), 392-399.

Schmidt, U., Renwick, B., Lose, A., Kenyon, M., Dejong, H., Broadbent, H., . . . Landau, S. (2013). The MOSAIC study - comparison of the maudsley model of treatment for adults with anorexia nervosa (MANTRA) with specialist supportive clinical management (SSCM) in outpatients with anorexia nervosa or eating disorder not otherwise specified, anorexia nervosa type: Study protocol for a randomized controlled trial. *Trials, 14*, 160-160.

Schmidt, U., Startup, H., & Treasure, J. (2018). A Cognitive-Interpersonal Therapy Workbook for Treating Anorexia Nervosa: The Maudsley Model. Routledge.

Schmidt, U., Tiller, J., Blanchard, M., Andrews, B., & Treasure, J. (1997). Is there a specific trauma precipitating anorexia nervosa? *Psychological Medicine, 27*(03), 523-530.

Schmidt, U., & Treasure, J. (2006). Anorexia nervosa: Valued and visible. A cognitive-interpersonal maintenance model and its implications for research and practice. *British Journal of Clinical Psychology, 45*(3), 343-366.

Schmidt, N. B., Joiner, T. E., Young, J. E., & Telch, M. J. (1995). The schema questionnaire: Investigation of psychometric properties and the hierarchical structure of a measure of maladaptive schemas. *Cognitive therapy and research*, *19*(3), 295-321.

Schmitz, N., Kruse, J., Heckrath, C., Alberti, L., & Tress, W. (1999). Diagnosing mental disorders in primary care: The general health questionnaire (GHQ) and the symptom check list (SCL-90-R) as screening instruments. *Social Psychiatry and Psychiatric Epidemiology, 34*(7), 360-366.

Schneer, A. (2002). Eating disorders: A disorder of in and out. *Eating Disorders, 10*(2), 161-176.

Schoemaker, C., Smit, F., Bijl, R. V., & Vollebergh, W. A. M. (2002). Bulimia nervosa following psychological and multiple child abuse: Support for the self-medication hypothesis in a population-based cohort study. *International Journal of Eating Disorders, 32*(4), 381-388.

Schön Donald, A. (1983). The reflective practitioner: How professionals think in action.

Schore, A. N. (2015). *Affect regulation and the origin of the self: The neurobiology of emotional development* Routledge.

Schulte, D., & Eifert, G. H. (2002). What to do when manuals fail? the dual model of psychotherapy. *Clinical Psychology: Science and Practice, 9*(3), 312-328.

Seale, C. (1999). Quality in qualitative research. *Qualitative Inquiry, 5*(4), 465-478.

Seale, C., Gobo, G., Gubrium, J. F., & Silverman, D. (2004). *Qualitative research practice* Sage.

Seawright, J., & Gerring, J. (2008). Case selection techniques in case study research: A menu of qualitative and quantitative options.*Political Research Quarterly, 61*(2), 294-308.

Sechrest, L., Stewart, M., Stickle, T. R., & Sidani, S. (1996). Effective and persuasive case studies. *Cambridge, MA: Human Services Research Institute,*

Segal, Z. V., Williams, J. M. G., & Teasdale, J. D. (2002). Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse. Guilford Press.

Seijo, N. (2016). The rejected self: working with body image distortion in eating disorders. ESTD Newsletter, 5(4), 5-13.

Sekar, M. K. (2009). Robinson paul (2009), severe and enduring eating disorder (SEED): Management of complex presentations of anorexia nervosa and bulimia nervosa, wiley-blackwell press: Chichester, UK, p. 168, ISBN 978-0-470-06207-4. *European Eating Disorders Review, 17*(5), 399-400.

Selby, C. L. B. (2011). Acceptance and commitment therapy for body image dissatisfaction: A practitioner's guide to using mindfulness, acceptance and values-based behavior change strategies. *Eating Disorders, 19*(4), 369-371.

Selby, E. A., Doyle, P., Crosby, R. D., Wonderlich, S. A., Engel, S. G., Mitchell, J. D., & Le Grange, D. (2012). Momentary emotion surrounding bulimic behaviors in women with bulimia nervosa and borderline personality disorder. *Journal of Psychiatric Research, 46*(11), 1492-1500.

Selby, E. A., Ward, A. C., & Joiner Jr., T. E. (2010). Dysregulated eating behaviors in borderline personality disorder: Are rejection sensitivity and emotion dysregulation linking mechanisms? *International Journal of Eating Disorders, 43*(7), 667-670.

Senekal, M., Steyn, N. P., & Nel, J. H. (2003). Factors associated with overweight/obesity in economically active south african populations. *Ethnicity & Disease, 13*(1), 109-116.

Sepulveda, A. R., Lopez, C., Macdonald, P., & Treasure, J. (2008). Feasibility and acceptability of DVD and telephone coaching-based skills training for carers of people with an eating disorder. *International Journal of Eating Disorders, 41*(4), 318-325.

Sepulveda, A. R., Kyriacou, O., & Treasure, J. (2009). Development and validation of the accommodation and enabling scale for eating disorders (AESED) for caregivers in eating disorders. *BMC Health Services Research, 9*(1), 171.

Serpell, L. E. (2000). No title. *'Anorexic Thinking': Cognitive Processes in Anorexia Nervosa.,*

Serpell, L., Treasure, J., Teasdale, J., & Sullivan, V. (1999). Anorexia nervosa: Friend or foe? *International Journal of Eating Disorders, 25*(2), 177-186.

Serpell, L., Teasdale, J. D., Troop, N. A., & Treasure, J. (2004). The development of the P-CAN, a measure to operationalize the pros and cons of anorexia nervosa. *International Journal of Eating Disorders, 36*(4), 416-433.

Shadish, W. R., Navarro, A. M., Matt, G. E., & Phillips, G. (2000). The effects of psychological therapies under clinically representative conditions: A meta-analysis. *Psychological Bulletin, 126*(4), 512.

Shafran, R., Cooper, Z., & Fairburn, C. G. (2002). Clinical perfectionism: A cognitive–behavioural analysis. *Behaviour Research and Therapy, 40*(7), 773-791.

Shafran, R., & Fairburn, C. G. (2002). A new ecologically valid method to assess body size estimation and body size dissatisfaction. *International Journal of Eating Disorders, 32*(4), 458-465.

Shafran, R., & Mansell, W. (2001). Perfectionism and psychopathology: A review of research and treatment. *Clinical Psychology Review, 21*(6), 879-906.

Shapiro, J. R., Berkman, N. D., Brownley, K. A., Sedway, J. A., Lohr, K. N., & Bulik, C. M. (2007). Bulimia nervosa treatment: A systematic review of randomized controlled trials. *International Journal of Eating Disorders, 40*(4), 321-336.

Shapiro, J. R., Bauer, S., Andrews, E., Pisetsky, E., Bulik-Sullivan, B., Hamer, R. M., & Bulik, C. M. (2010). Mobile therapy: Use of text-messaging in the treatment of bulimia nervosa. *International Journal of Eating Disorders, 43*(6), 513-519.

Shatford, L. A., & Evans, D. R. (1986). Bulimia as a manifestation of the stress process: A LISREL causal modeling analysis. *International Journal of Eating Disorders, 5*(3), 451-473.

Shaw, R. L. (2012). Identifying and synthesizing qualitative literature. *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners,* , 9.

Sheehy, J., & Rabinor, J. R. (2002). The therapist's voice. *Eating Disorders, 10*(4), 345.

Sheffield, A., Waller, G., Emanuelli, F., Murray, J., & Meyer, C. (2005). Links between parenting and core beliefs: Preliminary psychometric validation of the young parenting inventory. *Cognitive Therapy and Research, 29*(6), 787-802.

Sheffield, A., & Waller, G. (2012). Clinical use of schema inventories. *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice,* , 111-124.

Sheffield, A., Waller, G., Emanuelli, F., & Murray, J. (2006). Is comorbidity in the eating disorders related to perceptions of parenting? criterion validity of the revised young parenting inventory. *Eating Behaviors, 7*(1), 37-45.

Sheffield, A., Waller, G., Emanuelli, F., Murray, J., & Meyer, C. (2009). Do schema processes mediate links between parenting and eating pathology? *European Eating Disorders Review: The Professional Journal of the Eating Disorders Association, 17*(4), 290-300.

Shenton, A. K. (2004). Strategies for ensuring trustworthiness in qualitative research projects. *Education for Information, 22*(2), 63-75.

Sherman, B. J., Savage, C. R., Eddy, K. T., Blais, M. A., Deckersbach, T., Jackson, S. C., . . . Herzog, D. B. (2006). Strategic memory in adults with anorexia nervosa: Are there similarities to obsessive compulsive spectrum disorders? *International Journal of Eating Disorders, 39*(6), 468-476.

Sherry, S. B., Hewitt, P. L., Besser, A., Mcgee, B. J., & Flett, G. L. (2004). Self-oriented and socially prescribed perfectionism in the eating disorder inventory perfectionism subscale. *International Journal of Eating Disorders, 35*(1), 69-79.

Sherry, S. B., Vriend, J. L., Hewitt, P. L., Sherry, D. L., Flett, G. L., & Wardrop, A. A. (2009). Perfectionism dimensions, appearance schemas, and body image disturbance in community members and university students. *Body Image, 6*(2), 83-89.

Shoebridge, P., & Gowers, S. G. (2000). Parental high concern and adolescent-onset anorexia nervosa. A case-control study to investigate direction of causality. *The British Journal of Psychiatry : The Journal of Mental Science, 176*, 132-137.

Shomaker, L. B., & Furman, W. (2009). Interpersonal influences on late adolescent girls' and boys' disordered eating. *Eating Behaviors, 10*(2), 97-106. doi:10.1016/j.eatbeh.2009.02.003

Shorey, R. C., Stuart, G. L., & Anderson, S. (2012). The early maladaptive schemas of an opioid-dependent sample of treatment seeking young adults: A descriptive investigation. *Journal of Substance Abuse Treatment, 42*(3), 271-278. doi:10.1016/j.jsat.2011.08.004

Shroff, H., Reba, L., Thornton, L. M., Tozzi, F., Klump, K. L., Berrettini, W. H., . . . Treasure, J. (2006). Features associated with excessive exercise in women with eating disorders. *International Journal of Eating Disorders, 39*(6), 454-461.

Siegel, D. J., & Hartzell, M. (2003). *Parenting from the inside out* Penguin.

Siegel, D. J. (1999). *The developing mind: Toward a neurobiology of interpersonal experience.* Guilford Press.

Siegel, D. J. (2020). *The developing mind: How relationships and the brain interact to shape who we are* Guilford Press.

Sierra-Baigrie, S., Lemos-Giráldez, S., & Fonseca-Pedrero, E. (2009). Binge eating in adolescents: Its relation to behavioural problems and family-meal patterns. *Eating Behaviors, 10*(1), 22-28.

Sim, L. A., Homme, J. H., Lteif, A. N., Vande Voort, J. L., Schak, K. M., & Ellingson, J. (2009). Family functioning and maternal distress in adolescent girls with anorexia nervosa. *International Journal of Eating Disorders, 42*(6), 531-539.

Simeon, D. (2004). Schema therapy: A practitioner's guide: Jeffrey E. young, janet S. klosko, marjorie weishaar guilford press, 2003, 470 pages, $45.00. *Journal of Psychosomatic Research, 57*(1), 114-115.

Simeone-DiFrancesco, C., Roediger, E., & Stevens, B. A. (2015). *Schema therapy with couples: A practitioner's guide to healing relationships*. John Wiley & Sons.

Simmons, A. M., Milnes, S. M., & Anderson, D. A. (2008). Factors influencing the utilization of empirically supported treatments for eating disorders. *Eating Disorders, 16*(4), 342-354.

Simons, H. (2009). *Case study research in practice* SAGE publications.

Simpson, S. G., Morrow, E., van Vreeswijk, M., & Reid, C. (2010). Group schema therapy for eating disorders: A pilot study. *Frontiers in Psychology, 1*

Simpson, S. (2012). Schema therapy for eating disorders. *The wiley-blackwell handbook of schema therapy* (pp. 143-171) John Wiley & Sons, Ltd.

Simpson, S. G., Pietrabissa, G., Rossi, A., Seychell, T., Manzoni, G. M., Munro, C., ... & Castelnuovo, G. (2018). Factorial structure and preliminary validation of the Schema Mode Inventory for Eating Disorders (SMI-Ed). Frontiers in psychology, 9, 600.

Simpson, S. G., & Slowey, L. (2011). Video therapy for atypical eating disorder and obesity: A case study. *Clinical Practice & Epidemiology in Mental Health, 7*(1)

Simpson, S., Bell, L., Britton, P., Mitchell, D., Morrow, E., Johnston, A. L., & Brebner, J. (2006). Does video therapy work? A single case series of bulimic disorders. *European Eating Disorders Review, 14*(4), 226-241.

Simpson, S. (2012). No title. *Schema Therapy for Eating Disorders: A Case Study Illustration of the Mode Approach,*

Simpson, S. (2019). Schema therapy assessment of eating disorders. *Schema therapy for eating disorders* (pp. 37-55) Routledge.

Simpson, S. G., Morrow, E., & Reid, C. (2010). Group schema therapy for eating disorders: A pilot study. *Frontiers in Psychology, 1*, 182.

Simpson, S., & Arntz, A. (2019). Core principles of imagery. *Creative methods in schema therapy: Advances and innovation in clinical practice.* Routledge.

Simpson, S., Simionato, G., Smout, M., van Vreeswijk, M. F., Hayes, C., Sougleris, C., & Reid, C. (2019). Burnout amongst clinical and counselling psychologist: The role of early maladaptive schemas and coping modes as vulnerability factors. *Clinical Psychology & Psychotherapy, 26*(1), 35-46.

Sinai, M. (1965). Evolution of psychosomatic concepts—anorexia nervosa: A paradigm. *The International Psycho-Analytic Library,* (65)

Skårderud, F. (2007a). Eating one's words, part I:'concretised metaphors' and reflective function in anorexia nervosa—An interview study. *European Eating Disorders Review, 15*(3), 163-174.

Skårderud, F. (2009). Bruch revisited and revised. *European Eating Disorders Review, 17*(2), 83-88.

Skodol, A. E., Oldham, J. M., Hyler, S. E., Kellman, H. D., Doidge, N., & Davies, M. (1993). Comorbidity of DSM-III-R eating disorders and personality disorders. *International Journal of Eating Disorders, 14*(4), 403-416.

Small, M. L. (2009). How many cases do I need?' on science and the logic of case selection in field-based research. *Ethnography, 10*(1), 5-38.

Smethurst, W., Wales, J., & Arcelus, J. (2010). Puff the magic slimmer? *European Eating Disorders Review, 18*(6), 431-433.

Smink, F. R., Hoeken, D., Oldehinkel, A. J., & Hoek, H. W. (2014). Prevalence and severity of DSM-5 eating disorders in a community cohort of adolescents. *International Journal of Eating Disorders, 47*(6), 610-619.

Smink, F. R., Van Hoeken, D., & Hoek, H. W. (2012). Epidemiology of eating disorders: Incidence, prevalence and mortality rates. *Current Psychiatry Reports, 14*(4), 406-414.

Smith, A., & Cook-Cottone, C. (2011). A review of family therapy as an effective intervention for anorexia nervosa in adolescents. *Journal of Clinical Psychology in Medical Settings, 18*(4), 323-334.

Smith, J. A. (2004). Reflecting on the development of interpretative phenomenological analysis and its contribution to qualitative research in psychology. *Qualitative Research in Psychology, 1*(1), 39-54.

Smith, J. A., Harré, R., & Van Langenhove, L. (Eds.). (1995). *Rethinking methods in psychology*. Sage.

Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. *Doing Social Psychology Research*, 229-254.

Smith, M. H., Richards, P. S., & Maglio, C. J. (2004). Examining the relationship between religious orientation and eating disturbances.*Eating Behaviors, 5*(2), 171-180.

Smolak, L., Levine, M. P., & Schermer, F. (1999). Parental input and weight concerns among elementary school children. *International Journal of Eating Disorders, 25*(3), 263-271.

Smolak, L., & Murnen, S. K. (2002). A meta-analytic examination of the relationship between child sexual abuse and eating disorders. *International Journal of Eating Disorders, 31*(2), 136-150.

Smucker, M. R., Dancu, C., Foa, E. B., & Niederee, J. L. (1995). Imagery rescripting: A new treatment for survivors of childhood sexual abuse suffering from posttraumatic stress. *Journal of Cognitive Psychotherapy, 9*(1), 3-17.

Smucker, M. R., & Dancu, C. V. (1999). *Cognitive-behavioral treatment for adult survivors of childhood trauma: Imagery rescripting and reprocessing* Jason Aronson.

Smyth, J. M., Wonderlich, S. A., Sliwinski, M. J., Crosby, R. D., Engel, S. G., Mitchell, J. E., & Calogero, R. M. (2009). Ecological momentary assessment of affect, stress, and binge-purge behaviors: Day of week and time of day effects in the natural environment. *International Journal of Eating Disorders, 42*(5), 429-436.

Soares, M. J., Macedo, A., Bos, S. C., Marques, M., Maia, B., Pereira, A. T., . . . Azevedo, M. H. (2009). Perfectionism and eating attitudes in portuguese students: A longitudinal study. *European Eating Disorders Review, 17*(5), 390-398.

Soenens, B., Nevelsteen, W., & Vandereycken, W. (2007). The significance of perfectionism in eating disorders: A comparative study. [De betekenis van perfectionisme bij eetstoornissen. Een vergelijkend onderzoek] *Tijdschrift Voor Psychiatrie, 49*(10), 709-718.

Soh, N. L., Touyz, S. W., & Surgenor, L. J. (2006). Eating and body image disturbances across cultures: A review. *European Eating Disorders Review, 14*(1), 54-65.

Solenberger, S. E. (2001). Exercise and eating disorders: A 3-year inpatient hospital record analysis. *Eating Behaviors, 2*(2), 151-168. doi:10.1016/S1471-0153(01)00026-5

Sollid, C. P., Wisborg, K., Hjort, J., & Secher, N. J. (2004). Eating disorder that was diagnosed before pregnancy and pregnancy outcome. *American Journal of Obstetrics and Gynecology, 190*(1), 206-210.

Somerville, K., & Cooper, M. (2007). Using imagery to identify and characterise core beliefs in women with bulimia nervosa, dieting and non-dieting women. *Eating Behaviors, 8*(4), 450-456.

Sookman, D., & Pinard, G. (1999). Integrative cognitive therapy for obsessive-compulsive disorder: A focus on multiple schemas. *Cognitive and Behavioral Practice, 6*(4), 351-362.

Soufre, L.A. (1997). Emotional development: The organization of emotional life in the early years. New York: Cambridge University Press.

Soukup, V. M., Beiler, M. E., & Terrell, F. (1990). Stress, coping style, and problem solving ability among eating-disordered inpatients.*Journal of Clinical Psychology, 46*(5), 592-599.

Sours, J. A. (1980). *Starving to death in a sea of objects: The anorexia nervosa syndrome* J. Aronson New York.

Southgate, L., Tchanturia, K., Collier, D., & Treasure, J. (2008). The development of the childhood retrospective perfectionism questionnaire (CHIRP) in an eating disorder sample. *European Eating Disorders Review, 16*(6), 451-462.

Soy, S. (2015). The case study as a research method.

Spangler, D. L. (2010). Heavenly bodies: Religious issues in cognitive behavioral treatment of eating disorders. *Cognitive and Behavioral Practice, 17*(4), 358-370.

Specht, M. W., Chapman, A., & Cellucci, T. (2009). Schemas and borderline personality disorder symptoms in incarcerated women.*Journal of Behavior Therapy and Experimental Psychiatry, 40*(2), 256-264.

Spelt, J. R., & Meyer, J. M. (1995). Genetics and eating disorders. *Behavior genetic approaches in behavioral medicine* (pp. 167-185) Springer.

Spence, D. P. (1984). *Narrative truth and historical truth: Meaning and interpretation in psychoanalysis* WW Norton & Company.

Spence, D. P. (1986). Narrative smoothing and clinical wisdom.

Spence, D. P. (1993). Traditional case studies and prescriptions for improving them.

Spencer, L., & Ritchie, J. (2012). In pursuit of quality. *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners,* , 225-242.

Spindler, A., & Milos, G. (2007). Links between eating disorder symptom severity and psychiatric comorbidity. *Eating Behaviors, 8*(3), 364-373.

Spinella, M., & Lyke, J. (2004). Executive personality traits and eating behavior. *International Journal of Neuroscience, 114*(1), 83-93.

Spitzer, R. L., Yanovski, S., Wadden, T., Wing, R., Marcus, M. D., Stunkard, A., . . . Horne, R. L. (1993). Binge eating disorder: Its further validation in a multisite study. *International Journal of Eating Disorders, 13*(2), 137-153.

Spranger, S. C., Waller, G., & Bryant-Waugh, R. (2001). Schema avoidance in bulimic and non–eating-disordered women. *International Journal of Eating Disorders, 29*(3), 302-306.

Sroufe, L. A. (1997). Psychopathology as an outcome of development. *Development and Psychopathology, 9*(02), 251-268.

Sroufe, L. A., & Waters, E. (1977). Attachment as an organizational construct. *Child Development, 48*, 1184-1199.

Stake, R. E. (1978). The case study method in social inquiry. *Educational Researcher, 7*(2), 5-8.

Stake, R. E. (1995). *The art of case study research* Sage.

Stake, R. E., & Trumbull, D. J. (1982). Naturalistic generalizations. *Review Journal of Philosophy and Social Science, 7*(1), 1-12.

Stanford, S. C., & Lemberg, R. (2012a). A clinical comparison of men and women on the eating disorder inventory-3 (EDI-3) and the eating disorder assessment for men (EDAM). *Eating Disorders, 20*(5), 379-394.

Stanford, S. C., & Lemberg, R. (2012b). Measuring eating disorders in men: Development of the eating disorder assessment for men (EDAM). *Eating Disorders, 20*(5), 427-436.

Steele, A. L., O'Shea, A., Murdock, A., & Wade, T. D. (2011). Perfectionism and its relation to overevaluation of weight and shape and depression in an eating disorder sample. *International Journal of Eating Disorders, 44*(5), 459-464.

Stefano, S. C., Bacaltchuk, J., Blay, S. L., & Appolinário, J. C. (2008). Antidepressants in short-term treatment of binge eating disorder: Systematic review and meta-analysis. *Eating Behaviors, 9*(2), 129-136. doi:10.1016/j.eatbeh.2007.03.006

Steiger, H., Richardson, J., Schmitz, N., Israel, M., Bruce, K. R., & Gauvin, L. (2010). Trait-defined eating-disorder subtypes and history of childhood abuse. *International Journal of Eating Disorders, 43*(5), 428-432.

Steiger, H., Stotland, S., Trottier, J., & Ghadirian, A. M. (1996). Familial eating concerns and psychopathological traits: Causal implications of transgenerational effects. *International Journal of Eating Disorders, 19*(2), 147-157.

Steiger, H., van, d. F., Goldstein, C., & Leichner, P. (1989). Defense styles and parental bonding in eating-disordered women. *International Journal of Eating Disorders, 8*(2), 131-140.

Steiger, H., & Zanko, M. (1990). Sexual traumata among eating-disordered, psychiatric, and normal female groups comparison of prevalences and defense styles. *Journal of Interpersonal Violence, 5*(1), 74-86.

Stein, A., Woolley, H., Cooper, S., Winterbottom, J., Fairburn, C. G., & Cortina-Borja, M. (2006). Eating habits and attitudes among 10-year-old children of mothers with eating disorders: Longitudinal study. *The British Journal of Psychiatry : The Journal of Mental Science, 189*, 324-329.

Stein, D. J., & Young, J. E. (1992). Schema approach to personality disorders.

Stein, H., Fonagy, P., Ferguson, K. S., & Wisman, M. (2000). Lives through time: An ideographic approach to the study of resilience. *Bulletin of the Menninger Clinic, 64*(2), 281.

Stein, H., Jacobs, N. J., Ferguson, K. S., Allen, J. G., & Fonagy, P. (1998). What do adult attachment scales measure? *Bulletin of the Menninger Clinic, 62*, 33-82.

Stein, K. F. (1996). The self-schema model: A theoretical approach to the self-concept in eating disorders. *Archives of Psychiatric Nursing, 10*(2), 96-109.

Stein, K. F., & Corte, C. (2008). The identity impairment model: A longitudinal study of self-schemas as predictors of disordered eating behaviors. *Nursing Research, 57*(3), 182-190.

Stein, M. K. (2002). Sociocultural influences and eating disorders around the globe. (cover story). *Eating Disorders Review, 13*(3), 1.

Steinglass, J. E., Sysko, R., Glasofer, D., Albano, A. M., Simpson, H. B., & Walsh, B. T. (2011). Rationale for the application of exposure and response prevention to the treatment of anorexia nervosa. *International Journal of Eating Disorders, 44*(2), 134-141.

Steinhausen, H., & Jensen, C. M. (2015). Time trends in lifetime incidence rates of first-time diagnosed anorexia nervosa and bulimia nervosa across 16 years in a danish nationwide psychiatric registry study. *International Journal of Eating Disorders, 48*(7), 845-850.

Steinhausen, H. (2002). The outcome of anorexia nervosa in the 20th century. *American Journal of Psychiatry, 159*(8), 1284-1293.

Sternheim, L., Startup, H., Saeidi, S., Morgan, J., Hugo, P., Russell, A., & Schmidt, U. (2012). Understanding catastrophic worry in eating disorders: Process and content characteristics. *Journal of Behavior Therapy and Experimental Psychiatry, 43*(4), 1095-1103.

Stewart, M., Schiavo, R. S., Herzog, D. B., & Franko, D. L. (2008). Stereotypes, prejudice and discrimination of women with anorexia nervosa. *European Eating Disorders Review, 16*(4), 311-318.

Stewart, R. E., & Chambless, D. L. (2007). Does psychotherapy research inform treatment decisions in private practice? *Journal of Clinical Psychology*, *63*(3), 267-281.

Stice, E. (1998). Modeling of eating pathology and social reinforcement of the thin-ideal predict onset of bulimic symptoms. *Behaviour Research and Therapy, 36*(10), 931-944.

Stice, E. (2001). Risk factors for eating pathology: Recent advances and future directions.

Stice, E. (2002). Risk and maintenance factors for eating pathology: A meta-analytic review. *Psychological Bulletin, 128*(5), 825-848.

Stice, E., Marti, C. N., & Durant, S. (2011). Risk factors for onset of eating disorders: Evidence of multiple risk pathways from an 8-year prospective study. *Behaviour Research and Therapy, 49*(10), 622-627.

Stice, E., Marti, C. N., & Rohde, P. (2013). DSM-5 eating disorder diagnoses in a community study of women. *PsycEXTRA Dataset*.

Stice, E., Ng, J., & Shaw, H. (2010). Risk factors and prodromal eating pathology. *Journal of Child Psychology and Psychiatry, 51*(4), 518-525.

Stice, E., Presnell, K., & Spangler, D. (2002). Risk factors for binge eating onset in adolescent girls: A 2-year prospective investigation.*Health Psychology, 21*(2), 131.

Stice, E., & Spoor, S. T. P. (2007). Stability of eating disorder diagnoses: A commentary. *International Journal of Eating Disorders, 40*, S79-S82.

Stierlin, H., & Weber, G. (1989). *Unlocking the family door: A systemic approach to the understanding and treatment of anorexia nervosa.* Brunner/Mazel.

Stiles, W. B. (2003). When is a case study scientific research. *Psychotherapy Bulletin, 38*(1), 6-11.

Stiles, W. (1999). Signs and voices in psychotherapy. *Psychotherapy Research, 9*(1), 1-21.

Stiles, W. B. (1993). Quality control in qualitative research. *Clinical Psychology Review, 13*(6), 593-618.

Stiles, W. B., Barkham, M., Connell, J., & Mellor-Clark, J. (2008). Responsive regulation of treatment duration in routine practice in united kingdom primary care settings: Replication in a larger sample. *Journal of Consulting and Clinical Psychology, 76*(2), 298.

Stiles, W. B., Honos-Webb, L., & Surko, M. (1998). Responsiveness in psychotherapy. *Clinical Psychology: Science and Practice, 5*(4), 439-458.

Stinson, S. M. (2002). Treatment manual for anorexia nervosa (book). *Eating Disorders, 10*(4), 351.

Stiver, I. P. (2000). Expanding the therapeutic boundary: Taking risks for change. *Eating Disorders, 8*(3), 247.

Stopa, L., Thorne, P., Waters, A., & Preston, J. (2001). Are the short and long forms of the young schema questionnaire comparable and how well does each version predict psychopathology scores? *Journal of Cognitive Psychotherapy, 15*(3), 253-272.

Strassberg, D. S., Ross, S., & Todt, E. H. (1995). MMPI performance among women with bulimia: A clusteAN-ralytic study. *Addictive Behaviors, 20*(1), 137-140.

Strauss, J., & Ryan, R. M. (1987). Autonomy disturbances in subtypes of anorexia nervosa. *Journal of Abnormal Psychology, 96*(3), 254-258.

Streeck, U. (2006). Psychoanalytisch-interaktionelle therapie. *Psychodynamische psychotherapien* (pp. 107-135) Springer.

Streeck, U. (2002). Disturbed relations–psychoanalytic interactional group therapy of patients with severe personality disorders. *Persönlichkeitsstörungen: Theorie Und Therapie, 6*(2), 109.

Streeck-Fischer, A., & Streeck, U. (2010). Psychoanalytic-interactional psychotherapy of severely disturbed adolescents. [Psychoanalytisch-interaktionelle Psychotherapie von Jugendlichen mit strukturellen Storungen] *Praxis Der Kinderpsychologie Und Kinderpsychiatrie, 59*(6), 435-452.

Striegeil-Moore, R., & Franko, D. L. (2003). Epidemiology of binge eating disorder. *International Journal of Eating Disorders, 34*, S19-S29.

STRIEGEL-MOORE, R. H. (1997). Risk factors for eating disorders. *Annals of the New York Academy of Sciences, 817*(1), 98-109.

Striegel-Moore, R. H., & Bulik, C. M. (2007). Risk factors for eating disorders. *American Psychologist, 62*(3), 181.

Striegel-Moore, R. H., Dohm, F., Pike, K. M., Wilfley, D. E., & Fairburn, C. G. (2002). Abuse, bullying, and discrimination as risk factors for binge eating disorder. *American Journal of Psychiatry, 159*(11), 1902-1907.

Striegel-Moore, R. H., Franko, D. L., Thompson, D., Barton, B., Schreiber, G. B., & Daniels, S. R. (2005). An empirical study of the typology of bulimia nervosa and its spectrum variants. *Psychological Medicine, 35*(11), 1563-1572.

Striegel-Moore, R. H., Silberstein, L. R., & Rodin, J. (1986). Toward an understanding of risk factors for bulimia. *American Psychologist, 41*(3), 246.

Striegel-Moore, R. H., Silberstein, L. R., & Rodin, J. (1993). The social self in bulimia nervosa: Public self-consciousness, social anxiety, and perceived fraudulence. *Journal of Abnormal Psychology, 102*(2), 297.

Striegel-Moore, R., & Bulik, C. M. (2007). Risk factors for eating disorders. *American Psychologist, 62*(3), 181-198.

Striegel-Moore, R., Franko, D. L., & Garcia, J. (2009). The validity and clinical utility of night eating syndrome. *International Journal of Eating Disorders, 42*(8), 720-738.

Striegel-Moore, R., Wilson, G. T., DeBar, L., Perrin, N., Lynch, F., Rosselli, F., & Kraemer, H. C. (2010). Cognitive behavioral guided self-help for the treatment of recurrent binge eating. *Journal of Consulting and Clinical Psychology, 78*(3), 312-321.

Striegel-Moore, R., & Wonderlich, S. (2007). Diagnosis and classification of eating disorders: Finding the way forward. *International Journal of Eating Disorders, 40*, S1.

Strober, M., Freeman, R., Lampert, C., & Diamond, J. (2007). The association of anxiety disorders and obsessive compulsive personality disorder with anorexia nervosa: Evidence from a family study with discussion of nosological and neurodevelopmental implications. *International Journal of Eating Disorders, 40*(S3), S46-S51.

Strober, M., Freeman, R., Lampert, C., Diamond, J., & Kaye, W. (2000). Controlled family study of anorexia nervosa and bulimia nervosa: Evidence of shared liability and transmission of partial syndromes. *American Journal of Psychiatry, 157*(3), 393-401.

Strober, M., & Humphrey, L. L. (1987). Familial contributions to the etiology and course of anorexia nervosa and bulimia. *Journal of Consulting and Clinical Psychology, 55*(5), 654-659.

Strober, M., & Johnson, C. (2012). The need for complex ideas in anorexia nervosa: Why biology, environment, and psyche all matter, why therapists make mistakes, and why clinical benchmarks are needed for managing weight correction. *International Journal of Eating Disorders, 45*(2), 155-178.

Strober, M., & Peris, T. (2011). The role of the family environment in etiology. *Eating Disorders in Children and Adolescents: A Clinical Handbook,* , 34-60.

Strong, K. G., & Huon, G. F. (1998). An evaluation of a structural model for studies of the initiation of dieting among adolescent girls.*Journal of Psychosomatic Research, 44*(3), 315-326.

Strother, E., Lemberg, R., Stanford, S. C., & Turberville, D. (2012). Eating disorders in men: Underdiagnosed, undertreated, and misunderstood. *Eating Disorders, 20*(5), 346-355.

Stunkard, A. J. (1980). Psychoanalysis and psychotherapy. *Obesity,* , 355-368.

StunKard, A. J., & Allison, K. C. (2003). Binge eating disorder: Disorder or marker? *International Journal of Eating Disorders, 34*, S107-S116.

Suisman, J. L., Alexandra Burt, S., McGue, M., Lacono, W. G., & Klump, K. L. (2011). Parental divorce and disordered eating: An investigation of a gene-environment interaction. *International Journal of Eating Disorders, 44*(2), 169-177.

Sullivan, H. S. (1950). The illusion of personal individuality. *Psychiatry, 13*(3), 317-332.

Sullivan, H. S. (1953). The interpersonal theory of psychiatry, New York (WW Norton) 1953.

Sullivan, P. F., Bulik, C. M., Carter, F. A., Gendall, K. A., & Joyce, P. R. (1996). The significance of a prior history of anorexia in bulimia nervosa. *International Journal of Eating Disorders, 20*(3), 253-261.

Sullivan, P. F., Bulik, C. M., Fear, J. L., & Pickering, A. (1998). Outcome of anorexia nervosa: A case-control study. *American Journal of Psychiatry,*

Sundgot-Borgen, J., Rosenvinge, J. H., Bahr, R., & Schneider, L. S. (2002). The effect of exercise, cognitive therapy, and nutritional counseling in treating bulimia nervosa. *Medicine and Science in Sports and Exercise, 34*(2), 190-195.

Sutandar-Pinnock, K., Blake Woodside, D., Carter, J. C., Olmsted, M. P., & Kaplan, A. S. (2003). Perfectionism in anorexia nervosa: A 6–24-month follow-up study. *International Journal of Eating Disorders, 33*(2), 225-229.

Sutton, S. (2001). Back to the drawing board? A review of applications of the transtheoretical model to substance use. *Addiction, 96*(1), 175-186.

Swanson, H., Power, K., Collin, P., Deas, S., Paterson, G., Grierson, D., . . . Taylor, L. (2010). The relationship between parental bonding, social problem solving and eating pathology in an anorexic inpatient sample. *European Eating Disorders Review, 18*(1), 22-32.

Swarr, A. E., & Richards, M. H. (1996). Longitudinal effects of adolescent girls' pubertal development, perceptions of pubertal timing, and parental relations on eating problems. *Developmental Psychology, 32*(4), 636.

Sweetingham, R., & Waller, G. (2008). Childhood experiences of being bullied and teased in the eating disorders. *European Eating Disorders Review, 16*(5), 401-407.

Swinbourne, J. M., & Touyz, S. W. (2007). The co-morbidity of eating disorders and anxiety disorders: A review. *European Eating Disorders Review, 15*(4), 253-274.

Sysko, R., & Hildebrandt, T. (2009). Cognitive-behavioural therapy for individuals with bulimia nervosa and a co-occurring substance use disorder. *European Eating Disorders Review, 17*(2), 89-100.

Sysko, R., Roberto, C. A., Barnes, R. D., Grilo, C. M., Attia, E., & Walsh, B. T. (2012). Test–retest reliability of the proposed DSM-5 eating disorder diagnostic criteria. *Psychiatry Research, 196*(2–3), 302-308.

Sysko, R., & Walsh, B. T. (2008). A critical evaluation of the efficacy of self-help interventions for the treatment of bulimia nervosa and binge-eating disorder. *International Journal of Eating Disorders, 41*(2), 97-112.

Szabo, C. P., & le Grange, D. (2001). Eating disorders and the politics of identity: The South African experience. *Eating Disorders and Cultures in Transition,* , 24-33.

Szabo, C. P., le Grange, D., Nasser, M., Katzman, M., & Gordon, R. (2001). Eating disorders and the politics of identity: The South African experience. *Eating Disorders and Cultures in Transition,* , 24-33.

Szabo, C. P., & Hollands, C. (1997). Factors influencing eating attitudes in secondary-school girls in South Africa--a preliminary study. *South African Medical Journal, 87*(4 Suppl), 531-534.

Szabo, C. P. (1999). Eating attitudes among black South Africans. *The American Journal of Psychiatry, 156*(6), 981-982.

Tagami, T., Satoh, N., Usui, T., Yamada, K., Shimatsu, A., & Kuzuya, H. (2004). Adiponectin in anorexia nervosa and bulimia nervosa. *The Journal of Clinical Endocrinology & Metabolism, 89*(4), 1833-1837.

Tagay, S., Schlegl, S., & Senf, W. (2010). Traumatic events, posttraumatic stress symptomatology and somatoform symptoms in eating disorder patients. *European Eating Disorders Review, 18*(2), 124-132.

Tamburrino, M. B., & McGinnis, R. A. (2002). Anorexia nervosa. A review. *Panminerva Medica, 44*(4), 301-311.

Tamminen, A. W., & Smaby, M. H. (1981). Helping counselors learn to confront. *Personnel & Guidance Journal, 60*(1)

Tan, J. O., Hope, T., Stewart, A., & Fitzpatrick, R. (2003). Control and compulsory treatment in anorexia nervosa: the views of patients and parents. *International journal of law and psychiatry*.

Tanaka, M., Naruo, T., Nagai, N., Kuroki, N., Shiiya, T., Nakazato, M., Nozoe, S. (2003). Habitual binge/purge behavior influences circulating ghrelin levels in eating disorders. *Journal of Psychiatric Research, 37*(1), 17-22.

Tanner, J. (1989). Fetus into man: Physical growth from conception to maturity. 2nd edn ed: Castlemead. *Ware, UK.*

Tanofsky-Kraff, M., Morgan, C. M., Yanovski, S. Z., Marmarosh, C., Wilfley, D. E., & Yanovski, J. A. (2003). Comparison of assessments of children's eating-disordered behaviors by interview and questionnaire. *International Journal of Eating Disorders, 33*(2), 213-224.

Tanofsky-Kraff, M., Shomaker, L. B., Young, J. F., & Wilfley, D. E. (2016). Interpersonal psychotherapy for the prevention of excess weight gain and eating disorders: A brief case study. *Psychotherapy*, *53*(2), 188-194.

Tanofsky-Kraff, M., Wilfley, D. E., Young, J. F., Mufson, L., Yanovski, S. Z., Glasofer, D. R., Schvey, N. A. (2010). A pilot study of interpersonal psychotherapy for preventing excess weight gain in adolescent girls at-risk for obesity. *International Journal of Eating Disorders, 43*(8), 701-706.

TANTILLO, M., MACDOWELL, S., ANSON, E., TAILLIE, E., & COLE, R. (2009). Combining supported housing and partial hospitalization to improve eating disorder symptoms, perceived health status, and health related quality of life for women with eating disorders.*Eating Disorders, 17*(5), 385-399.

Tasca, G. A. (2016). Relationship-focused psychotherapies for eating disorders come of age. *Psychotherapy, 53*(2), 216–219.

Tasca, G. A., & Balfour, L. (2014a). Attachment and eating disorders: A review of current research. *International Journal of Eating Disorders, 47*(7), 710-717.

Tasca, G. A., Ritchie, K., Conrad, G., Balfour, L., Gayton, J., Lybanon, V., & Bissada, H. (2006). Attachment scales predict outcome in a randomized controlled trial of two group therapies for binge eating disorder: An aptitude by treatment interaction. *Psychotherapy Research, 16*(1), 106-121.

Tasca, G. A., Szadkowski, L., Illing, V., Trinneer, A., Grenon, R., Demidenko, N., Bissada, H. (2009). Adult attachment, depression, and eating disorder symptoms: The mediating role of affect regulation strategies. *Personality and Individual Differences, 47*(6), 662-667.

Tasca, G. A., Demidenko, N., Krysanski, V., Bissada, H., Illing, V., Gick, M., Balfour, L. (2009). Personality dimensions among women with an eating disorder: Towards reconceptualizing DSM. *European Eating Disorders Review, 17*(4), 281-289.

Tasca, G. A., Illing, V., Balfour, L., Krysanski, V., Demidenko, N., Nowakowski, J., & Bissada, H. (2009). Psychometric properties of self-monitoring of eating disorder urges among treatment seeking women: Ecological momentary assessment using a daily diary method. *Eating Behaviors, 10*(1), 59-61.

Tasca, G. A., Kowal, J., Balfour, L., Ritchie, K., Virley, B., & Bissada, H. (2006). An attachment insecurity model of negative affect among women seeking treatment for an eating disorder. *Eating Behaviors, 7*(3), 252-257.

Tasca, G. A., Ritchie, K., & Balfour, L. (2011). Implications of attachment theory and research for the assessment and treatment of eating disorders. *Psychotherapy, 48*(3), 249-259.

Tatham, M. (2011). The role of imagery-based techniques in cognitive–behavioural therapy for adults with eating disorders. *Clinical Psychology Review, 31*(7), 1101-1109.

Taylor, C. D., Bee, P., & Haddock, G. (2016). Does schema therapy change schemas and symptoms? A systematic review across mental health disorders. *Psychology and Psychotherapy: Theory, Research and Practice, 90*(3), 456-479.

Taylor, G. J. (1994). The alexithymia construct: Conceptualization, validation, and relationship with basic dimensions of personality. *New Trends in Experimental & Clinical Psychiatry, 10(2), 61-74.*

Taylor, G. J., Bagby, R. M., & Parker, J. D. (1991). The alexithymia construct: A potential paradigm for psychosomatic medicine. *Psychosomatics, 32*(2), 153-164.

Taylor, G. J., Bagby, R. M., & Parker, J. D. (1999). *Disorders of affect regulation: Alexithymia in medical and psychiatric illness* Cambridge University Press.

Taylor, J. Y., Caldwell, C. H., Baser, R. E., Faison, N., & Jackson, J. S. (2007). Prevalence of eating disorders among blacks in the national survey of American life. *International Journal of Eating Disorders, 40*, S10-S14.

Taylor, R., Lovibond, P. F., Nicholas, M. K., Cayley, C., & Wilson, P. H. (2005). The utility of somatic items in the assessment of depression in patients with chronic pain: A comparison of the zung self-rating depression scale and the depression anxiety stress scales in chronic pain and clinical and community samples. *The Clinical Journal of Pain, 21*(1), 91-100.

Tchanturia, K., Campbell, l. C., Morris, R., & Treasure, J. (2005). Neuropsychological studies in anorexia nervosa. *International Journal of Eating Disorders, 37*, 72-76.

Tchanturia, K., Davies, H., Lopez, C., Schmidt, U., Treasure, J., & Wykes, T. (2008). Letter to the editor: Neuropsychological task performance before and after cognitive remediation in anorexia nervosa: A pilot case-series. *Psychological Medicine, 38*(09), 1371-1373.

Teasdale, J. D. (1993). Emotion and two kinds of meaning: Cognitive therapy and applied cognitive science. *Behaviour Research and Therapy, 31*(4), 339-354.

Teddlie, C., & Tashakkori, A. (2009). *Foundations of mixed methods research: Integrating quantitative and qualitative approaches in the social and behavioral sciences* Sage Publications Inc.

Telch, C. F., Agras, W. S., & Linehan, M. M. (2000). Group dialectical behavior therapy for binge-eating disorder: A preliminary, uncontrolled trial. *Behavior Therapy, 31*(3), 569-582.

Telch, C. F., Agras, W. S., & Linehan, M. M. (2001). Dialectical behavior therapy for binge eating disorder. *Journal of Consulting and Clinical Psychology, 69*(6), 1061.

Terence Wilson, G., & Schlam, T. R. (2004). The transtheoretical model and motivational interviewing in the treatment of eating and weight disorders. *Clinical Psychology Review, 24*(3), 361-378.

Tereno, S., Soares, I., Martins, C., Celani, M., & Sampaio, D. (2008). Attachment styles, memories of parental rearing and therapeutic bond: A study with eating disordered patients, their parents and therapists. *European Eating Disorders Review, 16*(1), 49-58.

Teusch, R. (2012). *Sado-masochistic relations between ego and superego in anorexic patients*. Scientific Paper presented at the 101st Annual Meeting of the American Psychoanalytic Association, Chicago, IL.

Teyber, E. (2000). *Interpersonal process in psychotherapy: A relational approach* Wadsworth Publishing Company.

Thackwray, D. E., Smith, M. C., Bodfish, J. W., & Meyers, A. W. (1993). A comparison of behavioral and cognitive-behavioral interventions for bulimia nervosa. *Journal of Consulting and Clinical Psychology, 61*(4), 639-645.

The McKnight Investigators. (2003). Risk factors for the onset of eating disorders in adolescent girls: Results of the Mcknight longitudinal risk factor study. *American Journal of Psychiatry*, *160*(2), 248-254.

Theander, S. S. (2006). How to use PubMed/medline to retrieve literature on eating disorders: A manual to be studied at the computer. *European Eating Disorders Review, 14*(5), 281-288.

Thelen, M. H., Mintz, L. B., & Vander Wal, J. S. (1996). The bulimia Test—Revised: Validation with DSM-IV criteria for bulimia nervosa. *Psychological Assessment, 8*(2), 219-221.

Thelen, M. H., Lawrence, C. M., & Powell, A. L. (2013). Body image, weight control, and eating disorders among children. Paper presented at the *The Etiology of Bulimia Nervosa: The Individual and Familial Context: Material Arising from the Second Annual Kent Psychology Forum, Kent, October 1990,* 81.

Thimm, J. C. (2010a). Mediation of early maladaptive schemas between perceptions of parental rearing style and personality disorder

Thimm, J. C. (2011a). Corrigendum to "Mediation of early maladaptive schemas between perceptions of parental rearing style and personality disorder symptoms" *Journal of Behavior Therapy and Experimental Psychiatry, 42*(4), 518.

Thimm, J. C. (2011b). Incremental validity of maladaptive schemas over five-factor model facets in the prediction of personality disorder symptoms. *Personality and Individual Differences, 50*(6), 777-782.

Thoma, H. (1967). Anorexia nervosa New York: Int.

Thomas, E., & Magilvy, J. K. (2011). Qualitative rigor or research validity in qualitative research. *Journal for Specialists in Pediatric Nursing, 16*(2), 151-155.

Thomas, J. G., Bond, D. S., Sarwer, D. B., & Wing, R. R. (2011). Technology for behavioral assessment and intervention in bariatric surgery. *Surgery for Obesity and Related Diseases, 7*(4), 548-557.

Thomas, J. J., Hartmann, A. S., & Killgore, W. D. (2013). Non-fat-phobic eating disorders: why we need to investigate implicit associations and neural correlates.

Thomas, J. J., Vartanian, L. R., & Brownell, K. D. (2009). The relationship between eating disorder not otherwise specified (EDNOS) and officially recognized eating disorders: Meta-analysis and implications for DSM. *Psychological Bulletin, 135*(3), 407-433.

Thompson, J. K., Heinberg, L. J., Altabe, M., & Tantleff-Dunn, S. (1999). *Exacting beauty: Theory, assessment, and treatment of body image disturbance.* American Psychological Association.

Thompson-Brenner, H., & Westen, D. (2005). Personality subtypes in eating disorders: Validation of a classification in a naturalistic sample. *The British Journal of Psychiatry, 186*(6), 516-524.

Thompson-Brenner, H. (2016a). Improving psychotherapy for anorexia nervosa: Introduction to the special section on innovative treatment approaches. *Psychotherapy, 53*(2), 220.

Thompson-Brenner, H. (2016b). Relationship-focused therapy for bulimia and binge eating: Introduction to the special section. *Psychotherapy, 53*(2), 185.

Thompson-Brenner, H., Eddy, K. T., Franko, D. L., Dorer, D., Vashchenko, M., & Herzog, D. B. (2008). Personality pathology and substance abuse in eating disorders: A longitudinal study. *International Journal of Eating Disorders, 41*(3), 203-208.

Thompson-Brenner, H., Weingeroff, J., & Westen, D. (2009). *Empirical support for psychodynamic psychotherapy for eating disorders.* Springer.

Thomsen, S. R., Weber, M. M., & Brown, L. B. (2002). The relationship between reading beauty and fashion magazines and the use of pathogenic dieting methods among adolescent females/steven R. *Thomsen, Michelle M.Weber and Lora Beth Brown,*

Thyme, K. E., Sundin, E. C., Stahlberg, G., Lindstrom, B., Eklof, H., & Wiberg, B. (2007). The outcome of short-term psychodynamic art therapy compared to short-term psychodynamic verbal therapy for depressed women. *Psychoanalytic Psychotherapy, 21*(3), 250-264.

Tierney, S., & Fox, J. R. E. (2009). Chronic anorexia nervosa: A delphi study to explore practitioners' views. *International Journal of Eating Disorders, 42*(1), 62-67.

Tierney, S., & Fox, J. R. (2010). Living with the anorexic voice: A thematic analysis. *Psychology and Psychotherapy: Theory, Research and Practice, 83*(3), 243-254.

Tiggemann, M., & Slater, A. (2013). NetGirls: The internet, facebook, and body image concern in adolescent girls. *International Journal of Eating Disorders, 46*(6), 630-633.

Tiller, J. M., Sloane, G., Schmidt, U., Troop, N., Power, M., & Treasure, J. L. (1997). Social support in patients with anorexia nervosa and bulimia nervosa. *International Journal of Eating Disorders, 21*(1), 31-38.

Timulak, L., & Elliott, R. (2003). Empowerment events in process-experiential psychotherapy of depression: An exploratory qualitative analysis. *Psychotherapy Research, 13*(4), 443-460.

Tobin, D. L., Johnson, C. L., & Johnson, C. L. (1991). Psychodynamic treatment of anorexia nervosa and bulimia. *The Integration of Psychodynamic and Behaviour Therapy in the Treatment of Eating Disorders: Clinical Issues Versus Theoretical Mystique,* , 374-397.

Tobin, D. L., Banker, J. D., Weisberg, L., & Bowers, W. (2007). I know what you did last summer (and it was not CBT): A factor analytic model of international psychotherapeutic practice in the eating disorders. *International Journal of Eating Disorders, 40*(8), 754-757.

Tobin, S. A. (1971). Saying goodbye in gestalt therapy. *Psychotherapy: Theory, Research & Practice, 8*(2), 150.

Touyz, S., Le Grange, D., Lacey, H., Hay, P., Smith, R., Maguire, S., Crosby, R. D. (2013). Treating severe and enduring anorexia nervosa: A randomized controlled trial. *Psychological Medicine, 43*(12), 2501-2511.

Touyz, S. W. (1994). Diagnoses of eating or dieting disorders: What may we learn from past mistakes? *International Journal of Eating Disorders, 16*(4), 349-362.

Touyz, S., Thornton, C., Rieger, E., George, L., & Beumont, P. (2003). The incorporation of the stage of change model in the day hospital treatment of patients with anorexia nervosa. *European Child & Adolescent Psychiatry, 12*

Tovée, M. J., Swami, V., Furnham, A., & Mangalparsad, R. (2006). Changing perceptions of attractiveness as observers are exposed to a different culture. *Evolution and Human Behavior, 27*(6), 443-456.

Tozzi, F., Thornton, L. M., Klump, K. L., Fichter, M. M., Halmi, K. A., Kaplan, A. S., . . . Kaye, W. H. (2005). Symptom fluctuation in eating disorders: Correlates of diagnostic crossover. *American Journal of Psychiatry, 162*(4), 732-740.

Tozzi, F., Aggen, S. H., Neale, B. M., Anderson, C. B., Mazzeo, S. E., Neale, M. C., & Bulik, C. M. (2004). The structure of perfectionism: A twin study. *Behavior Genetics, 34*(5), 483-494.

Tozzi, F., Sullivan, P. F., Fear, J. L., McKenzie, J., & Bulik, C. M. (2003). Causes and recovery in anorexia nervosa: The patient's perspective. *International Journal of Eating Disorders, 33*(2), 143-154.

Trace, S. E., Baker, J. H., Peñas-Lledó, E., & Bulik, C. M. (2013). The genetics of eating disorders. *Annual Review of Clinical Psychology, 9*, 589-620.

Treadwell, T. W., Dartnell, D., Travaglini, L. E., Staats, M., & Devinney, K. (2016). *Group therapy workbook: Integrating cognitive behavioral therapy with psychodramatic theory and practice* Outskirts Press.

Treasure, J., Sepulveda, A. R., MacDonald, P., Whitaker, W., Lopez, C., Zabala, M., . . . Todd, G. (2008). The assessment of the family of people with eating disorders. *European Eating Disorders Review, 16*(4), 247-255.

Treasure, J. (1997). *Clinician's guide to breaking free from anorexia nervosa: A survival guide for families, friends and sufferers* Psychology.

Treasure, J. (2004). Motivational interviewing. *Advances in Psychiatric Treatment, 10*(5), 331-337.

Treasure, J. (2010). Understanding models of health behaviours and the processes used to facilitate change. *The Clinician's Guide to Collaborative Caring in Eating Disorders.the New Maudsley Method,* , 84-103.

Treasure, J. (2012). Emotion in eating disorders. *European Eating Disorders Review, 20*(6), 429-430.

Treasure, J. L., Katzman, M., Schmidt, U., Troop, N., Todd, G., & de Silva, P. (1999). Engagement and outcome in the treatment of bulimia nervosa: First phase of a sequential design comparing motivation enhancement therapy and cognitive behavioural therapy. *Behaviour Research and Therapy, 37*(5), 405-418.

Treasure, J. L., Schmidt, U. H., & Troop, N. A. (2000). Cognitive analytic therapy and the transtheoretical framework. *Comparative Treatments for Eating Disorders,* , 283-308.

Treasure, J., & Cardi, V. (2017). Anorexia nervosa, theory and treatment: Where are we 35 years on from Hilde Bruch's foundation lecture? *European Eating Disorders Review, 25*(3), 139-147.

Treasure, J., Corfield, F., & Cardi, V. (2012). A three-phase model of the social emotional functioning in eating disorders. *European Eating Disorders Review, 20*(6), 431-438.

Treasure, J., & Holland, A. (1989). Genetic vulnerability to eating disorders: Evidence from twin and family studies. *Child and Youth Psychiatry: European Perspectives,* , 59-68.

Treasure, J., Macare, C., Mentxaka, I. O., & Harrison, A. (2010). The use of a vodcast to support eating and reduce anxiety in people with eating disorder: A case series. *European Eating Disorders Review, 18*(6), 515-521.

Treasure, J., & Schmidt, U. (2001). Ready, willing and able to change: Motivational aspects of the assessment and treatment of eating disorders. *European Eating Disorders Review, 9*(1), 4-18.

Treasure, J., & Schmidt, U. (2008). Motivational interviewing in the management of eating disorders. *Motivational Interviewing in the Treatment of Psychological Problems,* , 194-224.

Treasure, J., & Schmidt, U. (2013a). *Clinician's guide: Getting better bit (e) by bit (e): A survival kit for sufferers of bulimia nervosa and binge eating disorders* Routledge.

Treasure, J., Schmidt, U., & Macdonald, P. (2009). *The clinician's guide to collaborative caring in eating disorders: The new Maudsley method* Routledge.

Treasure, J., Schmidt, U., & van Furth, E. (2005). *The essential handbook of eating disorders* John Wiley & Sons.

Treasure, J., & Schmidt, U. (2013). The cognitive-interpersonal maintenance model of anorexia nervosa revisited: A summary of the evidence for cognitive, socio-emotional and interpersonal predisposing and perpetuating factors. *Journal of Eating Disorders*, *1*(1).

Treasure, J., Todd, G., Brolly, M., Tiller, J., Nehmed, A., & Denman, F. (1995). A pilot study of a randomised trial of cognitive analytical therapy vs educational behavioral therapy for adult anorexia nervosa. *Behaviour Research and Therapy, 33*(4), 363-367.

Treat, T. A., McCabe, E. B., Gaskill, J. A., & Marcus, M. D. (2008). Treatment of anorexia nervosa in a specialty care continuum. *International Journal of Eating Disorders, 41*(6), 564-572.

Troisi, A., Di Lorenzo, G., Alcini, S., Nanni, R. C., Di Pasquale, C., & Siracusano, A. (2006). Body dissatisfaction in women with eating disorders: Relationship to early separation anxiety and insecure attachment. *Psychosomatic Medicine, 68*(3), 449-453.

Troisi, A., Massaroni, P., & Cuzzolaro, M. (2005). Early separation anxiety and adult attachment style in women with eating disorders.*British Journal of Clinical Psychology, 44*(1), 89-97.

Troop, N. A., Allan, S., Serpell, L., & Treasure, J. L. (2008). Shame in women with a history of eating disorders. *European Eating Disorders Review, 16*(6), 480-488

Troop, N. A., Allan, S., Treasure, J. L., & Katzman, M. (2003). Social comparison and submissive behaviour in eating disorder patients.*Psychology and Psychotherapy: Theory, Research and Practice, 76*(3), 237-249.

Troop, N. A., Holbrey, A., & Treasure, J. L. (1998). Stress, coping, and crisis support in eating disorders. *International Journal of Eating Disorders, 24*(2), 157-166.

Trottier, K., Monson, C. M., Wonderlich, S. A., & Olmsted, M. P. (2017). Initial findings from project recover: Overcoming Co-Occurring eating disorders and posttraumatic stress disorder through integrated treatment. *Journal of Traumatic Stress, 30*(2), 173-177.

Trull, T. J., & Durrett, C. A. (2005). Categorical and dimensional models of personality disorder. *Annu.Rev.Clin.Psychol., 1*, 355-380.

Turner, H., & Bryant-Waugh, R. (2004). Eating disorder not otherwise specified (EDNOS): Profiles of clients presenting at a community eating disorder service. *European Eating Disorders Review, 12*, 18-26.

Turner, H. M., Rose, K. S., & Cooper, M. J. (2005). Parental bonding and eating disorder symptoms in adolescents: The meditating role of core beliefs. *Eating Behaviors, 6*(2), 113-118.

Turner, H., Bryant-Waugh, R., & Peveler, R. (2009). An approach to sub-grouping the eating disorder population: Adding attachment and coping style. *European Eating Disorders Review, 17*(4), 269-280.

Turner, H., Bryant-Waugh, R., & Peveler, R. (2010a). The clinical features of EDNOS: Relationship to mood, health status and general functioning. *Eating Behaviors, 11*(2), 127-130.

Ulfvebrand, S., Birgegård, A., Norring, C., Högdahl, L., & von Hausswolff-Juhlin, Y. (2015). Psychiatric comorbidity in women and men with eating disorders results from a large clinical database. *Psychiatry Research, 230*(2), 294-299.

Unoka, Z., Tölgyes, T., & Czobor, P. (2007). Early maladaptive schemas and body mass index in subgroups of eating disorders: A differential association. *Comprehensive Psychiatry, 48*(2), 199-204.

Urgesi, C., Fornasari, L., De Faccio, S., Perini, L., Mattiussi, E., Ciano, R., . . . Brambilla, P. (2011). Body schema and self-representation in patients with bulimia nervosa. *International Journal of Eating Disorders, 44*(3), 238-248.

Vajda, A., & Láng, A. (2014). Emotional abuse, neglect in eating disorders and their relationship with emotion regulation. *Procedia-Social and Behavioral Sciences, 131*, 386-390.

Valderas, J. M., Starfield, B., Sibbald, B., Salisbury, C., & Roland, M. (2009). Defining comorbidity: implications for understanding health and health services. *The Annals of Family Medicine*, *7*(4), 357-363.

Vallejo, M. A., Jordán, C. M., Díaz, M. I., Comeche, M. I., & Ortega, J. (2007). Psychological assessment via the internet: A reliability and validity study of online (vs papeAN-rd-pencil) versions of the general health questionnaire-28 (GHQ-28) and the symptoms check-list-90-revised (SCL-90-R). *Journal of Medical Internet Research, 9*(1), e2.

Van Breda, A. E. (2008). *Binge eating: An exploratory study of a group of South African women* .

van den Broek, E., Keulen-de Vos, M., & Bernstein, D. P. (2011a). Arts therapies and schema focused therapy: A pilot study. *The Arts in Psychotherapy, 38*(5), 325-332.

Van der Kolk, Bessel A. (1994). The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress. *Harvard Review of Psychiatry, 1*(5), 253-265.

Van der Kolk, Bessel A. (2017). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals, 35*(5), 401-408.

van Deth, R., & Vanderreycken, W. (1991). Was nervous consumption a precursor of anorexia nervosa? *The Journal of the History of Medicine and Allied Sciences, 46*, 3-19.

van Genderen, H. (2012). Case conceptualization in schema therapy. *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice,* , 125-141.

van Genderen, H., Rijkeboer, M., & Arntz, A. (2012). Theoretical model. *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research and Practice,* , 27.

van Gerko, K., Hughes, M. L., Hamill, M., & Waller, G. (2005). Reported childhood sexual abuse and eating-disordered cognitions and behaviors. *Child Abuse & Neglect, 29*(4), 375-382.

van Hoeken, D., Burns, J. K., & Hoek, H. W. (2016). Epidemiology of eating disorders in Africa. *Current Opinion in Psychiatry, 29*(6), 372-377.

van Hoeken, D., Veling, W., Sinke, S., Mitchell, J. E., & Hoek, H. W. (2009). The validity and utility of subtyping bulimia nervosa. *International Journal of Eating Disorders, 42*(7), 595-602.

van Vlierberghe, L., Braet, C., & Goossens, L. (2009). Dysfunctional schemas and eating pathology in overweight youth: A case–control study. *International Journal of Eating Disorders, 42*(5), 437-442. doi:10.1002/eat.20638

van Vreeswijk, M., & Broersen, J. (2006). *Schemagerichte therapie in groepen: Handleiding vor therapeuten*. Houten, Netherlands: Bohn Stafleu van Loghum

van Vreeswijk, M., Broersen, J., Bloo, J., & Haeyen, S. (2012). Techniques within schema therapy. *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice,* , 185-195.

van Vreeswijk, M., Broersen, J., & Nadort, M. (2015). *The wiley-blackwell handbook of schema therapy: Theory, research and practice.* John Wiley & Sons.

Vander Wal, J. S., Gibbons, J. L., & del Pilar Grazioso, M. (2008). The sociocultural model of eating disorder development: Application to a Guatemalan sample. *Eating Behaviors, 9*(3), 277-284.

Vander Wal, J. S., Waller, S. M., Klurfeld, D. M., McBurney, M. I., & Dhurandhar, N. V. (2005). Night eating syndrome: Evaluation of two screening instruments. *Eating Behaviors, 6*(1), 63-73.

Vandereycken, W. (2005). A review of: "Handbook of eating disorders, second edition, edited by Janet Treasure, Ulrike Schmidt, and eric van furth, Chichester, England". *Eating Disorders, 13*(3), 318-320.

Vandereycken, W. (2006a). Denial of illness in anorexia nervosa—a conceptual review: Part 1 diagnostic significance and assessment. *European Eating Disorders Review, 14*(5), 341-351.

Vandereycken, W. (2012). Self-change in eating disorders: Is "Spontaneous recovery" possible? *Eating Disorders, 20*(2), 87-98.

Vandereycken, W., & Devidt, K. (2010). Dropping out from a specialized inpatient treatment for eating disorders: The perception of patients and staff. *Eating Disorders, 18*(2), 140-147. doi:10.1080/10640260903585557

Vandereycken, W., & Louwies, I. (2005). "Parents for parents": A self-help project for and by parents of eating disorder patients. *Eating Disorders, 13*(4), 413-417.

Vandereycken, W., & Van Deth, R. (1994). *From fasting saints to anorexic girls: The history of self-starvation.* New York University Press.

Vandereycken, W., & Vansteenkiste, M. (2009). Let eating disorder patients decide: Providing choice may reduce early drop-out from inpatient treatment. *European Eating Disorders Review, 17*(3), 177-183.

Vanderlinden, J., Vandereycken, W., Van Dyck, R., & Vertommen, H. (1993). Dissociative experiences and trauma in eating disorders. *International Journal of Eating Disorders, 13*(2), 187-193.

Vanderlinden, J. (2008). Many roads lead to rome: Why does cognitive behavioural therapy remain unsuccessful for many eating disorder patients? *European Eating Disorders Review, 16*(5), 329-333.

Vanderlinden, J. (2010). Do different psychopathological pathways into eating disorder necessitate different therapeutic goals and/or approaches? *European Eating Disorders Review, 18*(3), 161-164.

Vansteelandt, K., Pieters, G., Vandereycken, W., Claes, L., Probst, M., & Van Mechelen, I. (2004). Hyperactivity in anorexia nervosa: A case study using experience sampling methodology. *Eating Behaviors, 5*(1), 67-74.

Vartanian, L. R. (2009). When the body defines the self: Self-concept clarity, internalization, and body image. *Journal of Social and Clinical Psychology, 28*(1), 94-126.

Vaught, A. S., Agras, W. S., Bryson, S. W., Crow, S. J., Halmi, K. A., & Mitchell, J. E. (2008). Changes in psychopathology and symptom severity in bulimia nervosa between 1993 and 2003. *International Journal of Eating Disorders, 41*(2), 113-117.

Velicer, W. F., Prochaska, J. O., Bellis, J. M., DiClemente, C. C., Rossi, J. S., Fava, J. L., & Steiger, J. H. (1993). An expert system intervention for smoking cessation. *Addictive Behaviors, 18*(3), 269-290.

Velotti, P., Garofalo, C., Bottazzi, F., & Caretti, V. (2017). Faces of shame: Implications for self-esteem, emotion regulation, aggression, and well-being. *The Journal of Psychology, 151*(2), 171-184.

Vincenzi, B., O'Toole, J., & Lask, B. (2010). PANDAS and anorexia nervosa—a spotters' guide: Suggestions for medical assessment. *European Eating Disorders Review, 18*(2), 116-123.

Vitousek, K. (2005). Alienating patients from the ''anorexic self'': Externalization and alternative strategies. Paper presented at the *International Eating Disorders Conference. London,*

Vitousek, K., & Manke, F. (1994). Personality variables and disorders in anorexia nervosa and bulimia nervosa. *Journal of Abnormal Psychology, 103*(1), 137.

Vitousek, K., Watson, S., & Wilson, G. T. (1998). Enhancing motivation for change in treatment-resistant eating disorders. *Clinical Psychology Review, 18*(4), 391-420.

Vitousek, K. B., & Hollon, S. D. (1990). The investigation of schematic content and processing in eating disorders. *Cognitive Therapy and Research, 14*(2), 191-214.

Vitousek, K. M. (1996). The current status of cognitive-behavioral models of anorexia nervosa and bulimia nervosa.

Vitousek, K. M., & Stumpf, R. E. (2005). Difficulties in the assessment of personality traits and disorders in eating-disordered individuals. *Eating Disorders, 13*(1), 37-60.

Voderholzer, U., Schwartz, C., Thiel, N., Kuelz, A. K., Hartmann, A., Scheidt, C. E., Zeeck, A. (2014). A comparison of schemas, schema modes and childhood traumas in obsessive-compulsive disorder, chronic pain disorder and eating disorders. *Psychopathology, 47*(1), 24-31.

Vollrath, M., Koch, R., & Angst, J. (1992). Binge eating and weight concerns among young adults. results from the zurich cohort study.*The British Journal of Psychiatry : The Journal of Mental Science, 160*, 498-503.

von Ranson, K. M., Klump, K. L., Lacono, W. G., & McGue, M. (2005). The Minnesota eating behavior survey: A brief measure of disordered eating attitudes and behaviors. *Eating Behaviors, 6*(4), 373-392.

Vrabel, K. R., Rosenvinge, J. H., Hoffart, A., Martinsen, E. W., & Rø, Ø. (2008). The course of illness following inpatient treatment of adults with longstanding eating disorders: A 5-year follow-up. *International Journal of Eating Disorders, 41*(3), 224-232.

Vreeswijk, M. F., Spinhoven, P., Eurelings-Bontekoe, E., & Broersen, J. (2012). Changes in symptom severity, schemas and modes in heterogeneous psychiatric patient groups following short-term schema Cognitive–Behavioural group therapy: A naturalistic pre-treatment and post-treatment design in an outpatient clinic. *Clinical Psychology & Psychotherapy,*

Waddington, L. (2002). The therapy relationship in cognitive therapy: A review. *Behavioural and Cognitive Psychotherapy, 30*(02), 179-191.

Wade, T. D. (2007). Epidemiology of eating disorders: Creating opportunities to move the current classification paradigm forward. *International Journal of Eating Disorders, 40*, S27-S30.

Wade, T. D., Byrne, S., & Bryant-Waugh, R. (2008). The eating disorder examination: Norms and construct validity with young and middle adolescent girls. *International Journal of Eating Disorders, 41*(6), 551-558.

Wade, T. D., Gillespie, N., & Martin, N. G. (2007). A comparison of early family life events amongst monozygotic twin women with lifetime anorexia nervosa, bulimia nervosa, or major depression. *International Journal of Eating Disorders, 40*(8), 679-686.

Wade, T. D., Treasure, J., & Schmidt, U. (2011). A case series evaluation of the Maudsley model for treatment of adults with anorexia nervosa. *European Eating Disorders Review, 19*(5), 382-389.

Walburg, V., & Chiaramello, S. (2015). Link between early maladaptive schemas and defense mechanisms. *Revue Européenne De Psychologie Appliquée/European Review of Applied Psychology, 65*(5), 221-226.

Waller, G. (2006). A schema-based cognitive behavioural model of the aetiology and maintenance of restrictive and bulimic pathology in the eating disorders. *Journal of Abnormal Psychology,*

Waller, G. (2008). A 'trans-transdiagnostic'model of the eating disorders: A new way to open the egg? *European Eating Disorders Review, 16*(3), 165-172.

Waller, G., Meyer, C., & Ohanian, V. (2001). Psychometric properties of the long and short versions of the young schema questionnaire: Core beliefs among bulimic and comparison women. *Cognitive Therapy and Research, 25*(2), 137-147.

Waller, G., Ormonde, L., & Kuteyi, Y. (2012). Clusters of personality disorder cognitions in the eating disorders. *European Eating Disorders Review,*

Waller, G., Sines, J., Meyer, C., Foster, E., & Skelton, A. (2007). Narcissism and narcissistic defences in the eating disorders. *International Journal of Eating Disorders, 40*(2), 143-148.

Waller, G. (1994). Childhood sexual abuse and borderline personality disorder in the eating disorders. *Child Abuse & Neglect, 18*(1), 97-101.

Waller, G. (1997). Drop-out and failure to engage in individual outpatient cognitive behavior therapy for bulimic disorders. *International Journal of Eating Disorders, 22*(1), 35-41.

Waller, G. (2003). Schema-level cognitions in patients with binge eating disorder: A case control study. *International Journal of Eating Disorders, 33*(4), 458-464.

Waller, G. (2008). A 'trans-transdiagnostic' model of the eating disorders: A new way to open the egg? *European Eating Disorders Review, 16*(3), 165-172.

Waller, G. (2012). The myths of motivation: Time for a fresh look at some received wisdom in the eating disorders? *International Journal of Eating Disorders, 45*(1), 1-16.

Waller, G., Babbs, M., Milligan, R., Meyer, C., Ohanian, V., & Leung, N. (2003). Anger and core beliefs in the eating disorders. *International Journal of Eating Disorders, 34*(1), 118-124.

Waller, G., Cordery, H., Corstorphine, E., Hinrichsen, H., Lawson, R., Mountford, V., Russell, K. (2007). *Cognitive behavioral therapy for eating disorders: A comprehensive treatment guide* Cambridge University Press.

Waller, G., Dickson, C., & Ohanian, V. (2002). Cognitive content in bulimic disorders: Core beliefs and eating attitudes. *Eating Behaviors, 3*(2), 171-178. doi:10.1016/S1471-0153(01)00056-3

Waller, G., Halek, C., & Crisp, A. H. (1993). Sexual abuse as a factor in anorexia nervosa: Evidence from two separate case series. *Journal of Psychosomatic Research, 37*(8), 873-879.

Waller, G., Hamilton, K., Rose, N., Sumra, J., & Baldwin, G. (1993). Sexual abuse and body-image distortion in the eating disorders.*British Journal of Clinical Psychology, 32*(3), 350-352.

Waller, G., Kennerley, H., & Ohanian, V. (2007). Schema-focused cognitive-behavioral therapy for eating disorders. In L. P. Riso, P. L. du Toit, D. J. Stein & J. E. Young (Eds.), *Cognitive schemas and core beliefs in psychological problems: A scientist-practitioner guide*(pp. 139-175) American Psychological Association.

Waller, G., Meyer, C., & Ohanian, V. (2001). Psychometric properties of the long and short versions of the young schema questionnaire: Core beliefs among bulimic and comparison women. *Cognitive Therapy and Research, 25*(2), 137-147.

Waller, G., Meyer, C., Ohanian, V., Elliott, P., Dickson, C., & Sellings, J. (2001). The psychopathology of bulimic women who report childhood sexual abuse: The mediating role of core beliefs. *The Journal of Nervous and Mental Disease, 189*(10), 700-708.

Waller, G., Ohanian, V., Meyer, C., & Osman, S. (2000). Cognitive content among bulimic women: The role of core beliefs. *International Journal of Eating Disorders, 28*(2), 235-241.

Waller, G., & Ruddock, A. (1995). Information-processing correlates of reported sexual abuse in eating-disordered and comparison women. *Child Abuse & Neglect, 19*(6), 745-759.

Waller, G., Shah, R., Ohanian, V., & Elliott, P. (2001). Core beliefs in bulimia nervosa and depression: The discriminant validity of young's schema questionnaire. *Behavior Therapy, 32*(1), 139-153.

Waller, G., Sines, J., Meyer, C., & Mountford, V. (2008). Body checking in the eating disorders: Association with narcissistic characteristics. *Eating Behaviors, 9*(2), 163-169.

Waller, J. V., Kaufman, M. R., & Deutsch, F. (1940). Anorexia nervosa: A psychosomatic entity. *Psychosomatic Medicine, 2*(1), 3-16.

Wallerstein, R. (1995). *The talking cures: The psychoanalyses and the psychotherapies* Yale University Press.

Wallerstein, R. S. (1989). The psychotherapy research project of the Menninger foundation: An overview. *Journal of Consulting and Clinical Psychology, 57*(2), 195.

Walsh, B. T. (2013). The enigmatic persistence of anorexia nervosa. *Perspectives, 170*(5)

Walsh, B. T., Agras, W. S., Devlin, M. J., Fairburn, C. G., Wilson, G. T., Kahn, C., & Chally, M. K. (2000). Fluoxetine for bulimia nervosa following poor response to psychotherapy. *American Journal of Psychiatry,*

Walsh, B. T. (2003). The current status of binge eating disorder. *International Journal of Eating Disorders, 34*, S1.

Walsh, B. T. (2007). DSM-V from the perspective of the DSM-IV experience. *International Journal of Eating Disorders, 40*, S3-S7. doi:10.1002/eat.20397

Walsh, B. T. (2009a). Eating disorders in DSM-V: Review of existing literature (part 1). *International Journal of Eating Disorders, 42*(7), 579-580. doi:10.1002/eat.20756

Walsh, B. T., & Sysko, R. (2009). Broad categories for the diagnosis of eating disorders (BCD-ED): An alternative system for classification. *International Journal of Eating Disorders, 42*(8), 754-764. doi:10.1002/eat.20722

Walters, E. E., & Kendler, K. S. (1995). Anorexia nervosa and anorexic-like syndromes in a population-based female twin sample. *American Journal of Psychiatry, 152*(1), 64-71.

WANDEN-BERGHE, R., SANZ-VALERO, J., & WANDEN-BERGHE, C. (2011). The application of mindfulness to eating disorders treatment: A systematic review. *Eating Disorders, 19*(1), 34-48.

Wang, C. E. A., Halvorsen, M., Eisemann, M., & Waterloo, K. (2010). Stability of dysfunctional attitudes and early maladaptive schemas: A 9-year follow-up study of clinically depressed subjects. *Journal of Behavior Therapy and Experimental Psychiatry, 41*(4), 389-396.

Ward, A., Ramsay, R., & Treasure, J. (2000). Attachment research in eating disorders. *British Journal of Medical Psychology, 73*(1), 35-51.

Ward, A., Ramsay, R., Turnbull, S., Benedettini, M., & Treasure, J. (2000). Attachment patterns in eating disorders: Past in the present.*International Journal of Eating Disorders, 28*(4), 370-376.

Ward, A., Ramsay, R., Turnbull, S., Steele, M., Steele, H., & Treasure, J. (2001). Attachment in anorexia nervosa: A transgenerational perspective. *Psychology and Psychotherapy: Theory, Research and Practice, 74*(4), 497-505.

Ward, A., Troop, N., Todd, G., & Treasure, J. (1996). To change or not to change—'How'is the question? *British Journal of Medical Psychology, 69*(2), 139-146.

Warren, C. S., Schafer, K. J., Crowley, M. E., & Olivardia, R. (2012). A qualitative analysis of job burnout in eating disorder treatment providers. *Eating Disorders, 20*(3), 175-195. doi:10.1080/10640266.2012.668476

Warren, F., Zaman, S., Dolan, B., Norton, K., & Evans, C. (2006). Eating disturbance and severe personality disorder: Outcome of specialist treatment for severe personality disorder. *European Eating Disorders Review, 14*(2), 69-78. doi:10.1002/erv.639

Wassenaar, D., Le Grange, D., Winship, J., & Lachenicht, L. (2000). The prevalence of eating disorder pathology in a cross-ethnic population of female students in South Africa. *European Eating Disorders Review, 8*(3), 225-236.

Wasserman, M. (2009). Ageing and sexuality. *Cape Town: Oshun Books*.

Watson, H. J., Raykos, B. C., Street, H., Fursland, A., & Nathan, P. R. (2011). Mediators between perfectionism and eating disorder psychopathology: Shape and weight overvaluation and conditional goal-setting. *International Journal of Eating Disorders, 44*(2), 142-149. doi:10.1002/eat.20788

Watson, J. C., Goldman, R. N., & Greenberg, L. S. (2007). *Case studies in emotion-focused treatment of depression: A comparison of good and poor outcome.* American Psychological Association.

Watson, J. C., & Greenberg, L. S. (1996). Pathways to change in the psychotherapy of depression: Relating process to session change and outcome. *Psychotherapy: Theory, Research, Practice, Training, 33*(2), 262.

Watson, M. J., Lydecker, J. A., Jobe, R. L., Enright, R. D., Gartner, A., Mazzeo, S. E., & Worthington, E. L. (2012). Self-forgiveness in anorexia nervosa and bulimia nervosa. *Eating Disorders, 20*(1), 31-41.

Watts, L. M. (2002). Inpatient nutrition care. *Eating Disorders Review, 13*(1), 6.

Watts, L. M., & Barker, D. J. (2002). Establishing an inpatient refeeding protocol. *Eating Disorders Review, 13*(2), 6.

Watts, R. E. (1999). The vision of adler: An introduction. *Interventions and Strategies in Counseling and Psychotherapy,* 1-13.

Waxman, S. E. (2009). A systematic review of impulsivity in eating disorders. *European Eating Disorders Review, 17*(6), 408-425.

Wearden, A., Peters, I., Berry, K., Barrowclough, C., & Liversidge, T. (2008). Adult attachment, parenting experiences, and core beliefs about self and others. *Personality and Individual Differences, 44*(5), 1246-1257.

Weaver, K., Wuest, J., & Ciliska, D. (2005). Understanding women's journey of recovering from anorexia nervosa. *Qualitative Health Research, 15*(2), 188-206.

Wechsler, D. (1981). *WAIS-R manual: Wechsler adult intelligence scale-revised* Psychological Corporation.

Weertman, A. (2012). The use of experiential techniques for diagnostics. *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice,* , 101-109.

Weertman, A., & Arntz, A. (2007a). Effectiveness of treatment of childhood memories in cognitive therapy for personality disorders: A controlled study contrasting methods focusing on the present and methods focusing on childhood memories. *Behaviour Research and Therapy, 45*(9), 2133-2143.

Weinstein, N. D., Rothman, A. J., & Sutton, S. R. (1998). Stage theories of health behavior: Conceptual and methodological issues.*Health Psychology, 17*(3), 290.

Weiss, K., & Wertheim, E. H. (2005). An evaluation of a prevention program for disordered eating in adolescent girls: Examining responses of high- and low-risk girls. *Eating Disorders, 13*(2), 143-156.

Weissman, M. M., & Markowitz, J. C. (1994). Interpersonal psychotherapy: Current status. *Archives of General Psychiatry, 51*(8), 599-606.

Welburn, K., Coristine, M., Dagg, P., Pontefract, A., & Jordan, S. (2002). The schema Questionnaire—Short form: Factor analysis and relationship between schemas and symptoms. *Cognitive Therapy and Research, 26*(4), 519-530.

Welch, E., Miller, J. L., Ghaderi, A., & Vaillancourt, T. (2009). Does perfectionism mediate or moderate the relation between body dissatisfaction and disordered eating attitudes and behaviors? *Eating Behaviors, 10*(3), 168-175.

Welch, S. L., Doll, H. A., & Fairburn, C. G. (1997). Life events and the onset of bulimia nervosa: A controlled study. *Psychological Medicine, 27*(03), 515-522.

Wellard, S., & McKenna, L. (2001). Turning tapes into text: Issues surrounding the transcription of interviews. *Contemporary Nurse, 11*(2-3), 180-186.

Wells, A. (2008). Metacognitive therapy: Cognition applied to regulating cognition. Behavioural and cognitive psychotherapy, 36(6), 651.

Welpton, D. F. (1973). Confrontation in the therapeutic process. *Confrontation in Psychotherapy,* , 249-269.

Wendell, J. W., Masuda, A., & Le, J. K. (2012). The role of body image flexibility in the relationship between disordered eating cognitions and disordered eating symptoms among non-clinical college students. *Eating Behaviors, 13*(3), 240-245.

Wengraf, T. (2001). *Qualitative research interviewing: Biographic narrative and semi-structured methods* Sage.

Wennerstrand, A. (2002). Catherine Baker, Editor When the Body is the Target: Self-Harm, Pain, and Traumatic Attachments. *Eating Disorders -New York then London*, *10*(3), 289-291.

Wennerstrand, A. (2009). Integrated treatment of eating disorders: Beyond the body betrayed. *Eating Disorders, 17*(3), 260-262.

Wertheim, E. H., Martin, G., Prior, M., Sanson, A., & Smart, D. (2002). Parent influences in the transmission of eating and weight related values and behaviors. *Eating Disorders, 10*(4), 321.

Wesemann, D., & Grunwald, M. (2008). Online discussion groups for bulimia nervosa: An inductive approach to internet-based communication between patients. *International Journal of Eating Disorders, 41*(6), 527-534.

Westen, D., & Harnden-Fischer, J. (2001). Personality profiles in eating disorders: Rethinking the distinction between axis I and axis II.*American Journal of Psychiatry, 158*(4), 547-562.

Westen, D., Novotny, C. M., & Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: Assumptions, findings, and reporting in controlled clinical trials. *Psychological Bulletin, 130*(4), 631.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends* WW Norton & Company.

White, W. L., & Miller, W. R. (2007). The use of confrontation in addiction treatment: History, science and time for change. *Counselor, 8*(4), 12-30.

Whiteside, U., Chen, E., Neighbors, C., Hunter, D., Lo, T., & Larimer, M. (2007). Difficulties regulating emotions: Do binge eaters have fewer strategies to modulate and tolerate negative affect? *Eating Behaviors, 8*(2), 162-169.

Whitney, J., & Eisler, I. (2005). Theoretical and empirical models around caring for someone with an eating disorder: The reorganization of family life and inter-personal maintenance factors. *Journal of Mental Health, 14*(6), 575-585.

Whitney, J., Easter, A., & Tchanturia, K. (2008). Service users' feedback on cognitive training in the treatment of anorexia nervosa: A qualitative study. *International Journal of Eating Disorders, 41*(6), 542-550.

Widiger, T. A., & Mullins-Sweatt, S. N. (2004). Categorical and dimensional models of personality disorder. In J. M. Oldham, A. E. Skodol & D. S. Bender (Eds.), *The American psychiatric publishing textbook of personality disorders.*

Widiger, T. A., & Trull, T. J. (2007). Plate tectonics in the classification of personality disorder: Shifting to a dimensional model. *American Psychologist, 62*(2), 71.

Wieczorek, M, & Brockman, ER (2016). *The schema model and core emotional needs: A self-determination theory perspective*. Master's thesis. University of Technology, Sydney

Wiese, J. E. (2009). Behavior therapy for anorexia nervosa: Taking a second look. *Eating Disorders, 17*(5), 400-408.

Wilfley, D. E., Friedman, M. A., Dounchis, J. Z., Stein, R. I., Welch, R. R., & Ball, S. A. (2000). Comorbid psychopathology in binge eating disorder: Relation to eating disorder severity at baseline and following treatment. *Journal of Consulting and Clinical Psychology*, *68*(4), 641-649.

Wilfley, D. E., Wilson, G. T., & Agras, W. S. (2003). The clinical significance of binge eating disorder. *International Journal of Eating Disorders, 34*, S96-S106.

Wild, B., Quenter, A., Friederich, H., Schild, S., Herzog, W., & Zipfel, S. (2006). A course of treatment of binge eating disorder: A time series approach. *European Eating Disorders Review, 14*(2), 79-87.

Wildes, J. E., Emery, R. E., & Simons, A. D. (2001). The roles of ethnicity and culture in the development of eating disturbance and body dissatisfaction: A meta-analytic review. *Clinical Psychology Review, 21*(4), 521-551.

Wildes, J. E., & Marcus, M. D. (2011). Development of emotion acceptance behavior therapy for anorexia nervosa: A case series. *International Journal of Eating Disorders, 44*(5), 421-427. doi:10.1002/eat.20826

Wildes, J. E., Ringham, R. M., & Marcus, M. D. (2010). Emotion avoidance in patients with anorexia nervosa: Initial test of a functional model. *International Journal of Eating Disorders, 43*(5), 398-404.

Wildes, J. E., Marcus, M. D., Cheng, Y., McCabe, E. B., & Gaskill, J. A. (2014). Emotion acceptance behavior therapy for anorexia nervosa: A pilot study. *International Journal of Eating Disorders, 47*(8), 870-873.

Wildman, P., Lilenfeld, L. R. R., & Marcus, M. D. (2004). Axis I comorbidity onset and parasuicide in women with eating disorders. *International Journal of Eating Disorders, 35*(2), 190-197.

Wilfley, D. E., Bishop, M. E., Wilson, G. T., & Agras, W. S. (2007). Classification of eating disorders: Toward DSM-V. *International Journal of Eating Disorders, 40*, S123-S129.

Wilfley, D. E., Agras, W. S., Telch, C. F., Rossiter, E. M., Schneider, J. A., Cole, A. G., . . . Raeburn, S. D. (1993). Group cognitive-behavioral therapy and group interpersonal psychotherapy for the non-purging bulimic individual: A controlled comparison. *Journal of Consulting and Clinical Psychology, 61*(2), 296.

Wilfley, D. E., Welch, R. R., Stein, R. I., Spurrell, E. B., Cohen, L. R., Saelens, B. E., Matt, G. E. (2002). A randomized comparison of group cognitive-behavioral therapy and group interpersonal psychotherapy for the treatment of overweight individuals with binge-eating disorder. *Archives of General Psychiatry, 59*(8), 713-721.

Williams, C. J., Power, K. G., Millar, H. R., Freeman, C. P., Yellowlees, A., Dowds, T., Jackson, M. A. (1993). Comparison of eating disorders and other dietary/weight groups on measures of perceived control, assertiveness, self-esteem, and self-directed hostility. *International Journal of Eating Disorders, 14*(1), 27-32.

Williams, C., & Squires, G. (2014). The session bridging worksheet: Impact on outcomes, homework adherence and participants' experience. *The Cognitive Behaviour Therapist, 7*, e4.

Williams, J., Watts, F. N., MacLeod, C., & Mathews, A. (1997). *Cognitive psychology and emotional disorders* (2nd ed.). Chichester: Wiley.

Williams, K., King, J., & Fox, J. R. (2016a). Sense of self and anorexia nervosa: A grounded theory. *Psychology and Psychotherapy: Theory,*

Williams, K. D., Dobney, T., & Geller, J. (2010). Setting the eating disorder aside: An alternative model of care. *European Eating Disorders Review, 18*(2), 90-96.

Williams, M. S., Thomsen, S. R., & McCoy, J. K. (2003). Looking for an accurate mirror: A model for the relationship between media use and anorexia. *Eating Behaviors, 4*(2), 127-134.

WILLIAMS, M., & HAVERKAMP, B. E. (2010). Identifying critical competencies for psychotherapeutic practice with eating disordered clients: A delphi study. *Eating Disorders, 18*(2), 91-109.

Williams, S., & Reid, M. (2012). 'It's like there are two people in my head': A phenomenological exploration of anorexia nervosa and its relationship to the self. *Psychology & Health, 27*(7), 798-815.

Williamson, D. A., Cubic, B. A., & Gleaves, D. H. (1993). Equivalence of body image disturbances in anorexia and bulimia nervosa. *Journal of Abnormal Psychology, 102*(1), 177-180.

Willinge, A. C., Touyz, S. W., & Thornton, C. (2010). An evaluation of the effectiveness and short-term stability of an innovative australian day patient programme for eating disorders. *European Eating Disorders Review, 18*(3), 220-233.

Wilson, C. P., Hogan, C. C., & Mintz, I. L. (1985). *Fear of being fat: The treatment of anorexia nervosa and bulimia* Jason Aronson.

Wilson, G. T. (2010a). Fairburn, CG, Marcus, MD, & Wilson, GT (1993). cognitive behaviour therapy for binge eating and bulimia nervosa: A comprehensive treatment manual. in CG Fairburn. *Graduate, 33*(1), 18.

Wilson, G. T. (2004). Acceptance and change in the treatment of eating disorders: The evolution of manual-based cognitive-behavioral therapy.

Wilson, G. T. (2010). Eating disorders, obesity and addiction. *European Eating Disorders Review, 18*(5), 341-351.

Wilson, G. T., Fairburn, C. C., Agras, W. S., Walsh, B. T., & Kraemer, H. (2002). Cognitive-behavioral therapy for bulimia nervosa: Time course and mechanisms of change. *Journal of Consulting and Clinical Psychology, 70*(2), 267.

Wilson, G. T., & Fairburn, C. G. (1998). Treatments for eating disorders.

Wilson, G. T., Fairburn, C. G., & Agras, W. S. (1997). Cognitive-behavioral therapy for bulimia nervosa.

Wilson, G. T., Grilo, C. M., & Vitousek, K. M. (2007). Psychological treatment of eating disorders. *American Psychologist, 62*(3), 199.

Wilson, G. T., & Schlam, T. R. (2004). The transtheoretical model and motivational interviewing in the treatment of eating and weight disorders. *Clinical Psychology Review, 24*(3), 361-378.

Wilson, G. T., & Shafran, R. (2005). Eating disorders guidelines from NICE. *The Lancet, 365*(9453), 79-81.

Wilson, G. T. (2010b). Eating disorders, obesity and addiction. *European Eating Disorders Review, 18*(5), 341-351.

Wilson, G. T., Fairburn, C. C., Agras, W. S., Walsh, B. T., & Kraemer, H. (2002). Cognitive-behavioral therapy for bulimia nervosa: Time course and mechanisms of change. *Journal of Consulting and Clinical Psychology, 70*(2), 267-274. doi:10.1037/0022-006X.70.2.267

Wilson, G. T., & Fairburn, C. G. (1993). Cognitive treatments for eating disorders. *Journal of Consulting and Clinical Psychology, 61*(2), 261-269. doi:10.1037/0022-006X.61.2.261

Wilson, G. T., Grilo, C. M., & Vitousek, K. M. (2007). Psychological treatment of eating disorders. *American Psychologist, 62*(3), 199-216. doi:10.1037/0003-066X.62.3.199

Wilson, G. T., Loeb, K. L., Walsh, B. T., Labouvie, E., Petkova, E., Liu, X., & Waternaux, C. (1999). Psychological versus pharmacological treatments of bulimia nervosa: Predictors and processes of change. *Journal of Consulting and Clinical Psychology, 67*(4), 451-459.

Wilson, G. T., & Sysko, R. (2006). Cognitive-behavioural therapy for adolescents with bulimia nervosa. Adapted, in part, from a paper prepared for the Annenberg foundation trust at Sunnylands', adolescent mental health initiative, and the Annenberg public policy center of.. *European Eating Disorders Review, 14*(1), 8-16.

Windelband, W. (1894). History of philosophy. *The Philosophical Review*, *3*(4), 480.

Winn, S., Perkins, S., Murray, J., Murphy, R., & Schmidt, U. (2004). A qualitative study of the experience of caring for a person with bulimia nervosa. part 2: Carers' needs and experiences of services and other support. *International Journal of Eating Disorders, 36*(3), 269-279. doi:10.1002/eat.20068

Winnicott, D. W., & Khan, M. M. R. (1965). *The maturational processes and the facilitating environment: Studies in the theory of emotional development* Hogarth Press London.

Winnicott, D. (1973). The child, the family and the outside world aspects of juvenile delinquency. *Harmondsworth. Penguin, 1973*, 227-231.

Winship, G. (2007). The ethics of reflective research in single case study inquiry. *Perspectives in Psychiatric Care, 43*(4), 174-182.

Winston, A. P., Alwazeer, A. E. F., & Bankart, M. J. G. (2008). Screening for osteoporosis in anorexia nervosa: Prevalence and predictors of reduced bone mineral density. *International Journal of Eating Disorders, 41*(3), 284-287.

Winters, N. C. (2003). Feeding problems in infancy and early childhood. *Primary Psychiatry, 10*(6), 30-47.

Wise, E. A. (2004). Methods for analyzing psychotherapy outcomes: A review of clinical significance, reliable change, and recommendations for future directions. *Journal of Personality Assessment, 82*(1), 50-59.

Wiseman, C. V., Sunday, S. R., Klapper, F., Klein, M., & Halmi, K. A. (2002). Short-term group CBT versus psycho-education on an inpatient eating disorder unit. *Eating Disorders, 10*(4), 313.

Wiser, S., & Arnow, B. (2001). Emotional experiencing: To facilitate or regulate? *Journal of Clinical Psychology, 57*(2), 157-168.

Wisniewski, L., & Kelly, E. (2003). The application of dialectical behavior therapy to the treatment of eating disorders. *Cognitive and Behavioral Practice, 10*(2), 131-138.

Wissink, L. M. (1994). A validation of transactional analysis in increasing self-esteem among participants in a self-reparenting program. *Transactional Analysis Journal, 24*(3), 189-196.

Wittchen, H., & Jacobi, F. (2005). Size and burden of mental disorders in Europe—a critical review and appraisal of 27 studies. *European Neuropsychopharmacology, 15*(4), 357-376.

Wnuk, S. M., Greenberg, L., & Dolhanty, J. (2015). Emotion-focused group therapy for women with symptoms of bulimia nervosa. *Eating Disorders, 23*(3), 253-261.

Woerwag-Mehta, S., & Treasure, J. (2008). Causes of anorexia nervosa. *Psychiatry, 7*(4), 147-151.

Wolfe, B. E., Baker, C. W., Smith, A. T., & Kelly-Weeder, S. (2009). Validity and utility of the current definition of binge eating. *International Journal of Eating Disorders, 42*(8), 674-686. doi:10.1002/eat.20728

Wolfe, B. E., Jimerson, D. C., Smith, A., & Keel, P. K. (2011). Serum amylase in bulimia nervosa and purging disorder: Differentiating the association with binge eating versus purging behavior. *Physiology & Behavior, 104*(5), 684-686.

Wolfe, B. E. (2012). Healing the research–practice split: Let's start with me. *Psychotherapy, 49*(2), 101.

Wolfert, A., & Mehler, P. S. (2002). Osteoporosis: Prevention and treatment in anorexia nervosa. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity, 7*(2), 72-81.

Wolk, S. L., & Devlin, M. J. (2001). Stage of change as a predictor of response to psychotherapy for bulimia nervosa. *International Journal of Eating Disorders, 30*(1), 96-100.

Wolpe, J. (1973). *The practice of behavior therapy.* Pergamon.

Wonderlich, S. A., Crosby, R. D., Joiner, T., Peterson, C. B., Bardon-Cone, A., Klein, M., & et al. (2005). Personality subtyping and bulimia nervosa: Psychopathological and genetic correlates. *Psychological Medicine, 35*, 649-657.

WONDERLICH, S. A., BREWERTON, T. D., JOCIC, Z., DANSKY, B. S., & ABBOTT, D. W. (1997). Relationship of childhood sexual abuse and eating disorders. *Journal of the American Academy of Child & Adolescent Psychiatry, 36*(8), 1107-1115.

Wonderlich, S. A., Crosby, R. D., Mitchell, J. E., & Engel, S. G. (2007). Testing the validity of eating disorder diagnoses. *International Journal of Eating Disorders, 40*, S40-S45.

Wonderlich, S. A., Fullerton, D., Swift, W. J., & Klein, M. H. (1994). Five-year outcome from eating disorders: Relevance of personality disorders. *International Journal of Eating Disorders, 15*(3), 233-243.

Wonderlich, S. A., Gordon, K. H., Mitchell, J. E., Crosby, R. D., & Engel, S. G. (2009). The validity and clinical utility of binge eating disorder. *International Journal of Eating Disorders, 42*(8), 687-705.

Wonderlich, S. A., Lilenfeld, L. R., Riso, L. P., Engel, S., & Mitchell, J. E. (2005). Personality and anorexia nervosa. *International Journal of Eating Disorders, 37*, 68-71.

Wonderlich, S. A., Zwaan, M. D., Mitchell, J. E., Peterson, C., & Crow, S. (2003). Psychological and dietary treatments of binge eating disorder: Conceptual implications. *International Journal of Eating Disorders, 34*, S58-S73.

Wonderlich, S. A., Crosby, R. D., Joiner, T., Peterson, C. B., Bardone-Cone, A., Klein, M., Steiger, H. (2005). Personality subtyping and bulimia nervosa: Psychopathological and genetic correlates. *Psychological Medicine, 35*(05), 649-657.

Wonderlich, S. A., Crosby, R. D., Mitchell, J. E., Thompson, K. M., Redlin, J., Demuth, G., Haseltine, B. (2001). Eating disturbance and sexual trauma in childhood and adulthood. *International Journal of Eating Disorders, 30*(4), 401-412.

Wonderlich, S. A., Rosenfeldt, S., Crosby, R. D., Mitchell, J. E., Engel, S. G., Smyth, J., & Miltenberger, R. (2007). The effects of childhood trauma on daily mood lability and comorbid psychopathology in bulimia nervosa. *Journal of Traumatic Stress, 20*(1), 77-87.

Wonderlich, S., Myers, T., Norton, M., & Crosby, R. (2002). Self-harm and bulimia nervosa: A complex connection. *Eating Disorders, 10*(3), 257-267.

Wonderlich-Tierney, A. L., & Vander Wal, J. S. (2010). The effects of social support and coping on the relationship between social anxiety and eating disorders. *Eating Behaviors, 11*(2), 85-91.

Woodside, D. B. (2005). Treatment of anorexia nervosa: More questions than answers. *International Journal of Eating Disorders, 37*, 41-42.

Wooldridge, T., & Lytle, P. (2012). An overview of anorexia nervosa in males. *Eating Disorders, 20*(5), 368-378.

Wooley, S. C., & Kearney-Cooke, A. (1986). Intensive treatment of bulimia and body–image disturbance. W: Brownell K, Foreyt J, red. handbook of eating disorders: Physiology, psychology and treatment of obesity, anorexia and bulimia.

Woolhouse, H., Knowles, A., & Crafti, N. (2012). Adding mindfulness to CBT programs for binge eating: A mixed-methods evaluation. *Eating Disorders, 20*(4), 321-339.

Workgroup for Classification of child and adolescent eating disturbances. (2007). *International Journal of Eating Disorders, 40*, S117-S122.

World Health Organization. (2002). Integrated management of cardiovascular risk.

Wright, K. M., & Hacking, S. (2012). An angel on my shoulder: A study of relationships between women with anorexia and healthcare professionals. *Journal of Psychiatric and Mental Health Nursing, 19*(2), 107-115.

Wright, M. O., Crawford, E., & Del Castillo, D. (2009). Childhood emotional maltreatment and later psychological distress among college students: The mediating role of maladaptive schemas. *Child Abuse & Neglect, 33*(1), 59-68.

Yager, J. (2002). DBT and eating disorders. *Eating Disorders Review, 13*(2), 8.

Yager, J., Rorty, M., & Rossotto, E. (1995). Coping styles differ between recovered and non-recovered women with bulimia nervosa, but not between recovered women and non-eating-disordered control subjects. *The Journal of Nervous and Mental Disease, 183*(2), 86-94.

Yalom, I. D. (1995). *The theory and practice of group psychotherapy* Basic Books.

Yanos, P. T., & Ziedonis, D. M. (2006). The patient-oriented clinician-researcher: Advantages and challenges of being a double agent. *Psychiatric Services, 57*(2), 249-253.

Yates, A. (1989). Current perspectives on the eating disorders: I. history, psychological and biological aspects. *Journal of the American Academy of Child & Adolescent Psychiatry, 28*(6), 813-828.

Yilmaz, M., Kumcagiz, H., Balci-Celik, S., & Eren, Z. (2011). Investigating communication skill of university students with respect to early maladaptive schemas. *Procedia - Social and Behavioral Sciences, 30*(0), 968-972.

Yin, R. (1994). Case study research: Design and methods. Beverly Hills.

Yin, R. K. (1989). Case study research: Design and methods, revised edition. *Applied Social Research Methods Series, 5*

Yin, R. (2010). Analytic generalization. Encyclopaedia of case study research, 1, 20-22.

Yin, R. K. (2011). *Applications of case study research* Sage.

Yin, R. K. (2013a). *Case study research: Design and methods* Sage publications.

Yin, R. K. (2013b). Validity and generalization in future case study evaluations. *Evaluation, 19*(3), 321-332.

Young, E. A., Clopton, J. R., & Bleckley, M. K. (2004). Perfectionism, low self-esteem, and family factors as predictors of bulimic behavior. *Eating Behaviors, 5*(4), 273-283.

Young, J. E. (1990). Practitioner’s Resource Series. Cognitive Therapy for Personality Disorders: A Schema-focused Approach. Sarasota, FL, England: Professional Resource Exchange, Inc.

Young, J. E., Arntz, A., Atkinson, T., Lobbestael, J., Weishaar, M. E., Van Vreeswijk, M. F., & Klokman, J. (2007a). The schema mode inventory. *New York: Schema Therapy Institute,*

Young, J. E., Arntz, A., Atkinson, T., Lobbestael, J., Weishaar, M. E., Van Vreeswijk, M. F., & Klokman, J. (2007b). The schema mode inventory (SMI). *New York: Schema Therapy Institute,*

Young, J. E. (1994). *Cognitive therapy for personality disorders: A schema-focused approach (rev* Professional Resource Press/Professional Resource Exchange.

Young, J. E., & Brown, G. (1994). Young schema questionnaire. *Cognitive Therapy for Personality Disorders: A Schema-Focused Approach*, 63-76.

Young, J. E., & Klosko, J. S. (1993). *Reinventing your life: How to break free from negative life patterns* Dutton.

Young, J. E., Klosko, J. S., & Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide* Guilford Press.

Young, J. E., & Lindemann, M. D. (1992). An integrative schema-focused model for personality disorders. *Journal of Cognitive Psychotherapy, 6*(1), 11.

Young, J., & Beck, A. T. (1980). Cognitive therapy scale: Rating manual. *Unpublished Manuscript,* , 36th.

Young, J., & Flanagan, C. (1998). Schema-focused therapy for narcissistic patients. *Disorders of Narcissism: Diagnostic, Clinical, and Empirical Implications*, 239-268.

Zabala, M. J., Macdonald, P., & Treasure, J. (2009). Appraisal of caregiving burden, expressed emotion and psychological distress in families of people with eating disorders: A systematic review. *European Eating Disorders Review, 17*(5), 338-349.

Zachrisson, H. D., & Kulbotten, G. R. (2006). Attachment in anorexia nervosa: An exploration of associations with eating disorder psychopathology and psychiatric symptoms. *Eating and Weight Disorders-Studies on Anorexia, Bulimia and Obesity, 11*(4), 163-170.

Zachrisson, H. D., & Skårderud, F. (2010a). Feelings of insecurity: Review of attachment and eating disorders. *European Eating Disorders Review: The Professional Journal of the Eating Disorders Association, 18*(2), 97-106.

Zaitsoff, S. L., Celio Doyle, A., Hoste, R. R., & le Grange, D. (2008). How do adolescents with bulimia nervosa rate the acceptability and therapeutic relationship in family-based treatment? *International Journal of Eating Disorders, 41*(5), 390-398.

Zaitsoff, S. L., & Taylor, A. (2009). Factors related to motivation for change in adolescents with eating disorders. *European Eating Disorders Review, 17*(3), 227-233.

Zanarini, M. C., Reichman, C. A., Frankenburg, F. R., Reich, D. B., & Fitzmaurice, G. (2010). The course of eating disorders in patients with borderline personality disorder: A 10-year follow-up study. *International Journal of Eating Disorders, 43*(3), 226-232.

Zanker, C. (2009). Anorexia nervosa and the body image myth. *European Eating Disorders Review, 17*(5), 327-330.

Zeigler-Hill, V., & Besser, A. (2011). Humor style mediates the association between pathological narcissism and self-esteem. *Personality and Individual Differences, 50*(8), 1196-1201.

Zeigler-Hill, V., Green, B. A., Arnau, R. C., Sisemore, T. B., & Myers, E. M. (2011). Trouble ahead, trouble behind: Narcissism and early maladaptive schemas. *Journal of Behavior Therapy and Experimental Psychiatry, 42*(1), 96-103.

Zeman, J., Cassano, M., & Adrian, M. C. (2013). Socialization influences on children's and adolescents' emotional self-regulation processes. *Handbook of Self-Regulatory Processes in Development: New Directions and International Perspectives,* , 79-106.

Zerbe, K. (2015). Psychodynamic theory of eating disorders. *The Wiley Handbook of Eating Disorders,* , 253-268.

Zerbe, K. J. (2008). *Integrated treatment of eating disorders: Beyond the body betrayed* Central European University Press.

Zerbe, K. J. (2010). Psychodynamic therapy for eating disorders. *The Treatment of Eating Disorders: A Clinical Handbook,* , 339-358.

Zerbe, K. J. (2001). The crucial role of psychodynamic understanding in the treatment of eating disorders. *Psychiatric Clinics of North America, 24*(2), 305-313.

Zhu, H., Luo, X., Cai, T., He, J., Lu, Y., & Wu, S. (2016a). Life event stress and binge eating among adolescents: The roles of early maladaptive schemas and impulsivity. *Stress and Health, 32*(4), 395-401.

Zimmerman, M., & Mattia, J. I. (1999). Axis I diagnostic comorbidity and borderline personality disorder. *Comprehensive Psychiatry, 40*(4), 245-252.

Zinker, J. (1977). *Creative process in gestalt therapy.* Brunner/Mazel.

Zipfel, S., Löwe, B., Reas, D. L., Deter, H., & Herzog, W. (2000). Long-term prognosis in anorexia nervosa: Lessons from a 21-year follow-up study. *The Lancet, 355*(9205), 721-722.

Zipfel, S., Wild, B., Groß, G., Friederich, H., Teufel, M., Schellberg, D., . . . Herpertz, S. (2014). Focal psychodynamic therapy, cognitive behaviour therapy, and optimised treatment as usual in outpatients with anorexia nervosa (ANTOP study): Randomised controlled trial. *The Lancet, 383*(9912), 127-137.

Zorn, P., Roder, V., Müller, D. R., Tschacher, W., & Thommen, M. (2007). Schemazentrierte emotiv-behaviorale therapie (SET): Eine randomisierte evaluationsstudie an patienten mit persönlichkeitsstörungen aus den clustern B und C. *Verhaltenstherapie, 17*(4), 233-241.

Zucker, N. L., Ferriter, C., Best, S., & Brantley, A. (2005). Group parent training: A novel approach for the treatment of eating disorders.*Eating Disorders, 13*(4), 391-405.

Zunker, C., Mitchell, J. E., & Wonderlich, S. A. (2011). Exercise interventions for women with anorexia nervosa: A review of the literature. *International Journal of Eating Disorders, 44*(7), 579-584.

APPENDISES

APPENDIX 1:

Table 1: The 18 Early Maladaptive Schemas within 5 Schema Domains (Edwards, 2016)

Domain One: Disconnection and Rejection

1. Abandonment/Instability Schema

The perceived instability or unreliability of those available for support and connection. Involves the sense that significant others will not be able to continue providing emotional support, connection, strength, or practical protection because they are emotionally unstable and unpredictable (e.g., angry outbursts), unreliable, or erratically present; because they will die imminently; or because they will abandon the patient in favour of someone better.

2. Mistrust/Abuse Schema

The expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence. May include the sense that one always ends up being cheated relative to others or "getting the short end of the stick."

3. Emotional Deprivation Schema

Expectation that one's desire for a normal degree of emotional support will not be adequately met by others. The three major forms of deprivation are:

(a) Deprivation of Nurturance; absence of attention, affection, warmth, or companionship.

(b) Deprivation of Empathy; absence of understanding, listening, self-disclosure, or mutual sharing of feelings from others.

(c) Deprivation of Protection; absence of strength, direction, or guidance from others.

4. Defectiveness/Shame Schema

The feeling that one is defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed. May involve hypersensitivity to criticism, rejection, and blame; self-consciousness, comparisons, and insecurity around others; or a sense of shame regarding one's perceived flaws. These flaws may be private (e.g., selfishness, angry impulses, unacceptable sexual desires) or public (e.g., undesirable physical appearance, social awkwardness).

5. Social Isolation/Instability Schema

The feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.

Domain Two: Impaired Autonomy and Performance

6. Dependence/Incompetence Schema

Belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others (e.g., take care of oneself, solve daily problems, exercise good judgment, tackle new tasks, make good decisions). Often presents as helplessness.

7. Vulnerability to Harm or Illness Schema

Exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it. Fears focus on one or more of the following:

(a) Medical Catastrophes: e.g., heart attacks, AIDS;

(b) Emotional Catastrophes: e.g., going crazy;
(c) External Catastrophes: e.g., elevators collapsing, victimized by criminals, airplane crashes, earthquakes.

8. Enmeshment/Undeveloped Self Schema
Excessive emotional involvement and closeness with one or more significant others (often parents), at the expense of full individuation or normal social development. Often involves the belief that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other. May also include feelings of being smothered by, or fused with, others or insufficient individual identity. Often experienced as a feeling of emptiness and floundering, having no direction, or in extreme cases questioning one's existence.

9. Failure to Achieve Schema
The belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, in areas of achievement (school, career, sports, etc.). Often involves beliefs that one is stupid, inept, untalented, ignorant, lower in status, less successful than others, etc.

Domain Three: Impaired Limits

10. Entitlement/Grandiosity Schema
The belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interaction. Often involves insistence that one should be able to do or have whatever one wants, regardless of what is realistic, what others consider reasonable, or the cost to others; or an exaggerated focus on superiority (e.g., being among the most successful, famous, wealthy) - in order to achieve power or control (not primarily for attention or approval). Sometimes includes excessive competitiveness toward, or domination of, others: asserting one's power, forcing one's point of view, or controlling the behaviour of others in line with one's own desires - without empathy or concern for others' needs or feelings.

11. Insufficient Self-Control/Self-Discipline Schema
Pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression of one's emotions and impulses. In its milder form, patient presents with an exaggerated emphasis on discomfort-avoidance: avoiding pain, conflict, confrontation, responsibility, or overexertion - at the expense of personal fulfillment, commitment, or integrity.

Domain Four: Other Directedness

12. Subjugation Schema
Excessive surrendering of control to others because one feels coerced - usually to avoid anger, retaliation, or abandonment. The two major forms of subjugation are:
(a) Subjugation of Needs; suppression of one's preferences, decisions, and desires.
(b) Subjugation of Emotions; suppression of emotional expression, especially anger. Usually involves the perception that one's own desires, opinions, and feelings are not valid or important to others. Frequently presents as excessive compliance, combined with hypersensitivity to feeling trapped. Generally leads to a build-up of anger, manifested in maladaptive symptoms (e.g., passive-aggressive behaviour, uncontrolled outbursts of temper, psychosomatic symptoms, withdrawal of affection, "acting out", substance abuse).

13. Self-Sacrifice Schema

Excessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one's own gratification. The most common reasons are: to prevent causing pain to others; to avoid guilt from feeling selfish; or to maintain the connection with others perceived as needy. Often results from an acute sensitivity to the pain of others. Sometimes leads to a sense that one's own needs are not being adequately met and to resentment of those who are taken care of. (Overlaps with concept of co-dependency.)

14. Approval Seeking/Recognition Seeking Schema

Excessive emphasis on gaining approval, recognition, or attention from other people, or fitting in, at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others rather than on one's own natural inclinations. Sometimes includes an overemphasis on status, appearance, social acceptance, money, or achievement - as means of gaining approval, admiration, or attention (not primarily for power or control). Frequently results in major life decisions that are inauthentic or unsatisfying; or in hypersensitivity to rejection.

Domain Five: Over-vigilance and Inhibition

15. Negativity/Pessimism Schema

A pervasive, lifelong focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc.) while minimizing or neglecting the positive or optimistic aspects. Usually includes an exaggerated expectation - in a wide range of work, financial, or interpersonal situations - that things will eventually go seriously wrong, or that aspects of one's life that seem to be going well will ultimately fall apart. Usually involves an inordinate fear of making mistakes that might lead to: financial collapse, loss, humiliation, or being trapped in a bad situation. Because potential negative outcomes are exaggerated, these patients are frequently characterized by chronic worry, vigilance, complaining, or indecision.

16. Emotional Inhibition Schema

The excessive inhibition of spontaneous action, feeling, or communication - usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses. The most common areas of inhibition involve:

(a) inhibition of anger and aggression;

(b) inhibition of positive impulses (e.g., joy, affection, sexual excitement, play);

(c) difficulty expressing vulnerability or communicating freely about one's feelings, needs, etc.; or

(d) excessive emphasis on rationality while disregarding emotions.

17. Unrelenting Standards/Hypercriticalness Schema

The underlying belief that one must strive to meet very high internalized standards of behaviour and performance, usually to avoid criticism. Typically results in feelings of pressure or difficulty slowing down; and in hypercriticalness toward oneself and others. Must involve significant impairment in: pleasure, relaxation, health, self-esteem, sense of accomplishment, or satisfying relationships. Unrelenting standards typically present as:

(a) perfectionism, inordinate attention to detail, or an underestimate of how good one's own performance is relative to the norm;

(b) rigid rules and “shoulds” in many areas of life, including unrealistically high moral, ethical, cultural, or religious precepts; or

(c) preoccupation with time and efficiency, so that more can be accomplished.

18. Punitiveness Schema

The belief that people should be harshly punished for making mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one's expectations or standards. Usually includes difficulty

forgiving mistakes in oneself or others, because of a reluctance to consider extenuating circumstances, allow for human imperfection, or empathize with feelings.

APPENDIX 2

Table 2: Personality Disorder Symptom Correlates with Early Maladaptive Schemas and Interpersonal Problems* (Ball & Cecero, 2001)

Personality Disorder	Early Maladaptive Schema	Interpersonal Problems
Paranoid	Mistrust/Abuse	Domineering Vindictive
Schizoid	Mistrust/Abuse Social isolation	Socially avoidant
Schizotypal	Mistrust/Abuse Social Isolation	Domineering
Antisocial	Mistrust/Abuse Vulnerability to harm Emotional inhibition	Domineering Vindictive Cold Exploitable (lower)
Borderline	Abandonment Mistrust/Abuse	
Histrionic	Mistrust/Abuse Social isolation Dependence/Incompetence Unrelenting standards	
Narcissistic		Over-assertiveness
Avoidant	Subjugation	Exploitable
Dependent	Abandonment Dependence/Incompetence Subjugation	Exploitable Overly nurturing
Obsessive-compulsive	Self-sacrifice (lower)	Exploitable (lower)

*Sample of 41 methadone-maintained outpatients diagnosed with PDs

APPENDIX 3:

Table 4: Schema Modes (Edwards, 2016, adapted from Lobbestael, van Vreeswijk, & Arntz, 2007).

Maladaptive Child Modes

Vulnerable child modes:

Lonely Child feels like a lonely child that is valued only insofar as she can aggrandize her parents. Because the most important emotional needs of the child have generally not been met, the patient usually feels empty, alone, socially unacceptable, undeserving of love, unloved and unlovable.

Abandoned and Abused Child feels the enormous emotional pain and fear of abandonment, which has a direct link with the abuse history. Has the affect of a lost child: sad, frightened, vulnerable, defenceless, hopeless, needy, victimized, worthless and lost. Patients appear fragile and childlike. They feel helpless and utterly alone and are obsessed with finding a parent figure who will take care of them.

Humiliated/Inferior Child is a subtype of the Abandoned and Abused Child mode, in which patients experience humiliation and inferiority related to childhood experiences within and outside the family.

Dependent Child feels incapable and overwhelmed by adult responsibilities. Shows strong regressive tendencies and wants to be taken care of. Related to the lack of development of autonomy and self-reliance, often caused by authoritarian upbringing.

Angry/Unsocialized child modes:

Angry Child feels intensely angry, enraged, infuriated, frustrated or inpatient, because the core emotional (or physical) needs of the vulnerable child are not being met. They vent their suppressed anger in inappropriate ways. May make demands that seem entitled or spoiled and that alienate others.

Enraged Child experiences intense feelings of anger that results in hurting or damaging people or objects. The displayed anger is out of control, and has the goal of destroying the aggressor, sometimes literally. Has the affect of an enraged or uncontrollable child, screaming or acting out impulsively to an (alleged) perpetrator.

Impulsive Child acts on non-core desires or impulses from moment to moment in a selfish or uncontrolled manner to get his or her own way, without regard to possible consequences for the self or others. Often has difficulty delaying short-time gratification and may appear `spoiled`.

Undisciplined Child cannot force him/herself to finish routine or boring tasks, gets quickly frustrated and gives up soon.

Surrender

Coping Modes

Compliant Surrenderer:

Acts in a passive, subservient, submissive, reassurance-seeking, or self-deprecating way towards others out of fear of conflict or rejection. Passively allows him/herself to be mistreated, or does not take steps to get healthy needs met. Selects people or engages in other behaviour that directly maintains the self-defeating schema-driven pattern.

Surrender to damaged child modes:

In these modes individuals behave as if they are like the child, with the same beliefs, emotions and behaviours as when the childhood pattern was set up.

Avoidance Coping Modes:

Detached Protector:

Withdraws psychologically from the pain of the schemas by emotionally detaching. The patient shuts off all emotions, disconnects from others and rejects their help, and functions in an almost robotic manner. May remain quite functional.

Spaced-out Protector:

Shuts off emotions by going numb or spacing out. Can give rise to an experience of being foggy or even unreal and gives rise to states of depersonalization and cognitive slowing which are dysfunctional.

Detached Self-Soother:

Shut off their emotions by engaging in activities that will somehow soothe, stimulate or distract them from feeling. These behaviours are usually undertaken in an addictive or compulsive way, and can include workaholism, gambling, dangerous sports, promiscuous sex, or drug abuse. Another group of patients compulsively engages in solitary interests that are more self-soothing than self-stimulating, such as playing computer games, overeating, watching television, or fantasizing.

Avoidant Protector:

Avoids triggering by behavioural avoidance - keeps away from situations of cues that my trigger distress.

Angry protector:

Uses a ‘wall of anger' to protect him/herself from others who are perceived as threatening. Displays of anger serve to keep others at a safe distance to protect against being hurt.

Overcompensation Coping Modes:

Attention and Approval Seeker:

Tries to get other people's attention and approval by extravagant, inappropriate and exaggerated behaviour. Usually compensates for underlying loneliness.

Self-Aggrandiser:

Behaves in an entitled, competitive, grandiose, abusive, or status-seeking way in order to have whatever they want. They are almost completely self-absorbed, and show little empathy for the needs or feelings of others. They demonstrate superiority and expect to be treated as special and do not believe they should have to follow the rules that apply to everyone else. They crave for admiration and frequently brag or behave in a self-aggrandizing manner to inflate their sense of self.

Overcontroller:

Attempts to protect self from a perceived or real threat by focusing attention, ruminating, and exercising extreme control.

- **Perfectionistic Overcontroller**: Focuses on perfectionism to attain control and prevent misfortune and criticism.
- **Suspicious Overcontroller**: Focuses on vigilance, scanning other people for signs of malevolence, and controls others' behaviour out of suspiciousness.
- **Scolding Overcontroller**: Controls the behaviour of others by blaming, criticizing, and telling them how to do things in a dictatorial and scolding manner.

Bully and Attack:

Directly harms other people in a controlled and strategic way emotionally, physically, sexually, verbally, or through antisocial or criminal acts. The motivation may be to overcompensate for prevent abuse or humiliation. Has sadistic properties.

Conning and Manipulative:

Cons, lies, or manipulates in a manner designed to achieve a specific goal, which either involves victimising others or escaping punishment.

Predator

Focuses on eliminating a threat, rival, obstacle, or enemy in a cold, ruthless, and calculating manner.

Maladaptive Parent Modes

Punitive Parent

The internalized voice of the parent, criticizing and punishing the patient. They become angry with themselves and feel that they deserve punishment for having or showing normal needs that their parents did not allow them to express. The tone of this mode is harsh, critical, and unforgiving. Signs and symptoms include self-loathing, self-criticism, self-denial, self-mutilation, suicidal fantasies, and self-destructive behaviour.

Demanding Parent

Continually pushes and pressures the child to meet excessively high standards. Feels that the `right' way to be is to be perfect or achieve at a very high level, to keep everything in order, to strive for high status, to be humble, to put other needs before one's own or to be efficient or avoid wasting time. The person feels that it is wrong to express feelings or to act spontaneously.

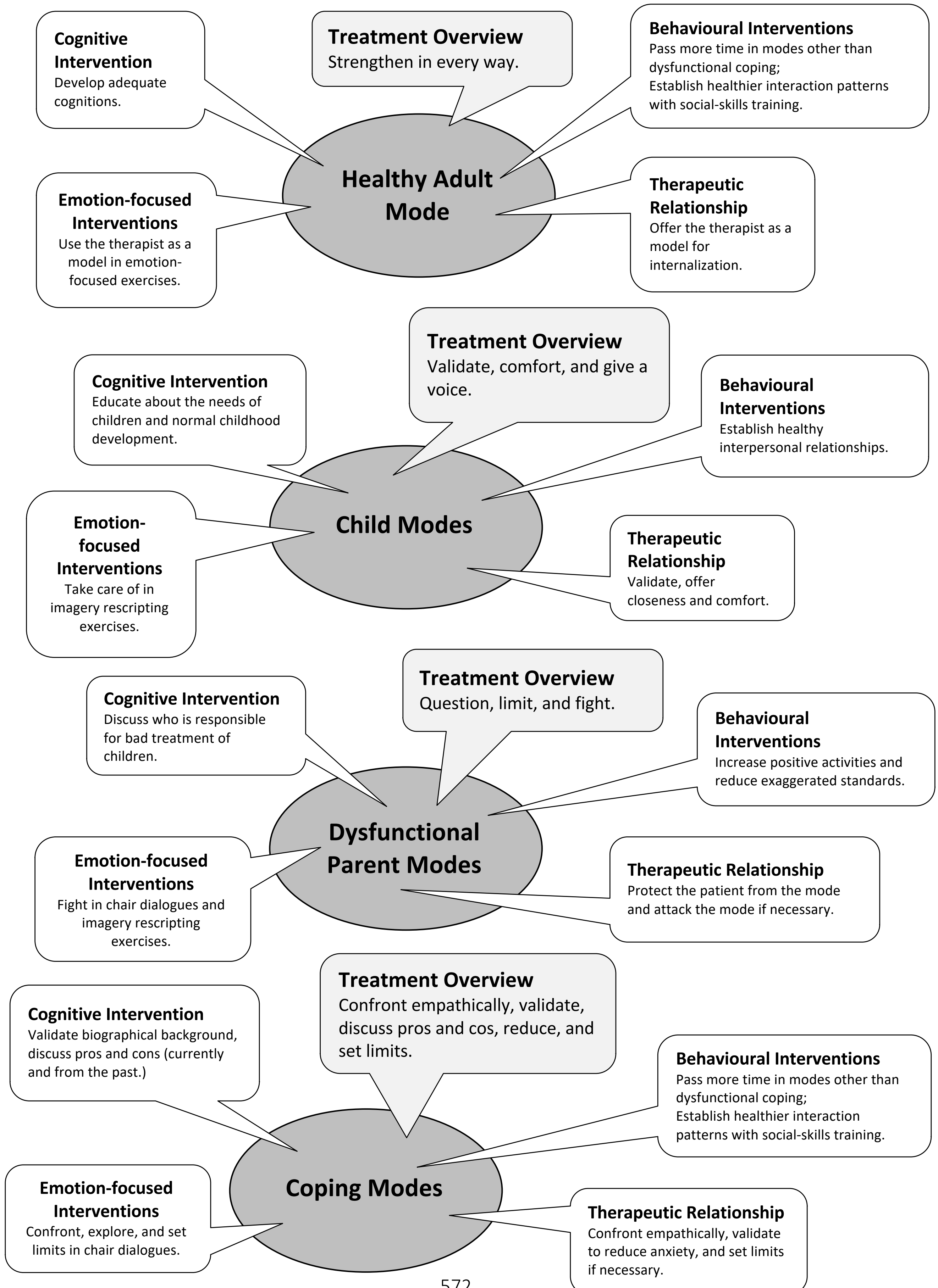
Healthy Modes

The **Healthy Adult** performs appropriate adult functions such as obtaining information, evaluating, problem-solving, working, parenting. Takes responsibility for choices and actions, and makes and keeps to commitments. In a balanced way, pursues activities that are likely to be fulfilling in work, intimate and social relationships, sporting, cultural and service-related activities.

The **Happy/Contented Child Mode** feels at peace because core emotional needs are currently met. Feels loved, contented, connected, satisfied, fulfilled, protected, praised, worthwhile, nurtured, guided, understood, validated, self-confident, competent, appropriately autonomous or self-reliant, safe, resilient, strong, in control, adaptable, optimistic and spontaneous.

APPENDIX 4

Figure 1: Schema Therapy Treatment (Adapted from Arntz & Jacob, 2013)



APPENDIX 5

Figure 2: Schema and Mode Worksheet for identifying and breaking self-defeating patterns

Name Date

Step 1: What happened, how did I react and what did I do?

What was the trigger situation that upset me?

What did I feel?

What thoughts did I have?

What would I ideally have liked to happen in this situation instead?

What did I actually do in the situation?

What was the immediate consequence of my behaviour?

What were the overall consequences of my behaviour in the long run?

Step 2: Understanding my reactions and finding solutions

1. Were my views of the situation and my emotional reactions realistic? In what ways did I misinterpret the situation or overreact?

2. What early maladaptive schemas got triggered… what Child and Parent modes?

3. What coping mode(s) was/were activated (surrender/ avoidance / overcompensation)?

4. What aspects of my childhood or teenage life may have influenced how I reacted (e.g., treatment by parent(s) or siblings, unstable family environment, treatment by other adults, other children)?

5. Memories of episodes when I had a similar feeling as a child or teenager.

6. Which of my core emotional needs were not met in the current situation?

7. How is the current situation different from what I remember as a child or a teenager?

8. How does my behaviour in this situation keep my original schema going?

9. How could I have behaved differently in the current situation so that my needs would have been better met?

10. Had I acted differently, as described in #9 above, what might have been the benefits or positive long-term consequences?

Schema Therapy Institute of South Africa 2015: Adapted from an original by Poul Perris & Jeffrey Young © 2007

APPENDIX 6

Figure 3: Schema Therapy Flash Card Template

Acknowledgement of current feeling

Right now I am feeling (emotions) because (trigger situation).

Identification of Schema(s)

However, I know that this is probably my (relevant schema) schemas, which I learned through (origin). These schemas lead me to exaggerate the degree to which (schema distortions).

Reality-testing

Even though I believe (negative thinking), the reality is that (healthy view). The evidence in my life supporting the healthy view includes: (specific life examples).

Behavioural instruction

Therefore, even though I feel like (negative behaviour), I could instead (alternative healthy behaviour).

APPENDIX 7

Table 5: Limited Reparenting Strategies for each Early Maladaptive Schema (adapted from Young et al., 2013)

Early Maladaptive Schema	Limited Reparenting Strategy
Abandonment/Instability	The therapist becomes a transition source of stability until such time that the patient is eventually able to other stable relationships outside of therapy. The therapist should correct distortions about how likely the therapist is to abandon the patient. The therapist should also assist and help the patient to prepare for times when the therapist is not available (vacation, conferences, cancellations) without detaching or becoming self-destructive. Of course, special attention needs to be provided in preparing the patient for the termination of treatment.
Mistrust/Abuse	The therapist is completely trustworthy, honest, and genuine with the patient. He should enquire about trust and intimacy frequently and encourage the patient to discuss any negative feelings she has towards him. The therapist should ask about vigilance in sessions. In order to foster trust, the therapist should be cautious about starting experiential exercises too early and rather focus on resolving traumatic memories in a cautious manner.
Emotional Deprivation	The therapist provides a nurturing environment with warmth, empathy, and guidance. He encourages the patient to ask for what she needs emotionally and to feel entitled to have emotional needs. The therapist should also encourage the patient to feelings of deprivation without lashing out or remaining silent. He helps her accept his limitations and to tolerate some deprivation while appreciating the nurturing that is available.
Defectiveness	The therapist is accepting and non-judgmental. He cares about the therapist, despite her flaws. The therapist is willing to be imperfect, sharing minor weaknesses with his patient. He affirms his patient as frequently as he can without being inauthentic.
Social Isolation	The therapist highlights ways in which he and the patient are similar, and ways in they are different, yet compatible.
Dependency/Incompetence	The therapist resists the patient's attempts at assuming the dependent role with him. He encourages her to make independent decisions and encourages her good judgments and progress.
Vulnerability to Harm or Illness	The therapist increasingly discourages the patient's dependence on his reassurance about the dangers of being in the world. He should reflect calm confidence in her ability to handle phobic situations and feared illnesses.
Enmeshment/Undeveloped Self	The therapist helps the patient by setting appropriate boundaries that are neither too close nor too distant. He encourages her to develop a separate sense of self.
Failure	The therapist supports the patient's work or school successes. He provides structure and sets limits.
Entitlement	The therapist support's the patient's vulnerable side and does not reinforce her entitled side. He empathically confronts entitlement and sets limits. He supports emotional connectedness more than status or power.
Insufficient Self-Control/ Self-Discipline	The therapist is firm in setting limits. He models appropriate self-control and self-discipline and rewards the patient for gradually developing these abilities.
Subjugation	The therapist is relatively non-directive, rather than controlling. He encourages the patient to make choices in therapy goals, treatment techniques, and homework assignments. He points out her deferential or rebellious behaviour and helps her recognize her anger, to vent it, and eventually to express is appropriately.
Self-Sacrifice	The therapist helps the patient to set appropriate boundaries and to assert their own rights and needs. He encourages her to rely on him, thereby validating her dependency needs. He discourages her form taking care of him, pointing out the pattern with an empathic confrontation.
Negativity/Pessimism	The therapist avoids playing the positive side to the patient's negativity, but rather asks the patient to play both sides. The therapist models healthy optimism.
Emotional Inhibition	The therapist encourages the patient to express affect spontaneously during sessions and models the appropriate expression of affect himself.
Unrelenting Standards	The therapist should model balanced standards in their approach to therapy and their own lives. Rather than maintaining an unbroken seriousness, the therapist should reward the patient for playfulness and spontaneity, and value the therapeutic relationship for more than simply goals being achieved. He should reflect acceptance and a normality of imperfect behaviour.
Punitiveness	The therapists should assume a forgiving attitude towards the patient and towards themselves, and acknowledge the patient for forgiving others.
Approval-Seeking	The therapist should emphasize the patient's core self over such superficial attainments as status, appearance, or wealth.

APPENDIX 8:

Table 6: Diagnostic Criteria for Anorexia Nervosa in the DSM-5 (2013, pp.338-339)

A. Restriction of energy intake relative to requirement, leading to a significantly low body weight in the context of age, sex, developmental trajectory, and physical health. Significant lower weight is defined as a weight that is less than minimally normal or, for children and adolescents, less than that minimally expected.

B. Intense fear of weight gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain, even though at a significantly low weight.

C. Disturbance in the way in which one's body weight or shape is experienced, undue influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

Coding note: The ICD-9-CM code for anorexia nervosa is 307.1, which is assigned regardless of the sub-type. The ICD-10-CM code depends on the subtype (see below).

Specify whether:

(F50.01) Restricting type: During the last 3 months, the individual has not engaged in recurrent episodes of binge eating or purging behavior (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas). This subtype describes presentations in which weight loss is accomplished primarily through dieting, fasting, and/or excessive exercise.

(F50.02) Binge-eating/purging type: During the last 3 months, the individual has engaged in recurrent episodes of binge eating or purging behaviour (i.e., self-induced vomiting or the misuse of laxatives, diuretics, or enemas).

Specify if:

In partial remission: After full criteria for anorexia nervosa were previously met, Criterion A (low body weight) has not been met for a sustained period, but either Criterion B (intense fear of gaining weight or becoming fat or behaviour that interferes with weight gain) or Criterion C (disturbances in self self-perception of weight and shape) is still met.

In full remission: After full criteria for anorexia nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based, for adults, on current body mass index (BMI) (see below) or, for children and adolescents, on BMI percentile. The ranges below are derived from World Health Organization categories for thinness in adults; for children and adolescents, corresponding BMI percentiles should be used. The level of severity may be increased to reflect clinical symptoms, the degree of functional disability, and the need for supervision.

Mild: BMI ≥ 17 kg/m^2

Moderate: BMI 16 – 16.99 kg/m^2

Severe: BMI 15 – 15.99 kg/m^2

Extreme: BMI < 15 kg/m^2

Table 7: Diagnostic Criteria for Bulimia Nervosa from the DSM-5 (2013, p.345)

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
2. As sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating.

B. Recurrent inappropriate compensatory behaviours in order to prevent weight gain, such as self-induced vomiting; misuse of laxatives, diuretics, or other medications; fasting; or excessive exercise.

C. The binge eating and inappropriate compensatory behaviours both occur, on average, at least once* a week for 3 months.

D. Self-evaluation is unduly influenced by body shape and weight.

E. The disturbance does not occur exclusively during episodes of anorexia nervosa.

Specify if:
In partial remission: After full criteria for bulimia nervosa were previously met, some but not all, of the criteria have been met for a sustained period of time.
In full remission: After full criteria for bulimia nervosa were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based on the frequency of inappropriate compensatory behaviours (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

Mild: An average of 1 – 3 episodes of inappropriate compensatory behaviours per week.

Moderate: An average of 4– 7 episodes of inappropriate compensatory behaviours per week.

Severe: An average of 8 – 13 episodes of inappropriate compensatory behaviours per week.

Extreme: An average of 14 or more episodes of inappropriate compensatory behaviours per week.

* This frequency was set at twice weekly for three months in the DSM-IV-TR (APA, 2000).

Table 8 Diagnostic Criteria for Binge-Eating Disorder from the DSM-5 (2013, p.350)

A. Recurrent episodes of binge eating. An episode of binge eating is characterized by both of the following:
   1. Eating, in a discrete period of time (e.g., within any 2-hour period), an amount of food that is definitely larger than what most individuals would eat in a similar period of time under similar circumstances.
   2. As sense of lack of control over eating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating.

B. The binge-eating episodes are associated with three (or more) of the following:
   1. Eating much more rapidly than normal.
   2. Eating until feeling uncomfortably full.
   3. Eating large amounts of food when not feeling physically hungry.
   4. Eating alone because of feeling embarrassed by how much one is eating.
   5. Feeling disgusted with oneself, depressed, or very guilty afterwards.

C. Marked distress regarding binge eating is present.

D. The binge eating occurs, on average, at least once a week for 3 months.

E. The binge eating is not associated with the recurrent use of inappropriate compensatory behaviour as in bulimia nervosa and does not occur exclusively during the course of bulimia nervosa or anorexia nervosa.

Specify if:

In partial remission: After full criteria for binge-eating disorder were previously met, binge eating occurs at an average frequency of less than one episode per week for a sustained period of time.
In full remission: After full criteria for binge-eating disorder were previously met, none of the criteria have been met for a sustained period of time.

Specify current severity:

The minimum level of severity is based on the frequency of episodes of binge eating (see below). The level of severity may be increased to reflect other symptoms and the degree of functional disability.

Mild: An average of 1 – 3 binge-eating episodes per week.

Moderate: An average of 4– 7 binge-eating episodes per week.

Severe: An average of 8 – 13 binge-eating episodes per week.

Extreme: An average of 14 or more binge-eating episodes per week.

APPENDIX 9

Table 9: Potential Risk Factors for Eating Disorders (adapted from Jacobi et al., 2004)

General and social factors
Gender
Race/ethnicity
Participation in weight-related social or professional subculture (dancer, model, athlete, gymnast, etc.)
Sex role orientation – for males: homosexuality
Familial factors
Parental obesity
Parental psychopathology
Family interaction/communication style, expressed emotion
Developmental factors
Adolescent age
Premorbid obesity
Childhood picky eating, problem eating, pica
Childhood feeding and digestive problems
Teasing/critical comments about weight and shape
Early pubertal maturation
Childhood anxiety disorders
Adverse life events
Trauma – especially sexual and physical abuse
Other stressful or adverse life events
Psychological and behavioural factors
Dieting, restrained eating
Over-concern with weight and shape, body dissatisfaction/negative body image, high drive for thinness
Low interoceptive awareness
Low self-esteem
Perfectionism, obsessive-compulsiveness, obsessive-compulsive personality disorder
Depression, anxiety disorders, substance and/or alcohol abuse problems, affective instability
Attachment style
Self-awareness
High-level exercise
Biological factors
Genetic factors
Neuroendocrine and metabolic disturbances
Changes in receptor density
Electroencephalogram changes
Changes in regulation of hunger and satiety

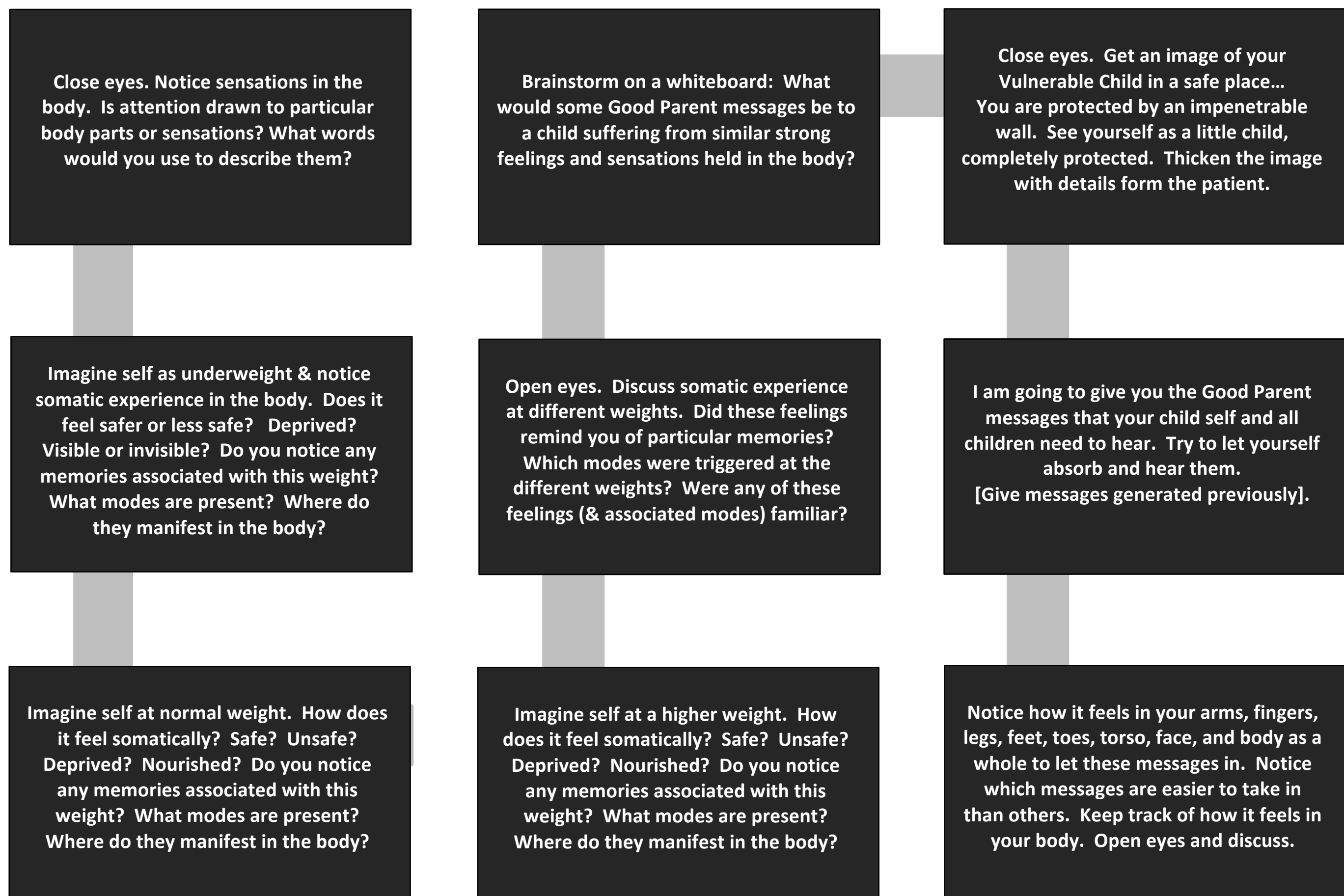
Table 10: Aetiology of Anorexia Nervosa (Woerwag-Mehta & Treasure, 2008)

	Physical	**Psychological**	**Social**
Predisposing	Genes	OCD/OCPD	Isolation
	Epigenetic effects	Anxiety disorders	Occupation (e.g., athlete, ballet dancer)
	Obstetric complications	Avoidant coping style	Abuse
	Prematurity	Cognitive deficits	Overprotective parenting
	Feeding difficulty in infancy	Negative self-evaluation	Attachment difficulties
	HPA axis deficits		
Precipitating	Puberty	Stress	Life events
		Dieting	Cultural values
Perpetuating	GI changes	OCD/OCPD	Family dynamics
	Low 5HT	Cognitive changes (e.g., increased rigidity)	High expressed emotion/criticism
	Low dopamine	Anxiety	Social isolation
	Low BDNF	Depression	
	Altered HPA axis		
	Low leptin, adiponectin		

BDNF, brain-derived neurotrophic factor; GI, gastrointestinal; HPA, hypothalamic-pituitary-adrenal; OCD, obsessive-compulsive disorder; OCPD, obsessive-compulsive personality disorder

APPENDIX 10

Figure 11: Body Image Restructuring Exercise (Simpson & Kapitel, 2016)



APPENDIX 11:

Table 12 Munro's Pathways to Recovery for AN that parallel the Transtheoretical Stages of Change Model* (1992) (adapted from Munro, 2016*)

* Prochaska and DiClemente

Munro's Pathway to Recovery	Transtheoretical Stages of Change Model	Description of Stage (Munro's particular mode labels are used)
The Loyal Anorexic	Pre-Contemplation	There is a determined commitment to the perceived value of the maladaptive modes, especially to the value of the Self-criticism and self-control. Weight loss is paramount, and any consideration of change equates to an admission of failure. Conflict inevitably erupts with anyone that threatens change.
The Desperate Defector	Contemplation	The vulnerability is intense and persistent despite the extreme commitment to self-control, denial, detachment from others and a continued reliance on maladaptive modes. Only fear has the patient considering change, but there remains much shame associated with wanting to have core needs met. They test out making small changes in a covert manner. They are terrified that changing will inevitably result in a backlash from the SeCr.
The Ambivalent Conscript	Preparation	Although the Vulnerable mode is still intense, there is a subtle presence of the Healthy mode. Despite increasing insight into the negative consequences of the AN condition, there remains intense fear at the prospect of change and being required to engage in a more nurturing way with oneself. There is still a strong belief the strict self-control and self-criticism will best ensure that order is maintained. They are anxious at the prospects of greater responsibilities if they resume a healthy existence. They anticipate that their SeCr mode will become increasingly punitive in the face of change. Despite the fear of being vulnerably exposed, they begin preparing for change. The therapist is inevitably required to 'hold' all hope.
The Freedom Fighter	Action	The negative consequences of the ED are increasingly appreciated and there is discernably more Healthy mode to facilitate healing in the Vulnerability mode. There is a fairly consistent desire to change or recover. However, there remains a consistent power struggle between the Healthy mode and the maladaptive modes. Lapses are inevitable, but steady progress towards change is made.
The Free Woman/Man	Action that leads to Maintenance	While actively engaged in recovery, the patient becomes increasingly aware that they are not going to assume the 'Feared Self' identity. They have developed a deeper trust their support system and reach out to others more readily. Eating is more regular and healthily moderated. They become increasingly aware of the evidence that they are and acceptable and lovable. Self-confidence and self-acceptance grow steadily

APPENDIX 12

Form1: Alison's* evaluation of the Therapy Narrative (* not a real name in order to provide anonymity)

You are being asked to evaluate Chapter 6 of the dissertation for its accuracy, which is divided into three sections, namely:

1. The Biographical Summary
2. The Mode Map
3. The Therapy Narrative

Please answer the questions as they pertain to each of these three sections. Where you are provided with a scale or "Yes/No" option, please mark you answer with a cross or a circled number ② in the pertinent box.

THE BIOGRAPHICAL SUMMARY

Having read the 5-page biographical summary that outlines important aspects of your life, please answer the following questions:

1. How accurate was the information provided?

1	2	3	4
Very Inaccurately	Somewhat Inaccurately	Fairly Accurately	Very Accurately

If you answered anything less than ④, please describe in the space below what inaccuracies you observed.

2. How accurately did the biographical reflect all the most important aspects of your life?

1	2	3	4
Very Inaccurately	Somewhat Inaccurately	Fairly Accurately	Very Accurately

If you answered anything less than ④, please list those and provides the reader with a comprehensive reflection of your life?

....

....

....

....

3. How accurately were your goals for therapy reflected?

1	2	3	4
Very Inaccurately	Somewhat Inaccurately	Fairly Accurately	Very Accurately

If you answered anything less than ④, please provide an accurate indication of the goals that you set for therapy.

....

....

....

....

4. If you noticed small details to be inaccurate (e.g., incorrect dates or places), please make corrections in the space provided below.

....

....

....

<u>THE MODE MAP</u>

5. Does the mode map reflect accurately to the mode map that we worked with throughout?

Yes	No

If you answered NO, please outline below where you see inaccuracies.

....

....

....

THE THERAPY NARRATIVE

6. As an overview, how accurately did the therapy narrative reflect your experience of the 100 sessions of schema therapy we engaged in together over the two years that the study lasted (August 2013 – September 2015)?

1	2	3	4
Very Inaccurately	Somewhat Inaccurately	Fairly Accurately	Very Accurately

If you answered anything less than ④, please describe in what ways you experienced the course of therapy to deviate from the descriptions provided in the therapy narrative.

7. How accurately did the therapy narrative reflect both your and my spoken word?

1	2	3	4
Very Inaccurately	Somewhat Inaccurately	Fairly Accurately	Very Accurately

If you answered anything less than ④, please outline where you believe that the therapy narrative did not accurately reflect our spoken word.

8. Although you are not a mental health professional, please comment from your lay perspective your thoughts about interpretative commentary at the end of each section of the therapy narrative?

9. Are there any significant experiences that you can recall from the therapy that you believe are not included in this therapy narrative?

Yes No

If you answered "Yes" to this question, please outline such experiences that were excluded.

10. Have you any suggestions in what way(s) this therapy narrative could more accurately or comprehensive reflect the therapy experience?

Yes	No

If you answered "Yes", please elaborate in the space provided.

11. Do you believe that there are any aspects of the narrative that reflect a bias that skew the accuracy of the therapy narrative, not reflecting its rigour and trustworthiness?

Yes No

If you answered "Yes" to this question, please outline where you feel there is bias.

12. Do you have any further comments?

APPENDIX 13

Form 2: Contractual Agreement Contract between Researcher and Research Participant

DEPARTMENT OF PSYCHOLOGY

CONTRACTUAL AGREEMENT BETWEEN RESEARCHER AND RESEARCH PARTICIPANT

I, ……………………………………………………………, have sought assessment and treatment for an eating disorder, and agree to participate in Graham Alexander's research project on the application of individual schema therapy for the treatment of eating disorders. I understand that:

1. The researcher is interested in evaluating individual schema therapy as a treatment for patients suffering from various eating disorders, and that this project has been approved by Rhodes University, which has reviewed and given ethical clearance.

2. The researcher is conducting the research as part of the requirements for a doctoral (Ph.D) degree in psychology from Rhodes University. The researcher may be contacted on 082 496 0907 (cell phone) or graalex@iafrica.com (email address), and is under the supervision of Professor David Edwards of the Department of Psychology at Rhodes University, who may be contacted on 082 779 0736 or d.edwards@ru.ac.za (email address).

3. My participation in the research will involve completion of the assessment, attendance of all individual schema therapy sessions, and attendance of a follow-up evaluation. All homework tasks, written material, questionnaires, and inventories need to be punctually completed at the relevant times throughout the assessment, treatment and post-treatment evaluation. All such material will be made available to the researcher and research supervisor for analysis, or the research evaluation team for inspection, if required.

4. Existing research literature already suggests that schema therapy is a modality of treatment well suited to provide to eating disorders patients. I will be assessed and treated in accordance with principles in the existing literature. This research and clinical literature is available on request.

5. The assessment will involve approximately four sessions, each lasting approximately one hour. The treatment will involve the attendance of approximately 30 to 40 once-weekly sessions, each lasting approximately an hour. I will also be required to complete short forms for a few minutes both prior to and following each therapy session as part of the session evaluation. There will be a follow-up evaluation process one or more months following completion of the treatment to evaluate progress. There will likely be short breaks of one or two weeks within the treatment, should it coincide with the festive season or student vacation.
6. My participation in the project will not prejudice the quality of professional care that I receive. In fact, it is likely to enhance it, given the extra attention for research purposes as well as additional guidance through supervision. I may not participate in any other psychotherapeutic or group therapy treatment during the research treatment, as this will compromise the validity of the research project. However, my safety and well-being is paramount, and where additional therapeutic treatment is indicated, I will be advised to receive such treatment. However, this may disqualify me from further participating in the treatment study. However, ongoing therapeutic treatment will still be available through the researcher's private practice to ensure that there is continuity in my treatment.

7. I am invited to approach the researcher and/or the study supervisor with any concerns I have about my participation in the study. It is assured that all such concerns will be satisfactorily addressed and resolved.

8. In addition to the normal clinical notes that would be made routinely as part of the assessment and treatment process, all sessions will be video-taped and audio-taped. Access to the audio recording is available on request, but might even be encouraged for therapeutic reasons if the researcher feels it would be beneficial to review the session(s). All the electronic material will be securely stored and kept confidential, and will only be available to the researcher, research supervisor, research evaluation team (if requested), and me.

9. In the event that a research assistant is employed to transcribe audio or video-recordings, the identity of that person will be made available for my expressed and signed approval.

10. The treatment will be provided at a reduced cost. Any additional medical or psychiatric expenses that are utilized (e.g., your psychiatric medication, medical examinations, pathology lab expenses, etc.) will be for my own expense. Where the researcher advises such medical interventions, it is my responsibility to ensure that such advice is adhered to for my own safety.

11. The researcher will write a PhD thesis and may subsequently publish academic literature based on the material in the form of an academic article or a book chapter. Such written material will provide detailed information about the process of individual schema therapy as well as my history and experiences. However personal information will be omitted or altered in order to preserve anonymity. This will be done in consultation with me and require my approval. I will have access to any material prior to it being submitted for publication.

12. I am free to withdraw from the treatment in serious circumstances. However, I understand that my full participation and commitment to the treatment is a vital element of both the research and the preservation of a safe and consistent treatment environment.

Signed on _____ /_____ / ________ at
____

____
Participant

____
Graham Alexander M.A. (Clin.Psych)(U.C.T.)
Clinical Psychologist
Registered with the Health Professions Council of SoutAfrica
Registration Number PS 0041408
Practice Number: 8628815

____
Participant Guardian (if participant under 18 years)

____
Professor David Edwards Ph.D.
Clinical Psychologist
Registered with the
Health Professions
Council of South Africa and U.K.
Registration Number PS 007005
Practice Number: 086 001 860381

Form 3: Release form for the use of Electronic Recordings for Research Purposes

RHODES UNIVERSITY
Where leaders learn

DEPARTMENT OF PSYCHOLOGY

RELEASE FORM FOR THE USE OF ELECTRONIC RECORDINGS FOR RESEARCH PURPOSES

I, ______________________________ have agreed to participate in Graham Alexander's Ph.D research project entitled "The treatment of transdiagnostic eating disorders in a group schema therapy setting." The project is being supervised by Professor David Edwards.

Participant details

Address ____

Cell number ____

Home number ____

Guardian's Name* ____

Guardian's Address* ____

Guardian's Cell Number* ____

Guardian's Hm Number* ____

* if participant under 18 years of age

Declaration

(Please ink the circle next to the relevant statements)

□The nature of the research and the nature of my participation in the treatment have been clearly explained to me. Yes O No O

□ I agree to receive therapeutic treatment and to allow electronic recordings (audio and visual) to be made of my assessment, each group therapy session, and any evaluation interviews. Yes O No O

□ The video-taped recordings may be transcribed: Without conditions O

Only by the researcher O

By a nominated third party * O

* A separate consent form will be provided for signing should any third party be employed for the purpose of transcribing sessions or interviews.

□ I have had it explained that all recorded material will be securely stored and only made available to the eight treatment participants (only within the treatment facility), researcher, group co-therapist, research supervisor, or the research evaluators (if required during the evaluation of the research). Yes O No O

□ Should it be considered that the recorded material would serve well as professional training material after completion of the study, I will consider this and consent via the relevant forms made available to me for signing. Should any of the participants not consent to such a request, then none of the material will be considered for professional training purposes. Yes O No O

Signed on ______ /______ / _________ at

____

____

Participant

____

Graham Alexander M.A. (Clin.Psych)(U.C.T.)
Clinical Psychologist
Registered with the Health Professions Council of SoutAfrica
Registration Number PS 0041408
Practice Number: 8628815

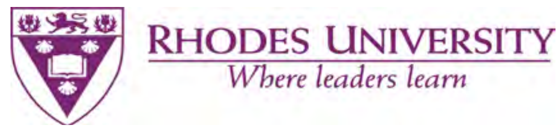
____

Participant Guardian (if participant under 18 years)

____

Professor David Edwards Ph.D.
Clinical Psychologist
Registered with the
Health Professions
Council of South Africa and U.K.
Registration Number PS 007005
Practice Number: 086 001 860381

Form 4: Consent Form for Research Participants



CONSENT FORM FOR RESEARCH PARTICIPANTS

I, Alison Brand, consent to clinical psychologist, Ilse du Preez, conducting a mid-treatment evaluation interview on the doctoral research project being conducted by Graham Alexander.

The interview will be audio-recorded, after which it will be transcribed by professional transcriber, Carin Favero. Graham will never have access to the audio-recording. He will receive a copy of the transcript when the therapy phase of the research ceases in 2015 (somewhere between April and June).

Both the interviewer (Ilse du Preez) and the transcriber (Carin Favero) are bound by the rules pertaining to confidentiality. The only other individual(s) who might receive access to the transcripts is the doctoral supervisor, Professor David Edwards and/or the three international dissertation examiners. However, it is extremely unlikely that such parties will require access to the transcript.

Signed this __________ day of ________________________________, 2014.

____

Participant Interviewer Researcher

APPENDIX 14

FORM 5: A Client's Guide to Schema Therapy

A Client's Guide to Schema Therapy

David C. Bricker, Ph.D. and Jeffrey E. Young, Ph.D. Schema Therapy Institute

Harry is a 45-year old middle-level manager. He has been married for 16 years, but his marriage has been very troubled. He and his wife are often resentful of each other, they rarely communicate on an intimate level, and they have few moments of real pleasure.

Other aspects of Harry's life have been equally unsatisfying. He doesn't enjoy his work, primarily because he doesn't get along with his co-workers. He is often intimidated by his boss and other people at the office. He has a few friends outside of work, but none that he considers close.

During the past year Harry's mood became increasingly negative. He was getting more irritable, he had trouble sleeping and he began to have difficulty concentrating at work. As he became more and more depressed, he began to eat more and gained 15 pounds. When he found himself thinking about taking his own life, he decided it was time to get help. He consulted a psychologist who practices cognitive therapy.

As a result of short-term cognitive therapy techniques, Harry improved rapidly. His mood lifted, his appetite returned to normal, and he no longer thought about suicide. In addition he was able to concentrate well again and was much less irritable. He also began to feel more in control of his life as he learned how to control his emotions for the first time.

But, in some ways, the short-term techniques were not enough. His relationships with his wife and others, while they no longer depressed him as much as they had, still failed to give him much pleasure. He still could not ask to have his needs met, and he had few experiences he considered truly enjoyable. The therapist then began schema therapy to help Harry change his long-term life patterns.

This guide will present the schema therapy approach, developed by Dr. Jeffrey Young to expand cognitive therapy for clients with more difficult long-term problems. Schema therapy can help people change long-term patterns, including the ways in which they interact with other people. This overview of schema therapy consists of six parts:

1) A brief explanation of short-term cognitive therapy;
2) An explanation of what a schema is and examples of schemas;
3) An explanation of the processes by which schemas function;
4) An explanation of modes and how they function within schema therapy; 5) Several case examples; and
6) A brief description of the therapeutic process.

Short-Term Cognitive Therapy

Cognitive therapy is a system of psychotherapy developed by Aaron Beck and his colleagues to help people overcome emotional problems. This system emphasizes changing the ways in which people think in order to improve their moods, such as depression, anxiety and anger.

Emotional disturbance is influenced by the cognitive distortions that people make in dealing with their life experiences. These distortions take the form of negative interpretations and predictions of everyday events. For instance, a male college student preparing for a test might make himself feel discouraged by thinking: “This material is impossible” (Negative Interpretation) and “I’ll never pass this test” (Negative Prediction).

The therapy consists of helping clients to restructure their thinking. An important step in this process is examining the evidence concerning the maladaptive thoughts. In the example above, the therapist would help the student to look at his past experiences and determine if the material was in fact impossible to learn, and if he knew for sure that he couldn’t pass the test. In all probability, the student would decide that these two thoughts lacked validity.

More accurate alternative thoughts are then substituted. For instance, the student might be encouraged to think: “This material is difficult, but not impossible. I’ve learned difficult material before” and “I’ve never failed a test before, so long as I’ve done enough preparation.” These thoughts would probably lead him to feel better and cope better.

Often short-term cognitive therapy is enough to help people overcome emotional problems, especially depression and anxiety. Recent research has shown this to be so. However, sometimes this approach is not enough. Some clients in short-term cognitive therapy find that they don’t get all the benefits they want. This has led us, as well as various other researchers, to look at deeper and more permanent cognitive structures as a means to understand and treat problem moods and behaviours. Schema therapy was created as a result of these efforts.

Schemas — What They Are

A schema is an extremely stable, enduring negative pattern that develops during childhood or adolescence and is elaborated throughout an individual’s life. We view the world through our schemas.

Schemas are important beliefs and feelings about oneself and the environment which the individual accepts without question. They are self-perpetuating, and are very resistant to change. For instance, children who develop a schema that they are incompetent rarely challenge this belief, even as adults. The schema usually does not go away without therapy. Overwhelming success in people’s lives is often still not enough to change the schema. The schema fights for its own survival, and, usually, quite successfully.

It’s also important to mention the importance of needs in schema formation and perpetuation. Schemas are formed when needs are not met during childhood and then the schema prevents similar needs from being fulfilled in adulthood. For instance a child whose need for secure attachments is not fulfilled by his parents may go for many years in later life without secure relationships.

Even though schemas persist once they are formed, they are not always in our awareness. Usually they operate in subtle ways, out of our awareness. However, when a schema erupts or is triggered by events, our thoughts and feelings are dominated by these schemas. It is at these moments that people tend to experience extreme negative emotions and have dysfunctional thoughts.

In our work with many patients, we have found eighteen specific schemas. Most clients have at least two or three of these schemas, and often more. A brief description of each of these schemas is provided below.

Emotional Deprivation

This schema refers to the belief that one’s primary emotional needs will never be met by others. These needs can be described in three categories: Nurturance—needs for affection, closeness and love; Empathy—

needs to be listened to and understood; Protection—needs for advice, guidance and direction. Generally parents are cold or removed and don't adequately care for the child in ways that would adequately meet the above needs.

Abandonment/Instability

This schema refers to the expectation that one will soon lose anyone with whom an emotional attachment is formed. The person believes that, one way or another, close relationships will end imminently. As children, these clients may have experienced the divorce or death of parents. This schema can also arise when parents have been inconsistent in attending to the child's needs; for instance, there may have been frequent occasions on which the child was left alone or unattended to for extended periods.

Mistrust/Abuse

This schema refers to the expectation that others will intentionally take advantage in some way. People with this schema expect others to hurt, cheat, or put them down. They often think in terms of attacking first or getting revenge afterwards. In childhood, these clients were often abused or treated unfairly by parents, siblings, or peers.

Social Isolation/Alienation

This schema refers to the belief that one is isolated from the world, different from other people, and/or not part of any community. This belief is usually caused by early experiences in which children see that either they, or their families, are different from other people.

Defectiveness/Shame

This schema refers to the belief that one is internally flawed, and that, if others get close, they will realize this and withdraw from the relationship. This feeling of being flawed and inadequate often leads to a strong sense of shame. Generally parents were very critical of their children and made them feel as if they were not worthy of being loved.

Failure

This schema refers to the belief that one is incapable of performing as well as one's peers in areas such as career, school or sports. These clients may feel stupid, inept or untalented. People with this schema often do not try to achieve because they believe that they will fail. This schema may develop if children are put down and treated as if they are a failure in school and other spheres of accomplishment. Usually the parents did not give enough support, discipline, and encouragement for the child to persist and succeed in areas of achievement, such as schoolwork or sport.

Dependence/Incompetence

This schema refers to the belief that one is not capable of handling day-to-day responsibilities competently and independently. People with this schema often rely on others excessively for help in areas such as decision-making and initiating new tasks. Generally, parents did not encourage these children to act independently and develop confidence in their ability to take care of themselves.

Vulnerability to Harm and Illness

This schema refers to the belief that one is always on the verge of experiencing a major catastrophe (financial, natural, medical, criminal, etc.). It may lead to taking excessive precautions to protect oneself. Usually there was an extremely fearful parent who passed on the idea that the world is a dangerous place.

Enmeshment/Undeveloped Self

This schema refers to a pattern in which you experience too much emotional involvement with others – usually parents or romantic partners. It may also include the sense that one has too little individual identity or inner direction, causing a feeling of emptiness or of floundering. This schema is often brought on by parents who are so controlling, abusive, or so overprotective that the child is discouraged from developing a separate sense of self.

Subjugation

This schema refers to the belief that one must submit to the control of others in order to avoid negative consequences. Often these clients fear that, unless they submit, others will get angry or reject them. Clients who subjugate ignore their own desires and feelings. In childhood there was generally a very controlling parent.

Self-Sacrifice

This schema refers to the excessive sacrifice of one's own needs in order to help others. When these clients pay attention to their own needs, they often feel guilty. To avoid this guilt, they put others' needs ahead of their own. Often clients who self-sacrifice gain a feeling of increased self-esteem or a sense of meaning from helping others. In childhood the person may have been made to feel overly responsible for the well being of one or both parents.

Emotional Inhibition

This schema refers to the belief that you must suppress spontaneous emotions and impulses, especially anger, because any expression of feelings would harm others or lead to loss of self-esteem, embarrassment, retaliation or abandonment. You may lack spontaneity, or be viewed as uptight. This schema is often brought on by parents who discourage the expression of feelings.

Unrelenting Standards/Hypercriticalness

This schema refers to the belief that whatever you do is not good enough, that you must always strive harder. The motivation for this belief is the desire to meet extremely high internal demands for competence, usually to avoid internal criticism. People with this schema show impairments in important life areas, such as health, pleasure or self- esteem. Usually these clients' parents were never satisfied and gave their children love that was conditional on outstanding achievement.

Entitlement/Grandiosity

This schema refers to the belief that you should be able to do, say, or have whatever you want immediately regardless of whether that hurts others or seems reasonable to them. You are not interested in what other people need, nor are you aware of the long- term costs to you of alienating others. Parents who overindulge their children and who do not set limits about what is socially appropriate may foster the development of this schema. Alternatively, some children develop this schema to compensate for feelings of emotional deprivation or defectiveness.

Insufficient Self-Control/Self-Discipline

This schema refers to the inability to tolerate any frustration in reaching one's goals, as well as an inability to restrain expression of one's impulses or feelings. When lack of self-control is extreme, criminal or addictive behaviour rule your life. Parents who did not model self-control, or who did not adequately discipline their children, may predispose them to have this schema as adults.

Approval-Seeking/Recognition-Seeking

This schema refers to the placing of too much emphasis on gaining the approval and recognition of others at the expense of one's genuine needs and sense of self. It can also include excessive emphasis on status and appearance as a means of gaining recognition and approval. Clients with this schema are generally extremely sensitive to rejections by others and try hard to fit in. Usually they did not have their needs for unconditional love and acceptance met by their parents in their early years.

Negativity/Pessimism

This schema refers to a pervasive pattern of focusing on the negative aspects of life while minimizing the positive aspects. Clients with this schema are unable to enjoy things that are going well in their lives because they are so concerned with negative details or potential future problems. They worry about possible failures no matter how well things are going for them. Usually these clients had a parent who worried excessively.

Punitiveness

This schema refers to the belief that people deserve to be harshly punished for making mistakes. People with this schema are critical and unforgiving of both themselves and others. They tend to be angry about imperfect behaviours much of the time. In childhood these clients usually had at least one parent who put too much emphasis on performance and had a punitive style of controlling behaviour.

How Schemas Work

There are two primary schema operations: Schema healing and schema perpetuation. All thoughts, behaviours and feelings may be seen as being part of one of these operations. Either they perpetuate the schema or they heal the schema. In a later section on the therapy process we will explain more about schema healing.

Schema perpetuation refers to the routine processes by which schemas function and perpetuate themselves. This is accomplished by cognitive distortions, self-defeating behaviour patterns and schema coping styles.

Earlier we mentioned that cognitive distortions are a central part of cognitive therapy. These distortions consist of negative interpretations and predictions of life events. The schema will highlight or exaggerate information that confirms the schema and will minimize or deny information that contradicts it. Likewise, unhealthy behaviour patterns will perpetuate the schema's existence. Someone who was abused in childhood and developed a Mistrust/Abuse schema may seek out abusive relationships in adulthood and remain in them, providing a constant stream of evidence for the schema.

In order to understand how schemas work, there are three schema coping styles that must be defined. These styles are schema surrender, schema avoidance, and schema overcompensation. It is through these three styles that schemas exert their influence on our behaviour and work to insure their own survival.

Schema surrender refers to ways in which people passively give in to the schema. They accept the schema as truth and then act in ways that confirm the schema. For instance, a young man with an Abandonment/Instability schema might choose partners who are unable to commit to long-term relationships. He might then react to even minor signs indications of abandonment, such as spending short times without his partner, in an exaggerated way and feel excessive negative emotion. Despite the emotional pain of the situation, he might also passively remain in the relationship because he sees no other possible way to connect with women.

Schema avoidance refers to the ways in which people avoid activating schemas. As mentioned earlier, when schemas are activated, this causes extreme negative emotion. People develop ways to avoid triggering schemas in order not to feel this pain. There are three types of schema avoidance: cognitive, emotional and behavioural.

Cognitive avoidance refers to efforts that people make not to think about upsetting events. These efforts may be either voluntary or automatic. People may voluntarily choose not to focus on an aspect of their personality or an event, which they find disturbing. There are also unconscious processes which help people to shut out information which would be too upsetting to confront. People often forget particularly painful events. For instance, children who have been abused sexually often forget the memory completely.

Emotional or affective avoidance refers to automatic or voluntary attempts to block painful emotion. Often when people have painful emotional experiences, they numb themselves to the feelings in order to minimize the pain. For instance, a man might talk about how his wife has been acting in an abusive manner toward him and say that he feels no anger towards her, only a little annoyance. Some people drink or abuse drugs to numb feelings generated by schemas.

The third type of avoidance is behavioural avoidance. People often act in such a way as to avoid situations that trigger schemas, and thus avoid psychological pain. For instance, a woman with a Failure schema might avoid taking a difficult new job which would be very good for her. By avoiding the challenging situation, she avoids any pain, such as intense anxiety, which could be generated by the schema.

The third schema process is Schema overcompensation. The individual behaves in a manner which appears to be the opposite of what the schema suggests in order to avoid triggering the schema. On the surface, it may appear that the overcompensators are behaving in a healthy manner, by standing up for themselves. But when they overshoot the mark they cause more problem patterns, which then perpetuate the schema. For instance, a young man with a Defectiveness schema might overcompensate by presenting himself as perfect and being critical of others. This would likely lead others to criticize him in turn, thereby confirming his belief that he is defective.

Working With Modes

When treating clients with schema therapy one of the most important innovations is the concept of mode. For our purposes we will define a mode as the set of schemas or schema operations that are currently active for an individual. Or you might think of a mode simply as a mindset or state that you might be in temporarily. Most people can relate to the idea that we all have these different parts of ourselves and we go in and out of them all the time. For instance, if a friend tells you she had a bad day because her boss (or her toddler) was in his raging bull mode, you'd know exactly what she means.

There are often occasions when a therapist will choose to work with a client's modes in therapy. If a client is extremely upset at the beginning of a session, the therapist may inquire about what part of the person is feeling the emotional pain and attempt to recognize it and deal with it directly. For instance, for several sessions, Myra was very sad and hurt because she was unable to talk out some problems with her husband.

In talking with her therapist they focused on a mode, or part of her, that she called Lonely Myra, that seemed to be active after these failed attempts. By engaging this part of Myra in this manner the therapist was able to give her an opportunity to express the feelings and thoughts connected with her pattern of loneliness.

The exact pattern of work with modes will vary from session to session. But some of the more common activities in mode work can be described. The history of the mode is often discussed; the client will speak about when the mode started and what was going on at the time. Connections are made between modes and current problems. Dialogues can be conducted between different modes when there is a conflict. For instance, a miser mode and a playboy mode might have it out over what type of car to buy. And there is always an effort to link mode work with other aspects of the therapy.

Case Examples

In this section six case examples are presented. In each one, the schema coping styles are demonstrated. By reading through this section, you will get a better feel for how these processes can operate in real life situations.

- • Abby is a young woman whose main schema is Subjugation. She tends to see people as very controlling even when they are being appropriately assertive. She has thoughts such as "I can't stand up for myself or they won't like me' and is likely to give in to others (Schema surrender). At other times she decides that no one will get the better of her and becomes very controlling (Schema overcompensation). Sometimes when people make unreasonable demands on her she minimizes the importance of her own feelings and has thoughts like "It's not that important to me what happens.' At other times she avoids acquaintances with whom she has trouble standing up for herself (Schema avoidance).
- • Stewart's main schema is Failure. Whenever he is faced with a possible challenge, he tends to think that he is not capable. Often he tries half- heartedly, guaranteeing that he will fail, and strengthening the belief that he is not capable (Schema surrender). At times, he makes great efforts to present himself in an unrealistically positive light by spending excessive amounts of money on items such as clothing and automobiles (Schema overcompensation). Often he avoids triggering his schema by staying away from challenges altogether and convinces himself that the challenge was not worth taking (Schema avoidance).

- • Rebecca's core schema is Defectiveness/Shame. She believes that there is something basically wrong with her and that if anyone gets too close, they will reject her. She chooses partners who are extremely critical of her and confirm her view that she is defective (Schema surrender). Sometimes she has an excessive defensive reaction and counterattacks when confronted with even mild criticism (Schema overcompensation). She also makes sure that none of her partners get too close, so that she can avoid their seeing her defectiveness and rejecting her (Schema avoidance).
- • Michael is a middle-aged man whose main schema is Dependence/Incompetence. He sees himself as being incapable of doing daily tasks on his own and generally seeks the support of others. Whenever he can, he chooses to work with people who help him out to an excessive degree. This keeps him from developing skills needed to work alone and confirms his view of himself as someone who needs others to help him out (Schema surrender). At times, when he would be best off taking advice from other people, he refuses to do so (Schema overcompensation). He reduces his anxiety by procrastinating as much as he can get away with (Schema avoidance).
- • Ann's core schema is Social Isolation/Alienation. She sees herself as being different from other people and not fitting in. When she does things as part of a group she does not get really involved (Schema surrender). At times she gets very hostile towards group members and can be very critical

of the group as a whole (Schema overcompensation). At other times she chooses to avoid group activities altogether (Schema avoidance).

• Sam's central schema is Emotional Deprivation. He chooses partners who are not very capable of giving to other people and then acts in a manner which makes it even more difficult for them to give to him (Schema surrender). At times he will act in a very demanding, belligerent manner and provoke fights with his partners (Schema overcompensation). Sam avoids getting too close to women, yet denies that he has any problems in this area (Schema avoidance).

Therapeutic Process — Changing Schemas

In schema therapy the goal of the treatment is to engage in schema healing processes. These processes are intended to weaken the early maladaptive schemas and coping styles as much as possible, and build up the person's healthy side. An alliance is formed between the therapist and the healthy part of the client against the schemas. Any of the therapy activities described below may be seen as examples of schema healing.

The first step in therapy is to do a comprehensive assessment of the client. The main goal of this assessment is to identify the schemas and coping styles that are most important in the client's psychological makeup. There are several steps to this process. The therapist generally will first want to know about recent events or circumstances in the clients' lives which have led them to come for help. The therapist will then discuss the client's life history and look for patterns which may be related to schemas.

There are several other steps the therapist will take in assessing schemas. We use the Young Schema Questionnaire, which the client fills out, listing many of the thoughts, feeling and behaviours related to the different schemas; items on this questionnaire can be rated as to how relevant to the client's life they are.

There are also various imagery techniques which the therapist can use to assess schemas. One specific technique involves asking clients to close their eyes and create an image of themselves as children with their parents. Often the images that appear will lead to the core schemas.

Jonathan is a 28 year old executive whose core schema is Mistrust/Abuse. He came to therapy because he was having bouts of intense anxiety at work, during which he would be overly suspicious and resentful of his co-workers. When asked to create an image of himself with his family, he had two different images. In the first he saw himself being terrorized by his older brother. In the second he saw his alcoholic father coming home and beating his mother, while he cowered in fear.

There are many techniques that the therapist can use to help clients weaken their schemas. These techniques can be broken down into four categories: emotive, interpersonal, cognitive and behavioural. Each of these categories will be briefly discussed, along with a few examples.

Emotive techniques encourage clients to experience and express the emotional aspects of their problem. One way this is done is by having clients close their eyes and imagine they are having a conversation with the person to whom the emotion is directed. They are then encouraged to express the emotions as completely as possible in the imaginary dialogue. One woman whose core schema was Emotional Deprivation had several such sessions in which she had an opportunity to express her anger at her parents for not being there enough for her emotionally. Each time she expressed these feelings, she was able to distance herself further from the schema. She was able to see that her parents had their own problems which kept them from providing her with adequate nurturance, and that she was not always destined to be deprived.

There are many variations on the above technique. Clients may take on the role of the other person in these dialogues, and express what they imagine their feelings to be. Or they may write a letter to the other person, which they have no intention of mailing, so that they can express their feelings without inhibition.

Mode work can be invaluable as an emotive technique. A client may be feeling a vague sense of sadness which he can't clarify. By looking at modes with his therapist he may connect with a mode that he labels as Unimportant. By dialoging with the therapist from the mode's point of view many feelings can come out which can be worked on further. In this case the client might get in touch not only with the sadness, but also with anger at being ignored.

Interpersonal techniques highlight the client's interactions with other people so that the role of the schemas can be exposed. One way is by focusing on the relationship with the therapist. Frequently, clients with a Subjugation schema go along with everything the therapist wants, even when they do not consider the assignment or activity relevant. They then feel resentment towards the therapist which they display indirectly. This pattern of compliance and indirect expression of resentment can then be explored to the client's benefit. This may lead to a useful exploration of other instances in which the client complies with others and later resents it, and how they might better cope at those times.

Another type of interpersonal technique involves including a client's spouse in therapy. A man with a Self-Sacrifice schema might choose a wife who tends to ignore his wishes. The therapist may wish to involve the wife in the treatment in order to help the two of them to explore the patterns in their relationship and change the ways in which they interact.

Cognitive techniques are those in which the schema-driven cognitive distortions are challenged. As in short-term cognitive therapy, the dysfunctional thoughts are identified and the evidence for and against them is considered. Then new thoughts and beliefs are substituted. These techniques help the client see alternative ways to view situations.

The first step in dealing with schemas cognitively is to examine the evidence for and against the specific schema which is being examined. This involves looking at the client's life and experiences and considering all the evidence which appears to support or refute the schema. The evidence is then examined critically to see if it does, in fact, provide support for the schema. Usually the evidence produced will be shown to be in error, and not really supportive of the schema.

For instance, let's consider a young man with an Emotional Deprivation schema. When asked for evidence that his emotional needs will never be met, he brings up instances in which past girlfriends have not met his needs. However, when these past relationships are looked at carefully, he finds that, as part of the schema surrender process, he has chosen women who are not capable of giving emotionally. This understanding gives him a sense of optimism; if he starts selecting his partners differently, his needs can probably be met.

Another cognitive technique is to have a structured dialogue between the client and therapist. First, the client takes the side of the schema, and the therapist presents a more constructive view. Then the two switch sides, giving the client a chance to verbalize the alternative point of view.

After having several of these dialogues the client and therapist can then construct a flashcard for the client, which contains a concise statement of the evidence against the schema.

A typical flashcard for a client with a Defectiveness/Shame schema reads: "I know that I feel that there is something wrong with me but the healthy side of me knows that I'm OK. There have been several people who have known me very well and stayed with me for a long time. I know that I can pursue friendships with many people in whom I have an interest."

The client is instructed to keep the flashcard available at all times and to read it whenever the relevant problem starts to occur. By persistent practice at this, and other cognitive techniques, the client's belief in the schema will gradually weaken.

Behavioural techniques are those in which the therapist assists the client in changing long-term behaviour patterns, so that schema surrender behaviours are reduced and healthy coping responses are strengthened.

One behavioural strategy is to help clients choose partners who are appropriate for them and capable of engaging in healthy relationships. Clients with the Emotional Deprivation schema tend to choose partners who are not emotionally giving. A therapist working with such clients would help them through the process of evaluating and selecting new partners.

Another behavioural technique consists of teaching clients better communication skills. For instance, a woman with a Subjugation schema believes that she deserves a raise at work but does not know how to ask for it. One technique her therapist uses to teach her how to speak to her supervisor is role-playing. First, the therapist takes the role of the client and the client takes the role of the supervisor. This allows the therapist to demonstrate how to make the request appropriately. Then the client gets an opportunity to practice the new behaviours, and to get feedback from the therapist before changing the behaviour in real life situations.

In summary, schema therapy can help people understand and change long-term life patterns. The therapy consists of identifying early maladaptive schemas, coping styles and modes, and systematically confronting and challenging them.

References

Young, J.E., and Klosko, J.S. (1993). Reinventing your life. New York: Dutton, 1993.

Young, J.E., Klosko, J.S., and Weishaar, M.E. Schema therapy: A practitioner's guide. New York: Guilford, 2003.

Copyright 2012, Cognitive Therapy Center of New York

For more information contact:

Schema Therapy Institute 130 West 42 Street
New York, NY 10036

(212) 221-0700

David Bricker, Ph.D. 160 Broadway
New York, NY 10038

(212) 406-3520

david@davidbricker.com

Using schemas and schema modes as a basis for formulation and treatment planning in schema therapy

David Edwards

Certified as a Schema Therapist by the International Society of Schema Therapy

www.schematherapysouthafrica.co.za

Schema therapy offers a comprehensive approach to addressing longstanding psychological difficulties. It is drawn from many of the discoveries about what is helpful in psychotherapy that have been made over the past 100 years or so. It is an integrative approach to therapy developed by Jeffrey Young. He began teaching trainees how to do schema therapy in the 1980s, and in due course published descriptions of the approach for clinicians (Young, 1990; Young, Klosko and Weishaar, 2002) and for clients (Young & Klosko, 1994). This document summarizes some of the important aspects of this approach to assessment and therapy. More information can be found on my website at www.schematherapysouthafrica.co.za and on Jeff Young's website www.schematherapy.com

Early maladaptive schemas

Early maladaptive schemas (EMSs) are longstanding patterns of psychological response that govern how we perceive the world, how we understand what is happening to us, what we feel and how we behave. They often have their origins in infancy and early childhood and may even be set up before we are born (for example, if a traumatic event happened to our mother while she was pregnant). Six features of EMSs are identified by Young et al. (2003, p. 7). An EMS is...

- a broad, pervasive theme or pattern ...
- comprised of memories, emotions, cognitions, and bodily sensations ...
- a regard of oneself and one's relationships with others...

- developed during childhood or adolescence ...
- elaborated throughout one's lifetime, and
- dysfunctional to a significant degree.

A consequence of EMSs is that we behave in ways which are self-defeating or even self-destructive. These schema driven behaviours may be at the root of the emotional distress or problematic behaviours that lead a person to seek psychotherapy. EMSs are automatic and habitual and typically we do not realize the impact they have on our relationships and our approach to work and other aspects of life. Because we may experience them as such an essential part of us, even when we recognize that they are problematic, we may feel helpless about changing them.

Maladaptive schemas are responses to unmet needs

As infants and children, humans are vulnerable and helpless, and in order to develop in a psychologically healthy way, certain basic needs must be met. When basic needs are unmet, normal, healthy psychological development goes wrong and gives rise to EMSs that can continue to cause problems throughout life if they are not addressed. The needs of the normal infant and child are summarized below, with comments on the kinds of conditions under which they might not be met.

1. The need for safety and stability: This need may not be met where children are born into unsafe situations: for example, into times of natural disasters (earthquake, tsunamis), or into neighborhoods or families where there is endemic violence.

2. The need for a secure, loving, and reliable bond with one or more caregivers: This need may not be met if the mother or main caregiver is not a warm, loving person who enjoys giving maternal care, or where she becomes unavailable through illness, depression, or economic hardship, or if she is emotionally unstable or unpredictable, or in a family where there is abuse and violence.

3. The need to be supported over the course of growing up, in moving from helplessness and dependence to a sense of competence (to function in the world), autonomy (ability to make one’s own choices). This need may not be met where need 1 is not met and children feel overwhelmed and unsafe in the world. Similarly, it may not be met where caregivers fail to meet need 2 and fail to give consistent loving support to children as they venture out into the world and learn how it works. It will also not be met where caregivers are overprotective or are attached to having children who are dependent and helpless and have difficulty letting them grow up and become independent.

4. The need to find appropriate expression for emotions and needs in a way that leads to needs being met. As children grow, if they have the right kind of loving support, they learn to identify and express their feelings and needs in appropriate ways.

5. The need to learn how to flexibly manage and control one's emotional and behavioural reactions: This need may not be met when the need for safety and stability is not met, as children may experience such extreme emotions that it is beyond their capacity to modulate them. This need may not be met when the need for a stable loving relationship is not met, since learning to manage one's emotions takes place in the interaction with a warm loving caregiver. Where parents are harsh and punitive, children may internalize their punitive voices as a means of maintaining self-control.

6. The need to express oneself spontaneously, playfully and creatively: Playfulness and spontaneity are normal features of human (and animal) behaviour, and with development, mature into warmth and creativity. When these aspects of behaviour are neglected or actively discouraged or punished, individuals may lose their capacity for spontaneity and playfulness.

There is considerable evidence that these needs are universal, where Young suggests that "a psychologically healthy individual is one who can adaptively get these core emotional needs met." Once EMSs form as a result of unmet needs, they have the perverse effect of making it difficult for the unmet needs to be met in the future. It is the aim of schema therapy to help people identify their schemas, to understand how these relate to their unmet needs, and to help them find adaptive ways to get these needs met in their current lives.

How early maladaptive schemas develop

Young, Klosko and Weishaar (2003) describe how early life experiences give rise to EMSs:

> "Toxic childhood experiences are the primary origin of early maladaptive schemas. The schemas that develop earliest and are the strongest typically originate in the nuclear family. To a large extent, the dynamics of a child's family are the dynamics of that child's entire early world. When patients find themselves in adult situations that activate their early maladaptive schemas, what they usually are experiencing is a drama from their childhood, usually with a parent. Other influences become increasingly important as the child matures, such as peers, school, groups in the community, and the surrounding culture, and may lead to the development of schemas. However, schemas developed later are generally not as pervasive or as powerful."

These authors suggest that there are four kinds of experience which give rise to EMSs:

- Toxic frustration of needs occurs when the child's basic needs for a stable loving relationship and consistent care are not met.

- Traumatization occurs when the child is harmed or victimized or exposed to traumatic situations such as natural disasters.

- Overindulgence and overprotectiveness on the part of parents or caretakers prevent children from developing autonomy or appropriate self-control.

- Internalization of or identification with significant others results in children taking on the thoughts, feelings, experiences, and behaviors of their parents or caretakers. For example, where a parent is punitive and critical, the child may become self-punitive and self-critical.

The 18 early maladaptive schemas and the YSQ

Clinical experience over several decades on the part of Young and his colleagues working with the schema therapy model has led to the development of a list of 18 early maladaptive schemas. This list (which is attached as an appendix) can be helpful, because each of these schemas is common and frequently contributes to the kinds of problems that lead people to seek psychotherapy. In helping you do identify the schemas which are affecting you and which may be contributing to your current difficulties, the therapist will use a combination of sources of information. These include:

1. Information about your life history, including the circumstances of your birth and childhood, and the nature of relationships in your family.
2. Information about the kinds of everyday events that become problematic for you in your relationships and at work.
3. Information about other kinds of events that may trigger emotional distress (scenes from movies, items on news bulletins).
4. The Young Schema Questionnaire (YSQ), which is a self-report inventory with questions which tap each of the 18 schemas.

Schema processes

Schemas are not all equally active all the time. A complex set of processes determines which ones are active, and how we deal with them once they are active. These processes, themselves, are mostly automatic and outside of conscious control, so that often we may have very limited awareness of how they affect us. As a result, we are often puzzled by our own reactions, which may take the form of gradual or sudden shifts in mood or feeling, or behaviour or repeated behaviour which is obviously self-defeating or self-destructive. An analysis of schema processes helps us understand what underlies these experiences.

Schema triggering

Schemas may lie dormant until triggered by particular events or situations. For example, in relationships, a remark from a friend or intimate partner may trigger schemas associated with rejection, abandonment, or abuse. Hearing about an accident or misfortune may trigger a schema associated with lack of safety or security. A disappointment or lack of achievement may trigger schemas associated with defectiveness, failure, or pessimism. A schema can be triggered by watching a scene from movie or reading a story in a magazine that is thematically similar to the schema.

Activation of a schema that is usually dormant can trigger a sudden rush of intense and confusing feelings. However, other schemas present themselves less intensely. However, once a schema is active, it strongly shapes our patterns of perception, interpretation, feeling and behaviour.

When faced with a threat, there are three characteristic patterns of response which are found in humans and animals. These are the three Fs: flight, fight and freeze. Thus, if an animal is attacked by a predator it can try to escape (flight), try to fight back (fight), or go limp and play dead (freeze). These three kinds of response can be seen in the way people deal with their schemas.

Schema surrender

Sometimes we simply experience the schema as it is, with its associated emotions and ways of thinking and behaving. For example, a person with an emotional deprivation schema may feel lonely, unloved, and unlovable and wonder if they will ever have an experience of loving relationship, or whether they are incapable of it. We call this surrendering to the schema. It feels as if it is our identity - that the beliefs associated feel true, and we feel trapped in the unpleasant feelings associated with it. We don't do anything active to make the situation better. This can be thought of as an example of a freeze response.

Schema surrender can be self-perpetuating in two ways. First, the schema biases our interpretation of events. This is called cognitive distortion. For example, when individuals are surrendered to an emotional deprivation schema, they may simply not notice or they may discount any warm or loving behaviour directed at them. Second, the way the person behaves under the influence of the schema may negatively affect how others relate to them. This is called self-defeating behaviour. For example, individuals who they feel unloved and uncared for may come across as withdrawn and cold and alienate others who might reach out to them.

Schema avoidance

Because schemas are associated with emotionally painful states, individuals actively avoid situations that might trigger them. A person with an abandonment schema may avoid getting emotionally close to anyone at all due to the intense pain that any separation or break in the relationship might cause. A person with an emotional deprivation schema may also avoid meaningful relationships due to these activating the pain of deprivation when the other person does not perfectly meet their needs. A person with a failure schema may avoid striving to achieve anything of significance as a way of ensuring that they do not fail and, thus, do not activate the failure schema. This can be seen as an example of a flight response.

Avoidance can take three main forms: behavioural (actively avoiding contact with particular places, people or situations), cognitive (actively avoiding thinking about things that might trigger a schema) and emotional (shutting down emotionally when a schema has been triggered to avoid having to experience the associated pain).

Avoidance may work up to a point, but a high price is paid. First, avoidance does not address the underlying schemas at all. They remain hidden and can be triggered if avoidance does not work. Second, avoidances are very limiting, and reduce an individual's quality of life and opportunities for engaging in potentially meaningful activities.

Schema overcompensation

When they overcompensate, individuals adopt strategies that contradict the schema to such an extent that it becomes invisible. A person who, as a child, felt flawed and worthless will become perfectionistic. A person whose needs as a child were not met becomes defiant and demanding. A person whose childhood longing for bonding and connection was not met becomes fiercely independent and seems to need nobody. Overcompensation is, thus, an example of a fight response.

Overcompensations may work up to a point and allow individuals to function more effectively in the world than if they were surrendered to their maladaptive schemas. However, they have two drawbacks. First the underlying schemas are not addressed. This means that when the compensation fails, the schemas can be triggered and the individual is overcome with intense feelings and is confused about where the schema comes from. Thus, individuals with a defectiveness/shame schema may overcompensate by being perfectionistic. However, even though they do achieve excellent results, the underlying vulnerability to shame is still there. Second, the overcompensatory behaviour can reinforce the underlying schemas. For example, a person who is controlling and demanding is likely to irritate others and push them away. This creates further evidence for underlying schemas associated with beliefs that other people do not really care. Thus, overcompensations are examples of self-defeating behaviours.

Schema modes

Another aspect of schema organization is that one or more schemas may function together to form a stable mode that functions like a kind of sub-personality. Individuals have several modes and may switch between them in ways that are confusing for other people (because it is as if the person has undergone a personality change) and may also be confusing for the individual (who will feel completely different, depending on which mode is active).

The main classes of modes are summarized below, and there is a longer list is in Appendix B. Note that your therapist will help you identify your own distinctive modes, some of which may not necessarily be the same as the examples given. You may be asked to complete the Schema Mode Inventory as a way of identifying important modes.

1. Healthy modes

Healthy functioning calls for the capacity to obtain and integrate information, identify and solve problems, and make balanced evaluations and decisions in the various domains of life so that activities are pursued in a balanced way. This leads to a sense of meaning and fulfillment in work, in intimate and social relationships, as well as sporting, cultural, and service-related activities. This involves being aware of feelings and their meaning, taking responsibility for choices and actions, and making and keeping commitments. This is the Healthy Adult mode. A child whose needs are met feels safe and contented, has a sense of personal connection to others, experiences excitement and curiosity about life and the world, and has a spontaneous capacity for happiness and contentment. These are the characteristics of the Happy or Contented Child mode.

2. Damaged child modes

These modes carry the experience of the child whose needs were not met. When a person experiences these childhood schemas, we say that they are in Vulnerable Child mode. Often the vulnerable child has distinctive experience that may be captured by referring to the Abandoned Child or the Lonely Child or the Dependent Child mode. In practice, we can personalize modes for each individual depending on the characteristic experience of the mode and the predominant schemas around which it is organized. Another set of child modes are responses developed in childhood due to neglect or abuse. These are the Angry Child mode and the Enraged Child. When these modes are activated, individuals become irrationally angry or even destructive. The Impulsive Child and Undisciplined Child modes may develop when parenting is too permissive and children are not treated with appropriate firmness, or when parents fail to provide the support towards building appropriate motivation in the child.

3. Coping modes

Coping modes develop as a way of coping with the emotional distress in the Vulnerable Child.

3.1 Surrender modes: At times, when vulnerable child modes are triggered, people act as if the beliefs associated with these modes are accurate and the associated feelings are, therefore, inevitable. In the Compliant Surrenderer mode they cope with this by pleasing, placating, and helping other people, while subordinating their own true feelings and needs.

3.2 Protector/avoidance modes: In these modes we cut off from the emotional pain associated with our underlying EMSs. In Avoidant Protector Mode we simply avoid people, activities or places that might act as triggers. In Detached Protector Mode we cut off from our feelings and go about in an emotionally numb or robotic state. In Angry Protector mode we cover what we are really feeling with a stream of resentment and anger to shut others out from our vulnerability. In Detached Self-Soother mode we avoid what we are really feeling by resorting to activities like comfort eating, using alcohol and other drugs, or

compulsive use of pornography or the internet. All these modes perpetuate the EMSs and prevent resolution and healing. They usually also add to our problems in significant ways.

3.3 Overcompensator modes: In these modes we act in a way that is the opposite of how we are when an EMS is triggered. A person who feels in need of others and dependent on them may act in a strong and independent manner. A person who feels worthless may act as if they are great, and resort to seeking admiration and placing themselves in a one-up position above others (Self-Aggrandiser mode), or strive to be perfect and in control (Perfectionistic Overcontroller mode). These strategies may work to some extent by helping us cope with life and get on in the world. However, they leave the vulnerable child untouched, and can lead to chronic alienation from spontaneity and authenticity.

4. Dysfunctional parent modes

Individuals behave towards themselves like dysfunctional parents, either by placing upon themselves unrealistic demands for achievement or self-control (Demanding Parent), or by scolding, criticizing and belittling themselves (Punitive Parent). These modes are often internalized from experiences with parents or teachers.

Developing a formulation and treatment plan based on an analysis of schemas and modes

We can develop a schema-focused understanding of your problems by reviewing your characteristic behaviours in everyday situations, reviewing the areas in which you experience significant problems, and examining your life history. In addition, you may be asked to complete one or more self-report scales such as the Young Schema Questionnaire, the Young Parenting Inventory and the Schema Mode Inventory. On this basis we can identify your most significant EMSs and the associated core beliefs and emotional states, and how you cope with them through various forms of surrender, avoidance or overcompensations. This can provide an understanding of how many of your problems may be caused by dysfunctional parent modes and coping modes.

This provides the basis for a comprehensive long term plan of action for changing the EMSs, building new more adaptive and self-enhancing behaviours, and findings ways to get your needs met on an ongoing basis in the contexts of your current life. This plan is likely to involve a wide range or activities, many of which can be understood as falling under the following three headings:

Healing the Vulnerable Child

Most EMSs are embedded in childhood experiences which were emotionally painful. These patterns continue into the future, driven by memories of critical experiences from long ago. As EMSs are activated, they allow us to get in touch with the memories from the past events that hurt us, and seemed to be impossible to resolve. It can be helpful to see how present-day feelings are actually memories of what happened in the past. In addition, the painful memories can, themselves, be addressed by way of rescripting them. These involves working with the Vulnerable Child, empathizing with him/her, and symbolically providing ways in which he/she can have these needs met that were not met at in the past.

Reducing the power of dysfunctional coping and parent modes

Coping modes prevent access to the child modes which are the source of spontaneity, authenticity and the capacity for meaningful interpersonal contact. They also create additional problems by giving rise to self-limiting, self-defeating, and self-destructive behaviours. These modes need to be identified and replaced with more effective and non-harmful ways of coping. Schema therapists help their clients to challenge avoidances. This will involve exposing yourself to situations, thoughts and feelings that you normally and automatically avoid. Your therapist will help you to plan this in a graded manner so that you can learn to tolerate uncomfortable feelings that might be evoked. Often these are feelings from childhood that can be worked with in therapy. They also help clients to relinquish compensatory behaviours. Although these are sometimes adaptive to some extent, they also have the negative effect of distancing us from our genuine experience, and this can have a negative impact on interpersonal relationships. By giving up compensations, we will expose ourselves to EMSs which we have not wanted to experience. As these EMSs come into focus, they can be worked on and resolved in therapy. This can lead to learning to interact in a more authentic and satisfying way.

Dysfunctional parent modes are also problematic. At the outset, they might appear to help you to motivate you to get things done. But, on closer inspection, they have the opposite effect. A critical voice that constantly repeats demeaning messages and undermines your self-esteem makes it difficult to enjoy everyday activities and relationships. A demanding voice that keeps imposing rigid standards in the form of rules and "shoulds" creates chronic tension and dissatisfaction. Both these voices can activate an angry or rebellious child mode that refuses to be pushed around, resulting in procrastination or a lack of motivation. To identify these parent modes, the messages they give need to be closely scrutinized, and where deemed unhelpful, need to be stopped and banished.

Building the healthy adult

Often the effect of vulnerable child states and the avoidances and compensations that are adopted to hide them is that individuals find it difficult to remain in a balanced state. In this balanced state they can exercise good judgment, have an accurate perception of their own and others' behaviour, and effectively solve every day problems. Building this balanced Healthy Adult state can be an important focus of therapy. This might involve:

- Building an understanding of how EMSs and schema modes work: As you understand how these work, you can step back and see clearly what you need to do to break out of the patterns, and how the various aspects of schema therapy can contribute to empowering you to do this.

- Addressing cognitive distortions: This will involve identifying beliefs and assumptions, as well as everyday thoughts that are inaccurate and serve to maintain the schema. Once done, you can actively challenging these distortions on the basis of rational thinking and the examination of evidence in real-life situations.

- Behavioural experiments/behavioural pattern-breaking: This will involve experimenting with new ways of behaving to replace your current self-defeating behaviours. We refer to behavioural experiments, because you will learn what works for you by trying out new behaviours which are likely

to be more effective, and by carefully examining the effects of these new behaviours. We refer to pattern-breaking, because it is important to break the power of self-defeating patterns, and replace them with patterns that will help you to lead a more satisfying life.

- Cultivating self-enhancing activities and behaviours: Positive change does not only involve working on old self-defeating patterns, but also identifying what you want out of life right now byh engaging in activities and relationships that are likely to be meaningful and satisfying for you. These need to be continually worked with in order to weave them into the fabric of your everyday life. This will involve evaluating your current goals and setting new ones. In particular, you will want to re-evaluate goals that are driven by schema overcompensation, because when such goals are achieved, the satisfaction is usually short-lived.

- Learning to use feelings as a guide to behaviour: As the healing process takes place in the Vulnerable Child, you will have more and more access to what you really feel about everyday situations and relationships, and the decisions you will need to make. You will be able to integrate these feelings into problem-solving processes, and increasingly decision-making that results in your getting your needs met and enjoying a greater sense of satisfaction out of life.

For further reading and information

Visit http://www.schematherapysouthafrica.co.za/ or read one of the books below:

Arntz, A. & Jacob, G. (2012). Schema Therapy in practice. Oxford: Wiley/Blackwell. A comprehensive introduction to schema therapy for non–specialist practitioners by authors who have pioneered the development of the schema mode approach.

Rafaeli, E., Bernstein, D. P. & Young, J. (2011). Schema Therapy (The CBT Distinctive features series). London: Routledge. This is a clear summary for clients and therapists. The focus is on the distinctive features of ST in relation to other integrative therapies that have grown out of the cognitive-behavioural tradition.

van Vreeswijk, M., Broersen, J. & Nadort, M. (2012). Handbook of Schema Therapy: Theory, research and practice. Chichester: Wiley. A comprehensive resource with contributions from a large number of researchers and practitioners covering a wide range of clinical aspects.

Young, J. E. & Klosko, J. (1994). Reinventing your life. New York: Plume. This is a great book for clients in schema therapy, but it's a good read for therapists too. As a client, it is highly advised to purchase your own copy of this book.

Young, J. E., Klosko, J., & Weishaar, M. E. (2003). Schema therapy: A practitioner's guide. New York: Guilford. This is a very comprehensive guide and resource with all the theory and many clinical examples. This is a must for therapists, but some clients might also enjoy reading it.

APPENDIX 15

Table 13: Summary Details of the Patient-Participants

Name [1]	Age [2]	Marital Status [2]	Highest Education [2]	ED Diagnosis	Assessed	Therapy	
						Start	Finish [3]
Alison[Ψ]	**Mid-60s**	**Married**	**Tertiary Diploma**	**AN-r**	**Jun '13**	**Jul '13**	**Oct '16**
Anna*	Late-20s	Single (NIR)*	Masters' Degree	BED	Aug '13	Sep'13	Sep '15
Carla	Late-20s	Single (NIR)	Honours Degree	BED	Aug '13	Sep '13	Jun '15
Cathy	Early-30s	Single (NIR)	Undergraduate Degree	OSFED	Jul '13	Aug '13	June '15
Joanne*[8]	Early-30s	Single (NIR)	Postgraduate Degree	AN-r	Jul '13	Aug '13	Sept '13
Judy* [8]	Late-40s	Married	Undergraduate Degree	BN	Jul '13	Sep '13	Oct '14
Lilly*	Mid-40s	Divorced (NIR)	Postgraduate Degree	BED	Jul '13	Sep '13	Aug '15
Rebecca	Mid-20s	In relationship	Undergraduate Degree	AN-b/p	Jul '13	Aug '13	Sep '15
Tessa	Late-20s	Single (NIR)	Postgraduate Degree	AN-r	Jul '13	Oct '13	Nov '15
Wendy	Late teens	Single (NIR)	Matric	AN-r	Jul '13	Sep '13	Oct '15

* = New patients (the remaining of which were existing patients in my private practice.

Ψ = the only participant written up as a case study in the thesis.

8 = Non-completers of the study.

1 = Pseudonym to ensure anonymity

2 = At the start of the study

3 = Date at which the study was complete. The asterisk indicates that this participant continued with therapy following the duration of the study

NIR = Not In Intimate Relationship

AN-r (Anorexia Nervosa – restrictive type) AN-b/p (Anorexia Nervosa – binge-eating/purge type) BED (Binge-Eating Disorder) OSFED (Other Specified Feeding or Eating Disorder) BN (Bulimia Nervosa)

APPENDIX 16
Form 7: Schema Therapy Case Conceptualisation Form for Alison

Schema Therapy
Case Conceptualization Form

2nd Edition
Version 2.18

Please type your responses into the boxes outlined in blue next to each item.

Therapist's Name:	Graham Alexander	Date:	[redacted]
Number of sessions:	235*	Months since first session:	73

* Alison has been in therapy with me for just over 6 years, or 73 months. However, we only started schema therapy (ST) approximately 2 and a half years later and the session being provided here was the 56th ST session.

I. Patient Background Information

Patient's Name/ID	Alison* *Not her real name	Age/DOB:	69 years old Born 09/08/1948
Current Relationship Status/Sexual Orientation/ Children (if any):	Married 36 years Heterosexual I son (Eric, 30 years)		
Occupation & Position	Home keeper. Retired from position of bank clerk when married		
Highest Educational Level	Teaching Diploma		
Country of Birth/Religious Affiliation/Ethnic group	South Africa. Catholic (practicing). South African Citizen. Caucasian.		

II. Why is the Patient in Therapy?

What are the primary factors motivating the patient to come for treatment? What aspects of the patient's life circumstances, significant events, symptoms/disorders, or problematic emotions/behaviours are contributing to his/her problems (e.g., health problems, relationship issues, angry outbursts, anorexia, substance abuse, work difficulties, stage of life)?

a. Initially	Client entered treatment in October 2011 after repeated requests from her son, Eric, due to longstanding Anorexia Nervosa (restricting type)(Extreme severity - BMI<15kg/m^2). She was very apprehensive to be re-entering therapy, although she had not received any psychotherapy for her eating disorder for decades. She had already been consulting for some time with a psychiatrist and dietician. Alison also presented as significant anxious emotionally detached. Her marriage was devoid of any form of intimacy and she was not able to engage in any meaningful interpersonal relationships with family and friends. She remained very socially isolated, but for attending church on a regular basis. Alison also displayed symptoms of Major Depression (emotionally blunt, empty and hopeless; diminished interest or pleasure in most activities; fatigue; feelings of worthlessness and excessive inappropriate guilt; poor concentration and indecisive).
b. Currently	While Alison has sustained almost three years of remission from her eating disorder and no longer meets the full criteria for an anxiety disorder, she still has some anxiety associated with facing new situations. Despite such anxiety occasionally provoking some limited restrictive eating, this has not resulted in her becoming underweight. Although Alison has acknowledged and addressed much of the emotional pain associated with her abused and emotionally deprived childhood, this has not been fully resolved. The Punitive and Demanding Parent modes are still quite prominent, but the Healthy Adult mode is gaining momentum in banishing these dysfunctional parent modes.

III. General Impressions of the Patient

Using everyday language, briefly describe how the patient comes across in a global sense during sessions (e.g., reserved, hostile, eager to please, needy, articulate, unemotional). Note: this item does not include discussion of the therapy relationship or change strategies.

a. Initially	Very neatly dressed, Alison's extremely fragile and severely emaciated frame gave the appearance of a woman many years older than the one sitting tentatively beside her husband on the couch opposite me. She was quiet-spoken, extremely polite and cooperative, and forthcoming in describing the severity of her anorexic condition. However, her blunted affect demonstrated the extent of her emotionally detached state. Only when she spoke about her husband and son did she display a warm, but tired-looking smile. She spoke in an idealized way about her deceased parents, despite clear evidence of their abuse and emotional neglect.
b. Currently	Alison has remained at a normal weight for the past three years. She has a warm and loving relationship with her husband, Michael, which is both emotionally and sexually intimate. She has also developed a very close and emotionally engaging relationship with her son. Together with Michael earlier this year, she travelled abroad for the first time in her life. Prior to this, she succeeded in developing a far more socially engaging lifestyle, regularly dining out and attending the theatre, and frequently enjoying the company of extended family members. In sessions, Alison is far more engaging and animated in expressing herself. However, she remains very apprehensive to allow herself to display the deep sadness associated with the neglect and trauma associated with her childhood and still engaged occasionally in Punitive Parent commentary to chastise herself. There is still evidence of her poor self-worth, but she has become increasingly responsive in engaging with her Vulnerable Child and realizing the self-nurturance she requires and deserves.

IV. Current Diagnostic Perspective on the Patient

A. Main Diagnoses (include the name & code for each ICD-10-CM disorder)

1.	Major Depressive Disorder (Mild) with anxious distress (F32.0)	2.	Other Specified Anxiety Disorder (Generalised anxiety not occurring more days than not). (F41.1)
3.	Other Specified Feeding or Eating Disorder Atypical Anorexia Nervosa (F50.8)	4.	Other Specified Personality Disorder (mixed personality features – dependent PD and Obsessive-Compulsive PD traits) (F60.89)

B. Current Level of Functioning in Major Life Areas

Rate the patient's current functioning for each of the 5 life areas in the table below. Detailed descriptions of each life area, and the 6-point rating scale, are included in the Instruction Guide (1=Not Functional/Very Low, 6=Very Good or Excellent Functioning). In Column 3, briefly explain your rationale for each rating in behavioural terms. If the patient's prior level of functioning was significantly different from the current level, please elaborate in Column 3.

MAJOR LIFE AREA	RATE CURRENT LEVEL OF FUNCTIONING	EXPLANATION OR ELABORATION
Occupational or School Performance	5	Alison is competent in the manner in which she maintains the home. She attends to all housekeeping and cooks. She is no longer obsessive in the manner in which she maintained the home before and in the early stages of treatment.
Intimate, Romantic, Longer-Term Relationships	5	Alison has made remarkable progress in engaging with her husband in an emotionally and sexually intimate manner. Sometime undermines her own value, which makes her hesitant to engage in a fully spontaneous manner. This is in stark contrast to the significant lack of intimacy (both emotionally and sexually) when she started treatment.
Family Relationships	5	Both Alison's parents are deceased. She has a warm and loving relationship with her son, Erik, who is 30 years old. However, she still feels guilty about the way that she neglected him during his childhood as a result of her eating

		disorder. She has difficulty forgiving herself, despite Erik having fully resolved the issue. She has been increasingly socialising with her extended family members (cousins, nephews, nieces, etc.)
Friends & Other Social Relationships	5	While Alison was extremely socially withdrawn throughout her active eating disorder, since entering remission she began to increasingly socialising by way of visiting and dining out with friends, entertaining at home, and engaging in public events.
Solitary Functioning & Time Alone	5	Alison handles everyday activities well on her own. Her husband attends to technical matters (e.g., electronics, home maintenance, etc.)Due to her husband frequently playing bowls, Alison has demonstrated comfort in keeping herself busy when she is alone. She enjoys reading and goes on walks on her own. She is autonomous with respects to her personal hygiene.

V. Major Life Problems & Symptoms

For each major life issue or psychiatric symptom/disorder, elaborate on the nature of the problem, and how it creates difficulties in the patient's current life. Try to avoid schema terminology in describing each problem or symptom.

1. Life Problem/Symptom:	Feeling inferior, inadequate, and a failure.

Especially in circumstances where Alison is affirmed or paid compliments, she reflexively feels and expresses a sense of inadequacy and inferiority compared to others. She often says in sessions, especially when I affirm her or point out her strengths: "I have no redeeming qualities." Alison generally feels that she has been a failure throughout her life. Even with regards to her significant recovery from her eating disorder, she insists that she has not done well in treatment and should have recovered in a significantly shorter period of time. She sometimes compensates to her feeling of inadequacy by being obsessive and perfectionistic in her tasks.

2. Life Problem/Symptom:	Feels guilty for having failed emotionally as a mother.

Alison compulsively feels guilty for the manner in which she deprived her son of the emotional care that he required when she was anorexic. Despite joint sessions with Eric having indicted that he has forgiven her and feels resolved of the effect his mother's anorexia had on his upbringing, she insists that she feel guilty and feel compelled that she still be punished/chastised for such shortcomings.

3. Life Problem/Symptom:	Lacks assertion and automatically attends to the needs of others before attending to her own needs.

Although Alison has made significant progress in expressing her needs and wants more recently, she is still too preoccupied with and submits to the needs of others. This is partly in order to be met with approval of others and partly due to feeling that the needs of others are more important than her own.

4. Other Life Problems/Symptoms:	Struggle to be spontaneous and anxious in engaging in new tasks.

Although Alison has made progress in this respect, she still struggles to allow herself to be spontaneous – fearing that this will be conducive to her becoming overly indulgent and undisciplined. It reflects an anxious need to feel in control at all times. She is very anxious in engaging in new tasks, convinced that she will fail to perform them adequately or become overwhelmed. For example, when she travelled to France earlier in the year, much preparation was required to attend to her fear of flying, given that she had not travelled abroad before. She had only flown once before – a domestic trip many decades before. She becomes overwhelmed at the prospect of operating an electronic device (cell phone, computer, Kindle®), but when assisted in such tasks, she demonstrates her capabilities. Another example was her anxiety at the prospect of hosting a 40 years reunion of her matriculation (Grade 12) school class. Although anxiously overwhelmed and anticipating that she would fail, she did an excellent job, which was greatly appreciated by her old friends.

VI. Childhood & Adolescent Origins of Current Problems

A. General Description of Early History

Summarize the important aspects of the patient's childhood and adolescence that contributed to his/her current life problems, schemas, and modes. Include any toxic experiences or life circumstances (e.g., cold mother, verbally abusive father, scapegoat for parents' unhappy marriage, unrealistically high standards, rejection or bullying by peers).

Alison was born more than a decade after her two brothers due, partly, to her father having served in the South African Army during World War II. He returned extremely traumatised from the war, most notably by his prisoner-of-war experience in Italy after being captured in North Africa. Upon returning home he coped with his traumas by drinking excessive and frequent quantities of alcohol, which often resulted in frequent bouts of verballed to abusive behaviour towards all family members. Although he was emotionally absent and uninvolved in family life, he was a daily source of fear and anxiety to Alison. In addition to regular aggressive outbursts, alcoholism accounted for much socially inappropriate behaviour that was a frequent source of embarrassment to Alison throughout her childhood and adolescent years. She made every effort to avoid her friends from being exposed to his drunken antics and she often tried to pacify him when he became aggressive and disruptive. He spent the majority of his limited income on gambling, which also created economic strain on the family. Alison's description of her father was of a weak man who was "an utter failure as a husband, father, family man, and provider."

Alison's very emotionally depriving mother accounted for a childhood filled with loneliness, uncertainty, fear, inadequacy, and an existence devoid of love, safety, and warmth. Alison maintained a largely idealised view of her mother until treatment started. She saw her mother as very self-sacrificing and devoutly religious in following her Catholic principles. However, she was also aware of a mother who was extremely puritanical, non-demonstrative, a strict disciplinarian, overly controlling, and emotionally absent. Never questioning her mother's attitudes, Alison emulated these extremely self-depriving and puritanical qualities throughout her life. Alison learned to not express her needs and seldom displayed any emotional vulnerability to her mother. Her mother instilled the notion that any notion of spontaneity, joy, desire, or happiness was wrong or sinful.

Significantly deprived by both parents and exposed to abuse and uncertainty left Alison feeling extremely lonely, empty, helpless, and undeserving of love. She was often shamed by her mother, who often left her feeling guilty. The uncertainty and inconsistency of the home environment left her frequently worrying, pessimistic, hyper-vigilant, and anxiously indecisive.

Although they left home early after completing their school careers, Alison's brothers fulfilled a healthy parental role while she was still attending high school, keeping a watchful eye on their young sister when they could. They were both diagnosed with major depression and received treatment from their early adulthood.

B. Specific Early Core Unmet Needs

For Items 1-3 below, specify one of the patient's core unmet needs. Then briefly explain how specific origins from section VI.A. above led to the need not being met. List any other core unmet needs in Item 4.

1. Specific Early Unmet Need:	Need for safe and stable attachments.
Origin(s)	● Father's absence, which was exacerbated by his severe alcoholism and associated unresolved war traumas, accounted for his unpredictable temper and angry outbursts, instability, his unreliability, and emotional inaccessibility. As such, Alison never experienced a bond with her father and never felt a sense of his emotional or practical support. Alison was frequently anxious in anticipation of her father's moodiness, unpredictability drunken behaviour and avoided being in his presence as much as possible. ● Father withdrew of left Alison alone for extended periods. ● Mother's emotionally cold, undemonstrative, and overly strict qualities left Alison feeling totally deprived of warmth, love, and any sense of care and safety. Her punitive and critical nature added to this. Alison also felt that she and her mother would be hurting each other if they were ever separated.

2. Specific Early Unmet Need:	Unconditional acceptance and praise.
Origin(s)	● Mother was critical, harsh, and preoccupied with an adherence to strict Catholic principles. She never affirmed or praised her daughter. She instilled feelings of guilt when Alison deviated to the slightest from her expectations. She never praised her daughter and vehemently discouraged any notion of self-praise or pride. Her mother shamed her body when she began to sexually develop. She had strict standards by which everything needed to be conducted ● Father was verbally abusive and never demonstrated any pride in his children.

3. Specific Early Unmet Need:	Love, nurturance, and attention.
Origin(s)	● Mother was emotionally cold and undemonstrative. She never showed any warmth or love towards any family member, including Alison's father. She was devoid of the ability to show vulnerability and never expressed love towards any family member. Mother regarded emotional warmth and the demonstration of affection as "weak" and "unnecessary". ● Father was absent or frequently intoxicated. He never demonstrated physical affection towards anyone and neglected to make any efforts to be close to Alison.

4. Other Early Unmet Needs:	[4] Autonomy, competence, sense of identity [5] Expression of needs/emotions, spontaneity and play.
Origin(s)	[4] Mother's overly controlling and critical nature left Alison too fearful to take initiative and exercise any form of independence. She always instructed what Alison should do and warned her that she would fail anything that she wished to embark on (e.g., getting a drivers' licence, studying teaching). Mother did too many things for Alison instead of letting her do things herself. She treated Alison as if she was much younger than her real age. As such, Alison was reluctant to take any risks and define her own life path. Father was uninvolved in any decision-making and never encouraged Alison to explore her own wishes and needs. Father never provided Alison with any form of discipline necessary to succeed in school [5] Mother's very strict and puritanical religious beliefs reflected in a very self-denying and self-disciplined culture, a need for self-sacrifice and a forbidding of one's own needs. Mother placed more emphasis on doing things well than on having fun or relaxing. This likely facilitated Alison's abstemious behaviour around food and drink. Similarly, her mother prohibited any form of emotional expression, whether anger, sadness (tearfulness), or feelings of joy and fun. A strict and rigid work culture was insisted upon, while any expression of spontaneity and fun was forbidden and regarded as ill-disciplined and sinful.

C. Possible Temperamental / Biological Factors:

List facets of temperament – and other biological factors – that may be relevant to the patient's problems, symptoms & the therapy relationship. (See the Instruction Guide for a list of specific adjectives frequently used to describe temperament. It is sufficient just to list adjectives from the Guide that you believe are part of the patient's basic temperament or "nature", rather than situation-specific.)

Even-tempered; conscientious; introverted; passive; co-operative; reserved; cautious; and easily overwhelmed.

D. Cultural Factors

If relevant, explain how specific norms and attitudes from the patient's ethnic, religious, and community background played a role in the development of his/her current problems (e.g., belonged to a community that put excessive emphasis on competition and status instead of quality of relationships).

The strict Catholic code practiced by the family (and most strictly implemented by Alison’s mother) strongly influenced Alison’s very self-sacrificing and self-deprecating manner. Her devout religious beliefs reinforced an abstemious lifestyle that, beyond the eating disorder, required a suppression of her sexuality, emotional expression, and a caution to be spontaneous and playful.

VII. Most Relevant Schemas (Currently)

For Items 1-4, select the 4 schemas that are most central to the patient's current life problems. First specify the name of the schema. Then describe how each schema plays itself out currently. Discuss a specific type of situation in which the schema is activated and describe the patient's reactions. What negative effect(s) does each schema have on the patient? List any other relevant schemas in Item 5.

1. Specific Early Maladaptive Schema :	Self-punitiveness (very high)

Alison still feels that she should be harshly punished for any mistakes- whether presently or in the past. Despite her son having explicitly forgiven her for the effect her anorexia had on her as a mother, she still insists that she should be punished. There is a strictly religious element to this need for punishment. Small mistakes that she makes in her life also elicit a need to face condemnation. Such a harsh attitude comes in the face of setting extremely high expectations for herself

2. Specific Early Maladaptive Schema :	Defectiveness/Shame (very high)

Alison still carried the strong notion that she "has no redeeming qualities" and that she is inherently defective and unintelligent. She is very sensitively attuned to the criticism from others and is also very self-critical. Any mistake that she makes results in self-condemnation. She cannot understand why her husband loves her and feels that she has always been a burden to him. She is hesitant to engage in new activities for fear of showing her lack of abilities. She feels very shameful about her perceived flaws and failures of the past. She still assumes that others perceive her as physically flawed, not just in terms of body image. Alison does not believe that she deserves to be loved because of who she inherently is and because of the many perceived mistakes.

3. Specific Early Maladaptive Schema :	Self-sacrifice (strong)

Influenced by her mother's deeply religious Catholic belief system, Alison was taught form a young age that life is about making personal sacrifices and prioritising the needs of others before her own. Being raised in an extremely dysfunctional and abusive home environment, she assumed adult responsibilities very early in her life, particularly for her incompetent and alcoholic father. Even now, Alison is uncomfortable to be pampered and affirmed, preferring to be the provider and still holds to the belief that the needs of others should always take priority over anything that she needs. Although a good example of her newfound ability to engage socially, insisting that she hosted her 40 years school reunion reflects her impulse to always volunteer tasks instead of being provided for by others. She is very preoccupied with never causing pain to others, feels intensely guilty whenever she is provided for or pampered.

4. Specific Early Maladaptive Schema :	Unrelenting standards (high)

Alison is still strongly influenced by the high expectations instilled by her mother. She has often descried herself as obsessive and perfectionistic and is hypercritical of her performance on most tasks. She underestimates her own performance and frequently feels that her progress relinquishing her eating disorder was too slow, despite the remarkable progress she made. She continued to abide by a very strict and rigid rule system, preoccupied by the many "should" in most areas of her life. Her high moral and ethical standards are based on her very deeply entrenched Catholic belief system for discipline and self-control. Alison is very preoccupied with not making mistakes and is extremely critical of herself if she does not do something perfectly. Her OCPD traits are reflected in this schema.

5. Other Early Maladaptive Schemas (optional) :	Emotional Inhibition (high) Emotional deprivation (high) Social Isolation Failure Subjugation (high)

One of the most challenging aspects of Alison's therapy has been the dismantling of the Emotional Inhibition EMS. Again, especially by way of the influence of her rigidly controlling and critical mother and the impact of the Catholic code, she is very inhibited in demonstrating spontaneity of her actions and emotions – fearful of it being met with disapproval and leaving her feel shameful or out of control. I have persisted in therapy to help her access and express the anger/rage that she has suppressed for her parents. She continued to inhibit spontaneity and the expression of positive feelings like joy because she still holds a core belief instilled by her mother that it is wrong and that spontaneity will lead to a "decadent", "slovenly" and "overindulgent" existence.

VIII. Most Relevant Schema Modes (Currently)

For Items 1-6, select the modes that are most central to the patient's current life problems. First label the mode (e.g., Lonely Child, Self-Aggrandizer, Punitive Parent). Then explain how this mode plays itself out currently. What types of situations activate the mode? Describe the patient's behaviours and emotional reactions. Which schema(s) often trigger the mode? What negative effect(s) does each mode have for the patient? (If a mode does not apply to the patient, leave it blank. You can add additional modes in Section D.)

A. Child Modes

1. Vulnerable Child Mode :	Shamed Child

This mode is activated by the Defectiveness/Shame early maladaptive schema (EMS). See the discussion on this EMS in section VII.2 (p.10). This Child mode developed and deepened as she became increasingly convinced that she was unwanted, inherently flawed, inferior, unintelligent, and totally unlovable. Her mother's frequent criticism, scolding and undermining of her exacerbated this mode. She remained "blind" to the many achievements and praiseworthy accolades she received during her adolescence because neither parent ever affirmed or acknowledged her accomplishments. In fact, her mother often made her doubt the deservedness of such accolades. She developed a deep sense of failure, feeling incompetent, inept, and inadequate in all respects when compared to her peers. Although she qualified as a teacher, she chose to maintain an unambitious junior clerk position in a bank for a decade before she married Michael. Alison continued to hesitate on the face of new tasks and opportunities and feels dis-ease when she is pampered or made a fuss of. Alison has also carried deep shame associated with her sexual identity, where her emaciated state served to suppress sexual feelings and a body that reflected her sexual maturity as a woman.

2. Other Relevant Child Mode(s):	[1] Anxious and Abused Child [2] Lonely Child

[1] Anxious and Abused Child :This child mode developed as a result of abusive and unpredictable home environment, whether the influence of her father's unpredictably abusive drunken behaviour or her mother's extremely critical stance. Today, Alison continues to be surprised by the loving warmth that she experiences from those close to her, and often expects that such love will be withdrawn as a result of her failings being exposed. Her secondary EMSs (unrelenting standards, self-sacrifice, subjugation) largely compensate for the anxious anticipation that she will be rejected or criticised by other. She refuses to be angry and will never be tearful in the company of others, as she fears that this will result in her being criticised and/or hurt.

[2] Lonely Child: As a result of significant neglect from both parents throughout her childhood and adolescent years, Alison spend much time alone and was wary about having her peers visit and see her father's embarrassing behaviour and her mother's strict and extremely conservative attitudes. When alone, Alison still gets lonely, but she does not easily display this.

B. Maladaptive Coping Modes

3. Surrender Mode :	Compliant Surrenderer

Alison's subjugation and self-sacrifice EMSs account for this coping mode. It is activated whenever there is the threat of a conflict situation. Most notably manifested during sessions when she felt obliged to follow her team's advice to follow her meal plan, despite having strong urges to restrict her intake. Alison automatically assesses and follows the needs of others in order to avoid a conflict situation or best ensure that she will be accepted or liked.

4. Detached / Avoidant Mode:	Avoidant Protector

This avoidant coping mode is particularly active when the Vulnerable Child is anxious at the prospect of facing new situations and unfamiliar circumstances. While she has made good progress, it typically accounted for her staying at home for the vast majority of the day in order to avoid feeling vulnerably exposed and her defects and possible criticism.

5. Overcompensating Mode:	Anorexic Overcontroller

This is a composite and highly developed overcontroller coping mode that emanated from an existing Perfectionistic Overcontroller. It is activated in by the Defectiveness/Shame, Failure, Incompetence/Dependency, Self-punitiveness, and the (secondary) Unrelenting Standards EMSs This complex and multifunctional mode is used to numb, avoid, and protect her from emotionally painful feelings – especially fear and anger. It provides a sense of comfort and control, as well as a sense of power. This overcompensatory coping mode also serves to avoid adult responsibilities that she fears that she is not capable of carrying out and has also served to suppress her sexuality – a source of shame associated with her mother's and her religious attitudes towards sex and sexual intimacy. This coping mode has also served as a means of inflicting punishment on herself whenever the Punitive Parent mode is active. Lastly, the Anorexic Overcontroller has also served to draw attention to her and provide her with a sense of identity and purpose due to years of feeling invisible and insignificant to others. The source of this lay in the neglect and negligence imposed by her parents throughout her childhood, adolescence, and young adulthood.

C. Dysfunctional Parent Mode

6. Dysfunctional Parent Mode:	Punitive/Demanding Parent

The Punitive/Demanding Parent mode is an introjection of Alison's mother's extremely critical, punitive, and demanding attitudes throughout her childhood. It is also the influence of the strict Catholic code most notably instilled by her mother. It is activated by her Punitiveness and Unrelenting Standards EMSs. The mode insists that Alison be chastised and punished for anything that she perceived herself to have done wrong in the past or present and demands that she meet the needs of others and behave in a particularly disciplined and controlled way. She often talks of the need to pay penance for her sins and she speaks of the notion of religious mortification.

D. Other Relevant Mode(s) (optional)	[1] Worrying Overcontroller [2] Perfectionistic Overcontroller [3] Compulsive Overcontroller

[1] Worrying Overcontroller: When Alison is facing new experiences (e.g., given a Kindle from her son for her birthday, received a smartphone from her husband, planning to fly to France with her husband to visit her son), she will ruminate excessively about her incompetence or fears of what could go wrong.

[2] Perfectionistic Overcontroller: In order to feel in control and avoid criticism, Alison focusses on doing everything perfectly. This has been particularly evident in the manner in which she does housekeeping and her vigilant adherence to the meal plan prescribed by the dietician. Homework tasks for therapy are also done very meticulously and in an impeccable tiny handwriting, where she uses a ruler to ensure that she writes in a straight line.

[3] Compulsive Overcontroller : This is the most prominent of Alison's avoidant coping modes. It is most commonly activated when the Vulnerable Child feels anxiously overwhelmed and faced with internal criticism emanating from the Punitive Parent mode. While there has been much improvement, heightened anxiety compels her to engage in obsessive housework, where she can spend hours cleaning and dusting, despite the house already being in an acceptably neat state. The compulsive housework instils a sense of control and peace and distracts her from feeling anxious.

E. Healthy Adult Mode

Summarize the patient's positive values, resources, strengths & abilities:

Alison is an extremely very kind and caring woman. She is very considerate of others and friendly in her manner. Despite her debilitating eating disorder, she has been a loyal and caring wife to her husband and dedicated herself significantly to meeting her son's needs to the best of her ability. She is diligent in her tasks and persistent when she engages in new tasks. She keeps well to her tasks and has begun entertaining friends and family at her home more frequently in recent months. She has committed herself thoroughly to her therapy treatment and has made significant progress in overcoming an eating disorder that spanned 4 decades. Her relationship with her husband is now both emotionally and sexually intimate. She has a much closer relationship with her son and is extremely proud and caring towards him. She initiates affection towards those closest to her.

IX. The Therapy Relationship

A. Therapist's Personal Reactions to the Patient

Describe the therapist's positive & negative reactions to the patient. What patient characteristics/behaviours trigger these personal reactions? What therapist schemas and modes are activated? What impact do the therapist's reactions have on the treatment?

Alison is a very likable woman and I have thoroughly valued working with her over the years in overcoming significant challenges, most notably a deeply entrenched and persistent extreme AN (restrictive type) that spanned four decades. Schema therapy helped me gain access to the very fragile Vulnerable Child that has been so emotionally deprived, abused, anxious, lonely, and shamed. Through experiential work (most notably chairwork), I have gained very close access to this child, eliciting in me strong parental and protective instinct. In chairwork, I have noticed the extent of genuine anger I feel when confronting Alison's (guilt-inducing) Demanding and Punitive Parent modes. Experiential tools like this and imagery rescripting have heightened my emotional capacity to engage and participate in the therapy process and demonstrate genuine care and protect I feel for my patient.

While Alison was extremely careful and vigilant to not infringe on my limits, I sometimes needed to be aware of my own self-sacrifice EMS and overly extend myself when she was particularly vulnerable and struggling to take sufficient care of herself. And while Alison very often lapsed back into anorexic behaviour and often flipped between modes to become unstable well into the therapy, this activated elements of my own Failure and Defectiveness/Shame EMSs, very concerned that I was being a good therapist , providing the best possible treatment, and being perceived as competent by my supervisor (especially while Alison is an integral component of my PhD research). While I have been well-supported in supervision, I am still aware of my often activated Unrelenting Standards EMS and the Demanding Parent mode response in trying to ensure that Alison makes exceptional progress, thus demonstrated my competence and progress as a developing schema therapist.

Comfortable with self-disclosure as a schema therapist and having worked from home in the past two years has resulted in Alison learning much about my personal circumstances. She has met my wife (who is also a psychologist working from home), my 6-year old daughter, and my housekeeper. I have felt particular warmth for Alison when she regularly enquired about my daughter's well-being and demonstrated such generosity towards her by ensuring that she buys a birthday and Christmas gift for her each year. In the mid-1990s, when I received my final training by way of the Kleinian Object Relations model of treatment, it was instilled in me to maintain very distinct and absolute boundaries around self-disclosure. However, the schema therapy's approach that encouraged appropriate, but closer engagement with the patient (especially where self-disclosure holds therapeutic value and enhances trust and a sense of collaboration in the therapy relationship) has helped me to feel that I am participating at a more genuine and authentic level, and it has enhanced the trust and rapport in the therapy relationship. This is particularly prevalent in my therapy relationship with Alison.

B. Collaboration on Therapy Objectives & Tasks

1. Rating for Collaboration on Objectives & Tasks: 5

See Instruction Guide for an explanation & a detailed Rating Scale from 1-Low to 5-High.

2. Briefly describe the collaborative process with this patient.

What positive and negative factors/behaviours serve as the basis for your rating in 1 above?

Despite Alison only entering into therapy at the repeated request of her son, once Alison began treatment, she was immediately willing to agree to a treatment contract to attend further sessions. In order to understand the nature of the schema therapy mode model of treatment, she enthusiastically read various written material that explained the basis behind the treatment model. She was forthcoming during the assessment phase of treatment and was forthcoming in providing a detailed person and family history. Her completion of numerous questionnaires, inventories, and surveys (including those required for the research study) contributed towards us being able to engaged collaboratively in the development of a case conceptualisation, which included the construction of a "mode map" which outlined her prominent EMSs and schema modes. Alison was very willing and participated enthusiastically in experiential exercises. Chairwork was a particularly effective tool through which we were able to identify and engage with pertinent modes on her mode map. She appreciated my participation in chairwork and trusted my ability to facilitate the process of identifying and confronting dysfunctional modes. Alison was responsive to limited reparenting of the Vulnerable Child and engaged in a committed manner in the building of her Healthy Adult mode. She was very diligent in doing homework tasks each week, which always included a short battery of questionnaires, including a Session Bridging Form (adapted from Beck, 1995) where she outlined reflections of the previous session and the outlining of items, issues and challenged for the forthcoming session. While Alison worked hard towards accessing the Angry Child and expressed this mode well in chairwork, she has really struggled to be vulnerably tearful in sessions, this being forbidden by the Demanding Parent. However, she is more readily acknowledging the sadness residing in the Child. Despite Alison's excellent progress in therapy and excellent insight, she is still very prone to flipping into Punitive Parent and chastising herself for any perceived errors of shortcomings on her side. I have encouraged telephone contact outside of sessions when Alison has needed additional support during difficult times. She has always made good use of this, but is often apologetic about calling and is overly cautious that she is not infringing on my personal space and time.

3. How could the collaborative relationship be improved?

What changes could the therapist and patient make to bring this about?

Collaborative efforts towards more readily banishing the interference of the Punitive and Demanding Parent modes will provide a safer space in sessions for the Vulnerable Child to more fully embrace the reparenting process. While there is great trust in the therapy relationship, the next significant breakthrough would be for Alison to endorse the sad and lonely child to be tearful and further broaden the level of emotional access to the Child. I would like Alison to become more comfortable in her contact with me outside of sessions. I could reinforce this more during sessions, even though I always affirm her decision to call me when she does.

C. Reparenting Relationship & Bond

1. Rating of the Reparenting Relationship and Bond : 4

See the Instruction Guide for an explanation & Rating Scale from 1-Weak to 5-Strong.

2. Briefly describe the Reparenting Relationship & Bond between the patient and therapist.

Elaborate on the patient's behaviours, emotional reactions, and statements in relation to the therapist that serve as indicators of how strong (or weak) the reparenting bond feels for the patient.

Despite the caution with which Alison entered into the first consultation years ago, she has been very responsive to limited reparenting and the bond between us has been steadily growing throughout the therapy process. There is a strong rapport between us and she is visibly emotionally responsive to the reparenting process when I engage with the Vulnerable Child. However, her determination to never be tearful during sessions is an ongoing challenge. Besides not wanting to expose such vulnerability, she is fearful that tearfulness will suggest that she is attention-seeking. She frequently expresses her deep trust in me and the therapy process and is appreciative of the efforts that I make in providing her with reading material (including books) to take home. The fact that I feel a deep sense of parental warmth and protection towards Alison is suggestive of the close connection. Alison is comfortable to be hugged and has even initiated hugs on occasion. Despite the concern that she is infringing on my personal space, she has always phoned me between sessions when I have requested her to do so. Alison has never missed an appointment which is reflective of her commitment to the therapy process and the value that she derives from it.

3. How could the Reparenting Relationship & Bond be strengthened?

Which unmet needs could the therapist fulfil more deeply or completely? What specific steps could the therapist take to make the bond stronger for the patient?

For Alison to feel more comfortable being tearful in sessions, I could persist in holding her in the emotional space where the Vulnerable Child feels deep sadness and grief. Making more use of imagery work with her eyes closed may allow her to engage more deeply with the Vulnerable Child and be less conscious of my presence in the room, which contributes to her resistance to be tearful.

D. Other Less Common Factors Impacting on the Therapy Relationship (Optional)

If there are any other factors that significantly influence, or interfere with, the therapy relationship (e.g., significant age difference, cultural gap, geographic distance), elaborate on them here. How could they be addressed with the patient?

Nil of Note.

X. Therapy Objectives: Progress & Obstacles

For Items 1-4, list the most important therapy objectives. Be as specific as possible. For each objective, describe how the Healthy Adult mode could be changed to meet it. Then, discuss the progress thus far, and describe any obstacles. You can add additional objectives in Question 5. (Objectives can be described in terms of: schemas, modes, cognitions, emotions, behaviours, relationship patterns, symptoms, etc.)

1. Therapy Objective:	Dismantle the Anorexic Overcontroller coping mode.
Schemas and modes to target	EMSs: Abandonment, Emotional Deprivation, Defectiveness/Shame, Failure, Emotional Inhibition, Unrelenting Standards, and Self-Punitiveness Schema Modes: (sad, defective) Vulnerable Child, Anorexic Overcontroller, Punitive and Demanding Parent Modes, Compliant Surrenderer, Healthy Adult
Progress & obstacles	Progress: Alison is in remission and has maintained her weight within a normal weight range for some time. The EMSs listed above lie at the root of the eating disorder – the Anorexic Overcontroller serving to stave off feelings of abandonment, defectiveness, and unworthiness in the Vulnerable Child. The dysfunctional Parent modes are what trigger the Vulnerable Child, so banishing them has been an important component of the therapy objective. The Compliant Surrenderer is listed in the relevant modes because early in therapy, Alison's compliance with the meal plan was largely emanating from a subjugation EMS, where the only motive for following the meal plan was her sense of obligation to conform to the expectations of her family and treatment team and avoid possible conflict being directed towards her. It was important for the treatment that the motive for eating normally and assuming a normal weight was emanating from an authentic Healthy Adult for the Child to be nurtured in an appropriate manner. Obstacles: When an event (usually a new or risky event) triggers the Anxious Child, Alison is still at risk to restrict her intake, albeit small amounts like snacks. The danger is that she easily mistakenly takes this to be a message from the Healthy Adult – indication that the Anorexic Overcontroller is capable of contaminating the Healthy Adult mode. The goal in sessions is to catch this process, where flashcards have been an effective tool to draw on whenever (and for whatever reason) Alison is tempted to deviate from the prescribed meal plan. Alison still readily enters into Punitive Parent and this poses a threat in which the eating disorder can recur.

2. Therapy Objective:	Dismantling Alison's idealised perception of her mother and then both acknowledging and permitting outward expression of anger for the abuse inflicted by both her mother and father.

Schemas and modes to target	EMSs: Emotional Deprivation, Abandonment, Mistrust/Abuse, Defectiveness/Shame, Failure, Subjugation, Self-sacrifice, Emotional inhibition. Schema Modes: Punitive Parent, Demanding Parent, Vulnerable Child, Compliant Surrenderer, Detached Protector, Healthy Adult.
Progress & obstacles	Progress: Particularly through experiential work, Alison has come to realise that her mother was extremely abusive and emotionally absent throughout her childhood. She now knows that her mother's frequent criticism of and pessimistic outlook for her daughter significantly impacted on her poor self-esteem, lack of confidence and feelings of defectiveness and failure. Much of the influence emanated from her mother's very strict and penitential religious convictions. Therapy has succeeded in helping Alison review her Catholic beliefs and separate out those attitudes that are inappropriately critical and penitential and those that reflect a Christ-like notion of love, forgiveness, and nurturance. Alison has also realised that her Punitive and Demanding Parent modes are largely an introjection of her mother's attitudes, and significant progress has been made in identifying and banishing them. Experiential work has succeeded in helping Alison express anger from the Angry Child mode towards her dysfunctional parent modes and her parents, bringing relief. The Compliant Surrenderer largely been marginalised from denying this angry expression, her fears being that she would be betraying and disrespecting her parents if she expressed anger and disappointment in them. Obstacles: Alison does still occasionally flip into Punitive Parent (which is sometimes experienced synonymously as her mother) forbidding angry expression. Where chairwork has been the most effective tool in helping Alison separate out the various modes, this needs to continue to be used to interrupt such influence.

3. Therapy Objective:	Forming an intimate relationship with her husband and son
Schemas and modes to target	EMSs: Emotional Deprivation, Abandonment, Social Isolation, Defectiveness/Shame, Emotional Inhibition Schema Modes: Vulnerable (shamed) Child, Detached Protector, Avoidant Protector, Punitive and Demanding Parent modes, Healthy Adult

Progress & obstacles	Progress: In light of Alison being shamed by her mother when she was sexually maturing during puberty and the influence of the strict and penitential Catholic code imposed by her mother left Alison feeling extremely shamed about her body and her sexual identity. Alison was able to identify that one of the primary functions of her anorexic condition was the role it played in supressing her sexuality. Therapy ensured that Alison recognised and confronted these abusive elements in her mother, while the process of limited reparenting ensured that Alison felt entitled to loving and nurturing relationships. Much work was done in therapy to work through the shame residing in the Child relating to sexual issues. This was largely done through chairwork and imagery rescripting. Providing Alison with literature [e.g., Ageing and Sexuality by Wasserman (2009)] significantly helped her to discover the importance of intimacy in a close relationship – emotionally and sexually. Alison is now proud of the meaningful intimate relationship she now has with her husband and is enjoying sexual intimacy for the first time in her life. Therapy has equally helped bring an emotional intimacy to her relationship with her son, Eric. She is very accepting and gives and loving hugs and affection with him. Obstacles: Alison still occasionally feels that her son should be chastising her for her failing as a mother when he was younger. This is despite some conjoint sessions with Eric clearly indicating that he has unconditionally forgiven his mother and is relieved by the newfound intimacy that they are developing. The Punitive Parent is confronted in this respect.

4. Therapy Objective:	Help Alison to reduce her sense of Defectiveness and accept affirmation from others.
Schemas and modes to target	EMSs: Defectiveness/Shame, Failure, Self-sacrifice, Unrelenting Standards, Self-punitiveness Schema Modes: Punitive Parent, Demanding Parent, Perfectionistic Overcontroller, Vulnerable (anxious and abused/defective) Child, Healthy Adult
Progress & Obstacles	Progress: While Alison's eating disorder lifted, it exposed a significantly defective Child beneath it, something that anorexia was serving to hide from others and hinder from her own consciousness. Limited reparenting has done much to instil a sense of worth in the Vulnerable Child. Imagery rescripting has been very effective in helping Alison see the Vulnerable Child receive the loving care that she required, while chairwork has displayed the multiplicity of modes and helped identify the relevant modes to address these issues. Alison has become adept at scolding and banishing the dysfunctional parent modes and the Healthy Adult has grown in stature to provide the Child with the loving care and worthiness that she deserves. Flashcards have been especially useful outside of sessions to interrupt the dysfunctional parent modes and mobilise the Healthy Adult.

	Obstacles: The Punitive Parent still emerges on occasion to undermine the Child, but Alison has become increasingly effective in interrupting this process.

5. Other Therapy Objectives:	N/A
Schemas and modes to target	
Progress & Obstacles	

XI. Additional Comments or Explanations (Optional):

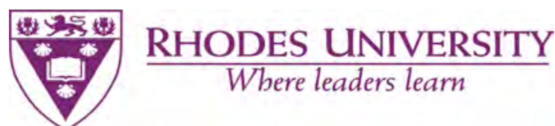
When Alison entered into treatment with me, I treated her largely from a CBT perspective, making primary use of the Fairburn mode of treatment. However, she was largely unresponsive to this method of treatment, despite some weight restoration. When I embarked on a qualitative case series (Ph.D.) study, Alison was an ideal candidate to participate in the study. She had no prior exposure to schema therapy and was not responding adequately to the existing treatment. It was clearly evident when we started the schema therapy that she was significantly more able to identify the functional role of the eating disorder and conceptualising it within the schema mode model of treatment further assisted her in identifying the true source of her eating disorder lying in the extremely abusive childhood and adolescence that she experienced at the hand of her parents. Chairwork played a significant role in identifying the multiplicity of schema modes involved in her myriad of psychological problems. It was especially helpful for her to be able to identify her eating disorder as a distinct overcompensatory coming mode – recognising its functional role, but also realising the deep betrayal that lay within it.

While the Catholic code by which she was raised has instilled some very toxic beliefs, therapy has done well to re-evaluate her religious beliefs and discern the punitive elements that have required expulsion, while the positive elements (e.g., a Christ-like love) have been mobilised into the Healthy Adult as a blueprint by which the Child in her should be loved and nurtured.

© 2017 International Society of Schema Therapy
Unauthorized reproduction or translation – in whole or in part -- without written consent of the Society is

APPENDIX 17

Form 8: Research Participant Therapy Review Interview Guide



Research Participant Therapy Review Interview

This interview works best as a relatively unstructured empathic exploration of the participant's experience of therapy. You should be trying to primarily help the participant tell you the story about her therapy so far. It is best if you adopt an attitude of curiosity about the topics raised in the interview, using the suggested open-ended questions as well as empathic and understanding responses to help the participant elaborate on her experiences. Thus, for each question, a number of alternative wordings have been suggested, but keep in mind that these may not be needed.

Ask the participant to provide as many details as possible. Use the "anything else" probe ("Are there any other changes that you have noticed?"). Inquire in a non-demanding way until the participant runs out of things to say.

The interview should last anything between 60 and 90 minutes.

Include the following information at the top of the first page of your response sheet:
Date, Participant's Name, Date of Commencement of Therapy, Date of Commencement of Research Treatment (Schema Therapy), Number of Schema Therapy Sessions to date.

Read this introduction to the participant:

"Due to your participation in Graham's research study, I have been asked to conduct this hour-long interview with you to explore what your experiences of therapy have been like thus far, especially your experiences of receiving schema therapy, which is the subject of Graham's study. I am interested to find out what changes you have experienced since starting the schema therapy and what you feel might have contributed to these changes. I am also interested in exploring what aspects of your therapy have been helpful or a hindrance. I encourage you to be as open and as honest in your reflections as you can be. Not only will this provide valuable insight into the benefits that this particular model of treatment could provide for future patients, but it might be useful in bringing to your attention aspects of your treatment for you to share with Graham, if you so wish. Although this interview is being audio-recorded, Graham will never get access to the audio. However, the interview will be independently transcribed and Graham will get access to it, but only towards mid-year 2015 when the data-collection for the research will be included in the written dissertation.

The main purpose of this interview is to allow you to tell us about the therapy and the research in your own words. There are no right or wrong responses, so please be relaxed and do not hesitate

to interrupt me for clarify on any questions or tell me if you are feeling for any reason that you are uncomfortable to continue with the interview."

Have you any questions so far?

Yes please list on answer sheet or No move to next section

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

How are you doing in general?

Were you in therapy prior to starting Schema Therapy with Graham in the current research study?

Yes answer the next question or No move to question X

Who was/were your therapist(s) and how helpful was your treatment? (List each therapist and explore what benefits and/or limitations the treatment provided. Question the nature of the therapeutic alliance and the effect of the model of treatment. To what extent were the goals of treatment achieved?)

Have you experienced Schema Therapy as a uniquely different treatment compared to any of your previous therapies?

Yes answer the next question or No move to question X

In what ways has Schema Therapy been different to your previous therapies, and can you identify particular benefits and/or limitations from such treatment?

There are some particular elements in the Schema Therapy that Graham might have brought into the treatment. I am going to list them and I would like you to comment on your experience of each of them, outlining what you may have found helpful or a hindrance, and whether you feel that Graham has made use of them effectively or not:

- Assessment Phase (Looking back, did Graham gather a thorough personal history, which might have been partially obtained though questionnaires, in order to form a good understanding of your life's experiences?)
- Assessment questionnaires, especially the schema questionnaires [Young Schema Questionnaire (schemas), Schema Mode Questionnaire (modes)]
- Mode Map and Formulation
- Identifying Modes, whether Child Modes, Destructive Adult Modes, Coping Modes, or Healthy modes (Healthy Adult, Happy/Content/Authentic Child modes
- Chairwork
- Role Play
- Guided Imagery/Imagery Re-scripting

What has been your experience of your therapy relationship with Graham? (Explore rapport, trust and ease of self-disclosure, empathy and compassion, containment, advice and guidance)

It is usual for schema therapists to encourage therapeutic activity outside of the schedules weekly sessions. I am going to list a number of these elements and I would like you to comment on your experience of each of them. Outline their helpfulness or hindrance, and whether you feel that Graham has made use of them effectively:

- Challenges (behavioural challenges like engaging in social activities, eating out, asserting oneself to a particular individual, etc.)
- The weekly collection of questionnaires
- The use of Flashcards
- Worksheets (e.g., Cog Sheets)
- Journal (that might include mode dialogues)
- Bibliotherapy (reading material) (e.g., the introductory information on Schema Therapy or the book, Reinventing your life)
- Audio material (CDs) (e.g., Mindfulness for Depression, Mindful Eating)
- Availability of audio-recordings of your session(s)

Which of these, if any, forms of contact have you experiences with Graham outside of the therapy session?

Phone Calls ☐
SMS or WhatsApp ☐
eMail ☐
Moodscope ☐

Where applicable, how have you experienced this form of contact, and in what way has it enhanced or hindered the therapeutic process?

How would you rate Graham's ability to empathize and provide compassion? How would you describe the manner in which he confronted you on difficult matters that needed to be addressed, but were difficult to deal with?

Schema therapists explore material on many different levels. For instance, sometimes material might emerge at a thoughts level and sometimes at an emotional feeling level. Then again, schema therapy might focus on behaviours, bodily physical sensations, memories and dreams to better understand the essence of what is happening in your world. Would you comment on the way in which each of these elements was used?

- Thoughts
- Emotional Feelings
- Behaviours
- Physical Bodily Sensations
- Memories (especially early childhood memories)
- Dreams

Let's construct a list of what <u>changes</u> (for the better of worse) you have noticed in yourself since you started Schema Therapy? What's more, is there anything that you <u>wanted</u> to change that hasn't since therapy started?

For each change, please rate how much you <u>expected</u> it, versus you were <u>surprised</u> by? (Use this rating scale):

- ◻ Very much expected it
- ◻ Somewhat expected it
- ◻ Neither expected nor surprised by the change
- ◻ Somewhat surprised by the change
- ◻ Very much surprised by it

For each change, please rate how <u>likely</u> you think it would have been if you <u>hadn't</u> been in therapy? (Use this rating scale):

- ◻ Very unlikely without therapy (clearly would not have happened)
- ◻ Somewhat unlikely without therapy (probably would not have happened)
- ◻ Neither likely or unlikely (no way of telling)
- ◻ Somewhat unlikely without therapy (probably would have happened)
- ◻ Very likely without therapy (clearly would have happened anyway)

How <u>important</u> or <u>significant</u> to you personally do you consider this change to be? (Use this rating scale)

- ◻ Not at all important
- ◻ Slightly important
- ◻ Moderately important
- ◻ Very important
- ◻ Extremely important

In general, what do you think has <u>caused</u> these various changes? In other words, what do you think might have brought them about? (Include things both outside and in therapy).

Can you sum up what has been <u>helpful</u> about your therapy so far? Please give examples. (For example, general aspects, and specific events)

What kind of things about your therapy have been <u>hindering</u>, unhelpful, negative, or disappointing to you? (For example, general aspects, and specific events)

Has Graham ever disclosed any aspects of his own life experiences? How have you found this, and has this in any way enhanced or hindered your therapy process?

Were there things in the therapy which were <u>difficult</u> or <u>painful</u>, but still okay or, perhaps, helpful? What were they?

Has anything been <u>missing</u> in your treatment? (What would make/have made your therapy more effective or helpful?)

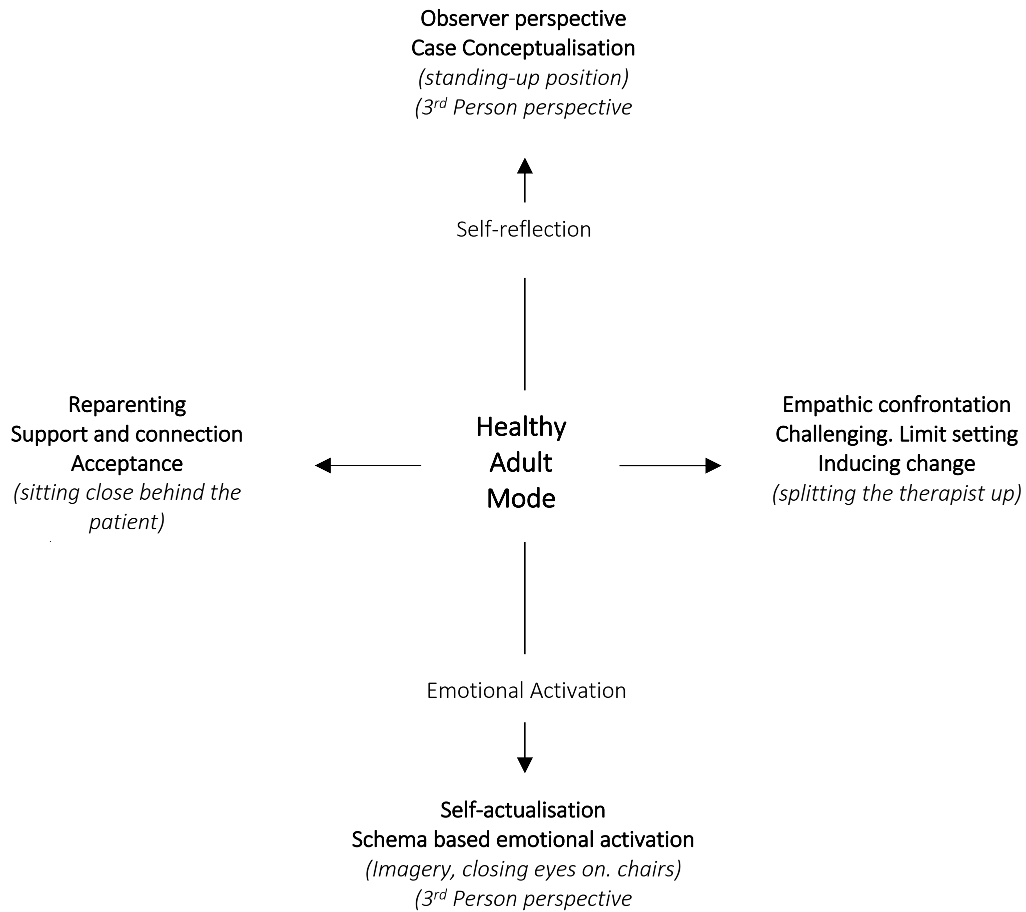
Do you feel that Schema Therapy has been an effective therapeutic approach for treating your eating disorder? Explain.

Do you have any suggestions for us, regarding the research or the therapy?

Do you have anything else that you wish to tell me?

APPENDIX 18

Figure 22: Therapy Relationship Field (Roediger and Archonti, 2020)



APPENDIX 19

Table 26: Dysfunctional schema modes associated with ambivalence and change resistance (Bernstein et al., 2012)

Mode Category	Exemplar Statements
Dysfunctional Child Modes	
Vulnerable Child	“I’m scared about getting better”
Abandoned Child	“People might forget about me if I recover”
Dependent Child	“It’s too hard to get better on my own”
Angry Child	“I don’t want other to feel relieved about my recovery”
Impulsive Child	“I’ll feel terrible if I don’t binge anymore”
Undisciplined Child	“It’s too hard to resist the urge to binge-eat”
Dysfunctional Coping Modes	
Avoidance	
Detached Protector	“Not eating cuts me off from my feelings”
Avoidant Protector	“I don’t have to make decisions when I’m this unwell”
Detached self-soother	“I don’t think when I’m exercising/binge-eating”
Angry Protector	“Just stop bothering me about getting better”
Overcompensation	
Perfectionistic Overcontroller	“I need to lose a little more weight before I am ready”
Paranoid Overcontroller	“I’ll start being noticed by others if I get better”
Self-Aggrandiser	“Being underweight makes me special”
Surrender	
Compliant-surrenderer	“My partner prefers the way I look at this weight”
Dysfunctional Parent Modes	
Punitive parent	“I don’t deserve a better life”
Demanding Parent	“I’m not allowed to eat any more than this”
Guild-inducing parent	“Other people need your support more than I do”