Understanding the Phenomenological Experience of Schema Therapy for Eating Disorders

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By

Alice Cunningham

BSc, MSc, GMBPsS, AFHEA

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Abbreviations

AFP: Adolescent-Focused Psychotherapy

AN: Anorexia Nervosa

AN-BP: Anorexia Nervosa Binge Purging Type

AN-R: Anorexia Nervosa Restrictive Type

BED: Binge Eating Disorder

BN: Bulimia Nervosa

BPD: Borderline Personality Disorder

CBT: Cognitive Behavioural Therapy

CBT-ED: Cognitive Behavioural Therapy for Eating Disorders

CEA: Childhood Emotional Abuse

CPA: Childhood Physical Abuse

CSA: Childhood Sexual Abuse

EDI (3): Eating Disorder Inventory

EDNOS: Eating Disorder Not Otherwise Specified

EMS(s): Early Maladaptive Schema(s)

FBT: Family Based Treatment

FMPS: Frost Multidimensional Perfectionism Scale

FPT: Focused Focal Psychodynamic Therapy

GET: Group Experiential Theme

IPA: Interpretative Phenomenological Analysis

MANTRA: Maudsley Model of Anorexia Treatment for Adults

MEED: Medical Emergencies in Eating Disorders

NG: Nasogastric (feeding)

NICE: National Institute for Clinical Excellence (Guidelines)

NP: No Parent Involved

OCD: Obsessive Compulsive Disorder

OSFED: Otherwise Specified Feeding or Eating Disorder

PET: Personal Experiential Theme

PI: Parent Involved

PTSD: Posttraumatic Stress Disorder

RCT: Randomised Controlled Trials

SSCM: Specialist Supportive Clinical Management

SMI: Schema Mode Inventory

SMI-ED: Schema Mode Inventory for Eating Disorders

YSQ: Young Schema Questionnaire

YSQ2-SF: Young Schema Questionnaire 2nd Edition – Short Form

Abstract

Introduction: This research investigated the experiences of schema therapy of those with an eating disorder and schema therapists treating eating disorders. Three studies used semi-structured online interviews. Two explored clients' experiences longitudinally (*N*=10 timepoint one, *N*=5 timepoint two), with a focus on schema modes and the eating disorder voice; a third explored schema therapists' experiences treating eating disorders (*N*=12).

Methods: Interviews were designed and analysed using Interpretative Phenomenological Analysis.

Results: Four Group Experiential Themes were developed from the first client study: *Adverse Experiences, Interpersonal Relationships, Self-Awareness,* and *Recovery*. Follow-up interviews 12-18 months later, produced four different Group Experiential Themes: *Making Sense of Schema Therapy, Friend or Foe? Connecting with parts of Self,* and *Barriers to Recovery.* Results from schema therapists produced four Group Experiential Themes: *Tools and Techniques, Beneath the Surface, Development of the Therapeutic Relationship,* and *Impact on Self.*

Conclusions: Clients and therapists emphasised the benefits of schema therapy in recognising and identifying with their modes; with clients also emphasising the benefits in recognising and identifying their eating disorder voice. Schema therapy empowered clients to assign meaningful attributes to their modes, creating a deeper understanding and connection to the parts of self. Participants initially described modes as an abstract concept, however, schema therapy encouraged clients to accept their modes as parts of themselves, particularly their Vulnerable Child. The findings suggest that schema therapy provides clients with an effective toolkit for their eating disorder in terms of identifying, recognising, and understanding the parts of themselves. This was facilitated by schema therapists who gained a deeper understanding of the function that eating disorders and schema modes served their clients. The findings thus support the schema mode model in treating eating disorders.

Introduction to Thesis

Qualitative research utilises a naturalistic approach to understand phenomena in a context-specific setting; this means *"any kind of research that produces findings not arrived at employing statistical procedures or other means of quantification"* (Corbin & Strauss, 1990, p. 17). A qualitative approach, specifically, Interpretative Phenomenological Analysis, was adopted to investigate phenomenological experiences of schema therapy for people with eating disorders and schema therapists delivering therapy.

The first three chapters of this thesis explore the relevant literature in this field: 1. Psychology of eating disorders; 2. Treatment of eating disorders; 3. Phenomenology of eating disorders. Chapter Four explores the research approach and methodology, Interpretative Phenomenological Analysis, including the theoretical underpinnings and rationale for using this methodology.

Chapter Five is a phenomenological exploration of clients' experience of schema therapy in those with an eating disorder; particular focus is given to experiences of schema modes and the eating disorder voice. Chapter Six is a longitudinal follow-up study of clients' experiences of schema therapy. Chapter Seven, the final study, is a phenomenological exploration of schema therapists' experience of using schema therapy to treat those with an eating disorder. The final chapter (Chapter Eight) brings the findings of this thesis together and acknowledges strengths and limitations.

Chapter One: Psychology of Eating Disorders

1.1 Introduction

This chapter examines the psychological factors underpinning eating disorders. Firstly, the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) diagnostic criteria for well-known eating disorders are introduced. Next, psychological theories including the Psychodynamic, Transdiagnostic and Cognitive-Behavioural are explored with specific focus on their role in the development of schema theory. Further, factors thought to contribute to the development and maintenance of eating disorders, early maladaptive schemas and schema modes are discussed with emphasis on the roles of self-esteem, drive for thinness and perfectionism. This chapter also explores the perceived functionality of eating disorders, schemas, and schema modes. Lastly, recovery is discussed with focus on the role that schemas and schema modes play in recovery.

1.2 What is an eating disorder?

Eating disorders are a major mental health concern, associated with significant morbidity and mortality (Smink et al., 2013). They are characterised by severe disturbances in eating behaviour and body weight. It is estimated that between 1.25 and 3.4 million people in the UK are affected by an eating disorder in their lifetimes (Statistics for Journalists - Beat, 2017). Eating disorders, particularly, anorexia nervosa (AN), have mortality rates among the highest across psychological health conditions, through medical complications, physical illnesses, including cardiac problems, or suicide (Herpertz-Dahlmann, 2015; Johns et al., 2019; Ortiz & Smith, 2020).

The DSM-4 (APA, 1994) and previous editions specified two eating disorders, AN and bulimia nervosa (BN). However, the DSM-5 revised this to Feeding and Eating Disorders and specified: AN, BN, eating disorder not otherwise specified (EDNOS), or as it now known, otherwise specified feeding and eating disorders (OSFED), and binge-eating disorder (BED); and included three feeding disorders: rumination disorder, pica, and avoidant/restrictive food

intake disorder. The additional changes highlight the growing recognition and understanding of eating disorders.

1.3 Types of Eating Disorder

1.3.1 Anorexia Nervosa

AN is classified by distorted body image, an intense fear of gaining weight, and the restriction of energy intake leading to extremely low weight, in the context of age, sex, developmental trajectory, and physical health (APA, 2013). Individuals with AN frequently struggle to maintain healthy body weight, often falling below 85% of their optimum weight (Bulik et al., 2005). To achieve their low weight, as well as restricting calories, many people over-exercise, purge, and/or use diuretics or laxatives.

Table 1

Diagnostic criteria for AN (DSM-5; APA, 2013)

1) Persistent restriction of energy intake leading to significantly low body weight (in the context of what is minimally expected for age, sex, developmental trajectory, and physical health).
2) Either an intense fear of gaining weight or of becoming fat, or persistent behaviour that interferes with weight gain (even though significantly low weight).
3) Disturbance in the way one's body weight or shape is experienced, undue influence of body shape and weight on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight.

1.3.2 Bulimia Nervosa

Those with BN often maintain a healthy weight (Fairburn et al., 2003). BN sufferers often engage in the persistent dietary restriction; however, this is eventually interrupted by episodes

of hyperphagia (e.g., binge eating) and compensatory weight loss behaviours such as self-induced vomiting and laxative abuse (Legenbauer et al., 2018).

Table 2

Diagnostic criteria for BN (DSM-5; APA, 2013)

1) Eating, in a discrete period (e.g., within any 2-hour period), an amount of food that is definitely larger than most people would eat during a similar period and circumstances.

2) A sense of lack of control over overeating during the episode (e.g., a feeling that one cannot stop eating or control what or how much one is eating).

A) Recurrent inappropriate compensatory behaviour to prevent weight gains, such as self-induced vomiting, misuse of laxatives, diuretics, or other medications, fasting, or excessive exercise

B) binge eating and inappropriate compensatory behaviours both occur, on average, at least once a week for three months.

C) Self-evaluation is unduly influenced by body shape and weight.

D) The disturbance does not occur exclusively during episodes of Anorexia Nervosa

1.3.3 Binge Eating Disorder

BED was introduced into the appendix of the DSM-4 (APA, 1994). BED is often seen in individuals who are obese, yet is distinct from obesity regarding levels of psychopathology, weight, and shape concerns (Tuschen-Caffier & Schlüssel, 2005). Although many individuals with BED do suffer from obesity, the diagnosis is not limited to obese individuals.

Binge eating was initially recognised in the DSM-3 (APA, 1980) under the classification of BN; an illness that not only encompassed bingeing but purging and preoccupation with weight and body shape. Evidence has long supported the idea that BED is a specific diagnosis that has validity and consistency (Cooper & Fairburn, 2003; Mitchell, 2008). In 2013, BED was included

in the DSM-5 (APA, 2013). The DSM-5 estimates that BED affects 1.5% of women and 0.3% of men worldwide.

Table 3

Diagnostic Criteria for BED (DSM-5; APA, 2013)

A) Recurrent episodes of binge eating. An episode of binge eating is characterised 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 larger than most people would eat during a similar period of time under similar circumstances
2. a sense of lack of control during the episodes (e.g., a feeling that one cannot stop eating or control what or how much is eating)

B) Binge-eating episodes are associated with three (or more) of the following:

1. eating more rapidly than normal
2. eating until uncomfortably full
3. eating large amounts of food when not physically hungry
4. eating alone because of being embarrassed by how much one is eating
5. feeling disgusted with oneself, depressed, or very guilty after overeating

C) Marked distress regarding binge eating is present.

D) Binge eating occurs, on average, at least 2 days a week for 6 months.

E) Binge eating is not associated with the regular use of inappropriate behaviours (e.g., purging, fasting, excessive exercise) and does not occur exclusively during Anorexia Nervosa or Bulimia Nervosa

1.3.4 Otherwise Specified Feeding and Eating Disorder

OSFED (previously EDNOS) is considered the most common eating disorder diagnosis in both clinical and community settings (Fairburn & Bohn, 2005; Smink et al., 2014). To be diagnosed with OSFED, a person must have eating behaviours that produce clinically substantial distress and impairment in areas of functioning but do not meet the full criteria for any of the other feeding and eating disorders, according to the DSM-5 criteria.

1.3.5 Summary of Types of Eating Disorders

Distinct patterns of symptoms are thought to form distinct eating disorders, for example, those with AN frequently have a low body mass index (BMI), often restricting their calorie intake and engaging in compensatory behaviours such as excessive exercise, whereas those with BN often engage in bingeing and purging behaviours. However, eating disorders appear to share common maintenance mechanisms (Fairburn et al., 2003) such as dietary restraint and preoccupation with food and eating. For example, those with BN will sometimes restrict their calorie intake to prevent weight gain or engage in excessive exercise. Correspondingly, those with AN may also purge as a compensatory behaviour. There is complexity in that there is overlap in symptoms, so the distinction between eating disorders is arbitrary.

Eating disorders are complex and multifaceted. To understand the conceptualisations of eating disorders, theories underpinning their development will now be explored. This subsequently leads to the introduction of schema theory, which is a focal point for this thesis.

1.4 Previous Theories of Eating Disorders

There are various theories surrounding the development of eating disorders ranging from the early psychoanalytic theory to transdiagnostic and cognitive behavioural theory. Schema theory was formulated by Young (1990) and is the basis for schema therapy. Schema therapy was developed for patients with chronic psychological problems failing to make significant gains in cognitive therapy, integrating elements of psychodynamic, transdiagnostic and cognitive behavioural theories, with the aim of developing a unified approach. Schema

therapy is discussed in-depth later in the chapter (Section 1.5). But first, the influence of psychoanalytic, transdiagnostic and cognitive behavioural theories on the development of schema theory is examined.

1.4.1 Psychoanalytic Theory

Psychoanalytic theories emphasise the role of food in early years of life. Thus, proposing that in a new-born's interactions with their primary caregiver, food signifies more than the satisfaction of a biological need and is intimately linked to relational exchanges. Children enjoy being fed by someone who is attuned to their emotional needs (Nicklaus, 2016) and thus, associate feelings with this person (Freud, 1946).

From a developmental viewpoint, exchanges in childhood are essential for cognitive, social, and emotional growth. A caregiver's ability to maintain emotional responsiveness during early feeding will nurture the well-being of the child, providing essential support for the child's development, thereby increasing positive emotions. If caregivers are emotionally unavailable, food can lose its role as psychological nurturing and become toxic nourishment (Eigen, 1999); acting as a catalyst that introjects negative relational experiences, bringing about feelings of anxiety. Children who have difficulty tolerating ambivalence may display their negative feelings by refusing to eat (Fenichel, 1946); frustration may be displaced on the oral fixation which may result in eating disturbances in later life. Early childhood eating disorders are symptomatic presentations of emotional pain caused by a lack of attuned mutuality during feeding (Winnicott, 1956).

The psychodynamic literature suggests that many people with eating disorders have unmet childhood needs, emotionally or physically, often because of childhood trauma (Patmore, 2020). Eating disorders subsequently become emotional regulation systems, providing a sense of control over one's emotions, particularly in restrictive disorders. Whereas in bulimic disorders, food can become a technique to self-soothe from the anguish experienced. Food is thus used as a coping mechanism to manage emotional neglect. From this viewpoint, the psychoanalytic

theory is an important foundation for the development of schema therapy; the emphasis on unmet childhood needs and early life events is significant in understanding eating disorders.

However, in Freudian and Neo-Freudian theory, biological impulses tend to be overemphasised. Further, not every child who is neglected or abused develops an eating disorder, implying that there are many other factors involved and an integrated approach is needed. Nevertheless, psychodynamic approaches emphasise that unmet needs in childhood, such as neglect and abuse can lead to the development of eating disorders later in life (Olofsson et al., 2020), consistent with schema theory. For instance, if a child has been deprived of food due to a lack of attunement from their caregiver, it can become toxic nourishment (e.g., Eigen, 1999), and they may develop AN to manage and control these emotions. Similarly, if food has been used as a way of soothing, this may persist into adulthood and may lead to a bulimic disorder. Thus, highlighting the influence of the psychodynamic approach on schema theory.

1.4.2 Transdiagnostic Theory

Schema therapy was developed as a transdiagnostic approach. This theory suggests that although each eating disorder has individual diagnostic criteria, they share distinct core psychopathology in their maintenance, including over-evaluation of shape, weight, and control. Longitudinal studies indicate that many people with an eating disorder migrate among diagnoses over time (Fairburn & Harrison, 2003). For instance, OSFED is a common outcome of AN (Van Alsten & Duncan, 2020); BN archetypally begins as AN or OSFED, and an outcome of BN is often chronic OSFED (Fairburn & Bohn, 2005). There is also the binge-purge subtype of AN (AN-BP).

Fairburn et al. (2003) argue that eating disorders such as AN and BN share common maintenance mechanisms, despite differences in presentations. Dietary restraint, preoccupation with thoughts about food and eating; recurrent body checking and engaging in weight-control methods are common characteristics in AN (including AN-BP) and BN (Cooper & Shafran,

2008). The fundamental distinction between AN and BN is the balance between under and over-eating, as well as the impact on body weight. In BN, these behaviours commonly balance each other out, resulting in body weight stability, whereas, in AN, under-eating frequently takes precedence. According to this theory of eating disorder psychopathology, the main sustaining processes are expected to be comparable across diagnoses.

Those who experience chronic and rigid level schemas are unlikely to respond to the standard cognitive behavioural model and may require treatment which specifically addresses these beliefs in a more focused way (Waller et al., 2000). The transdiagnostic model begins to explore rigid beliefs; however, this model is restricted to maintenance factors, with little attention to the early origins of underlying schema-level representation and behaviours.

At the core of the transdiagnostic theory is the underlying assumption that those with an eating disorder share core pathology in the maintenance of eating disorders, but present in different ways. For example, those with BN may engage in binge eating to regulate negative affect, whereas those with AN may use restriction. In response to negative affect, those with AN may restrict but may eat more in response to positive affect; the opposite occurs for BN (Meule et al., 2021). Similarly, both AN and BN exhibit a desire for control but in different ways. Those with AN are likely to exhibit control by restricting their calorie intake or engaging in excessive exercise; whereas those with BN may binge and purge to regulate their feelings. Inferring that solely focusing on one cause is not an accurate representation of how to conceptualise a disorder. Instead, to determine a causal relationship, researchers must investigate a range of variables that may include cognitions and attachment relationships.

1.4.3 Cognitive-Behavioural Approach

This approach proposes that emotions are influenced by thoughts and that emotional distress is a result of the subjective interpretation of events (Beck et al., 1979). For instance, if one's clothes feel tight, this may be interpreted as *'I am fat,'* which may result in body dissatisfaction and low mood; whereas, if one interprets this as *'these have been shrunk in the*

wash,' the emotion experienced could be anger. Cognitive therapy works to identify and correct cognitive distortions by encouraging the individual to use evidence to consider alternative explanations. For example, someone with an eating disorder who thinks *'I am fat'* can be encouraged to differentiate between the thought *'I think I am fat,'* and the feeling of *'I am fat.'*

Cognitive models emphasise the role of core beliefs as triggers for dysfunctional situation-specific thoughts (Legenbauer et al., 2018). It is assumed that restrictive eating is triggered by maladaptive thoughts (e.g., *I am not allowed to eat lunch*); these thoughts are associated with core beliefs (e.g., *I am nothing without my eating disorder*), therefore, signifying the importance of cognitive content as well as dysfunctional core beliefs for the perpetuation of disordered eating behaviours (Oldershaw et al., 2015; Pugh et al., 2018).

The first cognitive-behavioural model of BN outlining the basic psychopathology was established by Fairburn et al. (1986). This was defined as a dysfunctional system of self-evaluation, whereby control over shape, weight, or eating is the primary focus for the evaluation of self-worth. Those with high levels of dietary restraint often follow strict rules that they must adhere to. Informed by restraint theory (Polivy & Herman, 1985), the model outlines several pathways by which this dietary restraint maintains binge eating. By attempting to maintain control of over eating, the individual is left vulnerable to episodes of disinhibited eating when this cognitive control is disrupted. Secondly, physiological mechanisms such as hunger override cognitive control, resulting in a loss of control over eating. Third, transgression from strict dietary norms may trigger the abstinence violation effect (Mariait & Gordon, 1985), whereby eating is perceived as a catastrophic loss of control, leading to permissive thoughts about further eating. Following the bingeing episode, compensatory behaviours, such as purging are triggered by fears about the effect the binge has had (Lampard & Sharbanee, 2015), due to over concern about body shape and weight.

Individuals with eating disorders are theorised to have formed disordered schemas as a result of over-concern with eating and body size (Cooper & Fairburn, 1993), and are likely to

have a distorted body-shape schema. The body-shape schema is assumed to be an automatic process that is responsible for the body's interaction with the environment (Baumann et al., 2022). From this perspective, the schema takes precedence over other cognitive structures and focuses on body size, often in a distorted manner (Irvine at el., 2019).

This body-shape schema will likely manifest into intrusive, negative thoughts about their body. This could lead to feelings of defectiveness, and, for example, the development of a Defectiveness/Shame schema, defined by Young et al. (2003) as *"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"* (p.14). It is worth highlighting that this is much wider and deeper than concerns about body image.

Moreover, a Defectiveness schema might lead to disordered eating, as well as being developed due to body image concerns. From an eating disorder perspective, somebody with AN with a body-shape schema is likely to believe they are larger than they truly are, leading to compensatory behaviours such as calorie restriction or self-induced vomiting to alleviate feelings of defectiveness. Someone who frequently believes that they are defective may find it very difficult to change dysfunctional eating behaviours as they may view this as a pointless endeavour. Working to address underlying core issues is an essential factor in the treatment of eating disorders. Therefore, suggesting something more is needed to address an individual's fundamental, schema-level, core beliefs than what is addressed in first-line treatment (Simpson et al., 2010).

1.4.4 Summary of Previous Theories of Eating Disorders

Although well researched, explanations of eating disorders are diverse and there is no one explanation due to the complex interaction of biopsychosocial factors that are involved. The most widely investigated and recognised theoretical approach is the cognitive behavioural

(Fairburn et al., 2003), with early models emphasising the contributions of disordered eating and maladaptive attitudes towards shape and weight towards the maintenance of eating disorder pathology (Fairburn, 1981). However, there are limitations.

Despite cognitive behavioural therapy's (CBT) well-established efficacy, documented outcomes differ (e.g., McIntosh et al., 2016; Waller et al., 2014; Zipfel et al., 2014). This is reviewed in Chapter Two. Inconsistent treatment outcomes have been linked to reasons such as high levels of co-morbidities including anxiety, personality disorders, and post-traumatic stress disorder (PTSD; Khosravi, 2020; Talbot et al., 2015), developmental trauma (Brewerton, 2007), and entrenched cognitive schemas (Waller et al., 2007). These deeper elements of an eating disorder are not amenable to the current cognitive behavioural model (Waller & Kennerley, 2003). Thus, a schema-focused conceptualisation of eating disorders may be a more sophisticated way to address the factors implicated in poor treatment outcomes.

1.5 The Development of Schema Therapy;

Schema Therapy as a Synthesis of the Cognitive and the Psychodynamic

1.5.1 What is a Schema?

Schemas are knowledge structures within Cognitive Psychology. According to Kant (1781), a schema is an intrinsic knowledge system organising our universe. People's interpretation and recollection of events are significantly impacted by prior information or their expectations (Bartlett, 1932). Piaget (1936, 1976) also used the term schema to explain how children organise and develop their understanding of the world. According to Piaget, schemas determine what children are capable of understanding and children's schemas become more sophisticated as they develop. He also developed the key concepts of assimilation, accommodation, and generalisation.

Assimilation is the schema's ability to assimilate new information from new situations (Piaget, 1957). When the fit between schema and the new situation is poor, people may distort the new information to fit, or even entirely fail to notice incongruent information. For example, if

the person has never heard of a goat, then they may classify a goat as a sheep. Accommodation is the schema's ability to accommodate new information and adapt the schema (Piaget, 1957). For example, a person's sheep schema may begin to change when repeatedly exposed to goats, until they discover that they are considered two different species, thus, they should form a goat schema as well. Generalisation is how widely a schema is applied. As discussed in subsequent chapters, someone with an Abandonment schema may massively over-generalise this to the point that they reject most new social contacts before they are themselves rejected.

The basic idea of a schema was developed further in the 1970s and 1980s, primarily with research on people's knowledge of stories and how knowledge is organised in their memories (Thorndyke & Hayes-Roth, 1979). Most Cognitive Psychology research was on schemas for concrete objects (for example, in the UK, people have a crocodile schema that is green, although they are shades of brown) or common event scripts (Brewer & Lichtenstein, 1980), such as a schema for what typically goes on in a restaurant. Diners can become confused when a restaurant does not match their schema. A common issue is whether one pays at the table, the cash register, or when ordering.

Around the same time, in 1967, Beck introduced the concept of a schema to Clinical Psychology theory as *"a cognitive structure for screening, coding, and evaluating the stimuli that impinge on the organism. It is the mode in which the environment is broken down and organised into its many psychologically relevant facets. Based on schemas, the individual can categorise and interpret his experiences in a meaningful way"* (p.283). This initial definition was echoed in later works as *"specific rules that govern information processing and behaviour"* (Beck et al., 1990, p.8). In Cognitive Psychology, schemas are typically concerned with interacting with the physical and social world, whereas clinical schemas are more concerned with interpersonal relationships and relationships with the self.

Young (1990) adapted Beck's (1967) concept into what he called Early Maladaptive Schemas (EMS) and defined them as *"enduring themes that develop during childhood and are elaborated on throughout the individual's lifetime"* (p.9). This definition places greater emphasis on the early onset of schemas whilst retaining the information processing function of Beck's schemas. Young et al. (2003) further revised and defined an EMS as *"broad, pervasive themes or patterns, comprised of memories, emotions, cognitions, and bodily sensations, regarding oneself and one's relationships with others, developed during childhood or adolescence, elaborated throughout one's lifetime and dysfunctional to a significant degree"* (p.7). EMSs are maladaptive in part because they tend to be overgeneralised and have difficulty changing to accommodate new information. They are also maladaptive because they tend to have developed to understand and cope with dysfunctional situations in childhood or adolescence, such as the varieties of maltreatment, neglect, bullying and abuse that children can experience. Their application to more functional social situations in adulthood can be highly problematic.

1.5.2 Schema Domains and Early Maladaptive Schemas

Young (1990) developed the concept of EMSs to understand the relationships between negative interactions in early life and the impact on adulthood. EMSs are combinations of memories, emotions, bodily sensations, and cognitions that originate in childhood and have an adaptive role, such as survival in an abusive situation (Farrell et al., 2014, p.5). By adulthood, EMSs are generally maladaptive because they are over-generalised to situations where they are unnecessary and counterproductive. Consequently, they limit the person's effective functioning and are applied semi-automatically without the person's conscious awareness.

The concept of EMSs maintains the information processing component important to Beck's (1967) earlier definition but emphasises early development and thematic content. Young et al. (2003) proposed 18 EMSs under five categories: i) disconnection and rejection, ii) impaired autonomy and performance, iii) impaired limits, iv) other directedness, and v) over-vigilance and inhibition. They represent five needs in childhood: i) the need for safety and

nurturance, autonomy, competency, and sense of identity, ii) freedom to express needs, iii) opinions and emotions, iv) spontaneity and play, and v) realistic limits and self-control. Each schema domain is believed to have developed from the repeated experience of an unmet childhood need:

Domain 1: Disconnection and Rejection

Individuals believe their needs for safety, love, belonging, and stability will not be met and thus, are not capable of forming secure and satisfying attachments to others.

Domain 2: Impaired Autonomy and Performance

Individuals have expectations about themselves and the world that interfere with their perceived ability to separate, function independently, survive, or perform successfully.

Domain 3: Impaired Limits

Individuals have a deficiency in internal limits, responsibility to others, or long-term goal–orientation. This leads to difficulty respecting the rights of others, cooperating with others, making commitments, and meeting realistic personal goals.

Domain 4: Other-Directedness.

Individuals have an excessive focus on their feelings, desires, and responses to others, at the expense of their own needs; to gain approval, and love, maintain one's sense of connection or avoid retaliation.

Domain 5: Overvigilance and Inhibition

Individuals place excessive emphasis on suppressing one's feelings, choices, and impulses or on meeting rigid internalised rules about performance – often at the expense of one’s own happiness, health, and relaxation.

Each domain and associated schemas are presented in Table 4.

Table 4
Schema Domains and Associated EMS (Young et al., 2003)

Schema Domain	Early Maladaptive Schema(s)	Definition
Disconnection and Rejection	Abandonment/instability	Perceived instability or unreliability of those available for support and connection.
	Mistrust/Abuse	The expectation that people will hurt, abuse, or take advantage.
	Emotional deprivation	The expectation that one's desired emotional support will not be adequately met.
	Defectiveness/Shame	The feeling that one is internally flawed, unwanted, or inferior.
	Social isolation/alienation	The belief that one is isolated from the rest of the world and different to others.
	Social undesirability	The belief that one is unattractive and disliked by others.
Impaired Autonomy and Performance	Dependence/incompetence	Belief that one is unable to handle everyday responsibilities without considerable help.
	Enmeshment/undeveloped self	Excessive emotional involvement with one or more significant others at the expense of self.
	Vulnerability to harm or illness	Exaggerated fear that imminent catastrophe will strike at any time.

Schema Domain	Early Maladaptive Schema(s)	Definition
	Failure to achieve	The belief that one has failed or is fundamentally inadequate relative to one's peers in all areas of achievement.
Impaired Limits	Entitlement/grandiosity	Belief that one is superior to others; entitled to special rights; not tied by rules of reciprocity.
	Insufficient self-control/ self-discipline	Pervasive difficulty or refusal to exercise self-control to achieve personal goals.
Other-Directedness	Subjugation	Excessive focus on desires, feelings, and responses of others, at the expense of one's own needs to gain love or avoid retaliation.
	Self-sacrifice	Excessive focus on voluntarily meeting the needs of others at expense of oneself.
	Approval seeking	Emphasis on gaining approval, recognition, or attention from others.
Overvigilance and Inhibition	Negativity/pessimism	A pervasive, lifelong focus on the negative aspects of life while minimising or neglecting positive or optimistic aspects.
	Emotional inhibition	Excessive inhibition of spontaneous action, feeling, or communication.

Schema Domain	Early Maladaptive Schema(s)	Definition
	Unrelenting standards/ hypercriticalness	Belief that one must strive to meet very high internal standards of behaviour, and performance to avoid criticism.
	Punitiveness	Belief that people should be harshly punished for their mistakes.

EMSs are developed mainly through experiences with significant others (Young et al., 2003). This could be neglect, physical or emotional abuse, bullying, or being too overprotected in their childhood so that they have no true sense of self. EMSs are defined as pervasive themes regarding oneself, one's relationships with others, developed throughout childhood, elaborated on during one's lifetime and are dysfunctional to a significant degree (Young et al., 2003). EMSs develop to make sense of the child's experiences and alleviate the emotional pain that these experiences evoke. Some examples of schema beliefs are: *'I am a failure'* and *'I am not good enough.'* However, carried over from psychodynamic approaches is the idea that EMSs need not be formed by objectively terrible experiences. It is how the child perceives, evaluates, and responds to events that matters. For example, mild parental criticism that would be ignored by most children may have an enduring, damaging effect on children who are more sensitive. Indeed, hypersensitivity is theorised to be one of the primary, perhaps biological, causes of emotionally unstable personality disorder (Linehan, 1993), for which schema therapy was originally developed.

McGinn and Young (1996) suggest that EMSs influence how people understand subsequent life events. EMSs are typically extended throughout life, resulting in negative thinking and distress (Taylor et al., 2017), therefore, a potential target for intervention is to work to change the nature of the EMS. The early development of EMSs leads to an individual

becoming used to this pattern of thinking and behaving, fundamental to their self-concept; because of this familiarity, it is difficult to accept evidence that contradicts their EMSs, because a schematic change would cause disruption to their core cognitive organisation. Thus, to prevent such disruption, schema coping styles are employed.

Schema coping styles include: surrender, avoidance, and overcompensation (Young et al., 2003). Schema surrender is where individuals do not fight schema activation, instead they believe it is true and seek to maintain it, leading to cycles of maladaptive schema-driven patterns of behaviour. For example, someone with an Abandonment EMS may settle in an unstable relationship to avoid being abandoned. Schema avoidance occurs when individuals try to avoid the activated schemas. If an EMS is activated, attempts are made to block out the associated effects by withdrawing, often physically or emotionally, from the situation. For example, someone with an Abandonment EMS may abandon the situation before they are abandoned to prevent being hurt. Schema overcompensation attempts to dispute the EMS that has been triggered; it can also be considered as an exaggerated response that perpetuates the activated schema. For example, a person who felt worthless as a child may have internalised high standards as an adult and overcompensate in areas of work and academic achievement. Schema coping styles are explored further in Chapter Three, (3.8).

1.5.3 Empirical support for EMSs

Schmidt et al. (1995) used a factor analysis in a sample of those who had previously received psychological treatment and those who had not to evaluate the Young Schema Questionnaire (YSQ; Young & Brown, 1994). The samples revealed similar primary factors that matched Young's clinically developed EMSs. Seventeen factors emerged; 15 of the 16 proposed by Young (1990), except for Social Undesirability. Additional factors not proposed by Young included Money Worries, including items from Vulnerability to Harm EMS, and Loss of Control Fears, comprising of items from the Emotional Inhibition EMS.

Schmidt et al. (1995) used a second sample of students from the same population to cross-validate their findings; 13 of the 17 factors in the first study were repeated in the second study, (*N*=1654). The questionnaire was found to have discriminate validity on various measures of psychological distress, cognitive vulnerability, self-esteem, and personality disorder symptoms. Lee et al. (1999) utilised an Australian sample (*N*=433) to replicate this study and found the YSQ to have strong internal consistency, thus, concluding the YSQ's primary factor structure is stable across samples from two countries. Moreover, the reliability and validity of the YSQ short form-3 (YSQ-S3) were investigated by Phillips et al. (2019). Their results in older adults (*N*=104), demonstrated satisfactory internal consistency reliability in 13 of the 18 EMS. They concluded that the YSQ-S3 had internal and test-retest reliability in older adults. Thus, the YSQ's internal reliability is supported by the fact that similar results were obtained twenty years later; similarly, external validity is demonstrated by the fact that the results are comparable under different conditions.

Women with eating disorders tend to have more maladaptive core schema beliefs than those without (Leung et al., 1999). The impact of unhealthy core beliefs on eating disorders and their symptoms was explored using four groups following completion of the YSQ: restricting anorexics (*n*=20), bulimic anorexics (*n*=10), BN (*n*=27), and a control group (*n*=23). Differences in EMSs between the groups were compared. The relationship between EMSs, eating attitudes, and eating disorder symptoms was also compared. The eating disorder groups scored significantly higher on EMSs than the control group. There were different patterns of association between eating psychopathology and EMSs in women with restricting anorexia and bulimic disorders. Specifically, the frequency of binge eating was negatively correlated with Social Undesirability in BN, whereas frequency of vomiting was positively correlated with Failure to Achieve in restricting anorexics. Although present, restrictive anorexics scored significantly lower on Entitlement EMS in contrast to BN. There was little overall differences between the eating disorder groups in levels of EMSs, indicating that eating disorders share common

psychopathology. The results propose that it is not the strength of the EMSs that differentiate groups, but how they are associated with maladaptive eating attitudes that distinguished them.

Similar patterns of results were found by Waller et al. (2000) who recruited 50 women with bulimic disorders and 50 without to complete the YSQ and a diary to measure their bulimic behaviours. Those with BN (*n*=28), AN-BP (*n*=12) and BED (*n*=10) were included. Women in the comparison group displayed significantly lower levels of EMSs than the clinical group on all EMSs except Entitlement. No significant differences were found in EMSs between the diagnostic groups, supporting the transdiagnostic approach of eating disorders, that there are commonalities in maintenance factors, in this case, EMSs. However, as with Leung et al. (1999), the sample sizes were small, as such, results should be interpreted with caution.

These studies concluded that the strength of these EMSs does not distinguish women with AN and BN, it is the way in which these EMSs are related to unhealthy eating attitudes that distinguishes them. Those with AN, for example, who have an Unrelenting Standards EMS, may restrict their food intake if they are criticised and do not meet their internal high standards; whereas those with BN may binge and/or purge to alleviate this feeling. Although both have the commonality of an Unrelenting Standards EMS, how they behave is different. Thus, it is likely that taking EMSs into account in treatment would be beneficial for helping clients to understand how and why these are activated in certain situations.

Furthermore, a systematic review (Maher et al., 2022) found that those with an eating disorder or with a high level of eating disorder symptomology reported higher scores across all EMSs than controls. Unrelenting Standards was prevalent across all eating disorders, as were Defectiveness/Shame, Social Undesirability, and Social Isolation EMSs. Contrasting, Insufficient Self-Control was found to be unique to bulimic disorders, possibly because impulsivity is typically associated with BN and BED (Howard et al., 2020); impulsivity is less related to AN. These findings not only support the schema model but align with previous research, suggesting

that the development of EMSs, through adverse childhood experiences, may be a factor in the aetiology of eating disorders (Jenkins et al., 2013; Tasca, 2019).

The studies described in this section demonstrate the significance of schema-level cognitive beliefs in eating disorders. Excluding the Insufficient Self-Control EMS, EMSs did not differ significantly between individuals with AN and BN (Maher et al., 2022; Waller et al., 2002), supporting the transdiagnostic approach. This has implications for treatment as once the EMSs driving the disordered eating have been identified, treatment can be tailored to challenge the EMSs whilst simultaneously focusing on the perpetuating factors for the individual.

Clients with eating disorders are likely to identify with an array of EMSs and will react to them with different coping styles (e.g., avoidance, surrenderer, overcompensation); combinations of EMSs and coping styles can occur on a moment-to-moment basis. For example, someone with a Defectiveness/Shame EMS may experience an overcompensatory coping style and work to the point of burn out to prove they are not defective; someone else may experience avoidance and avoid the task that has triggered this EMS. This combination of EMSs and responses led to the development of schema modes. EMSs reflect stable, trait-like beliefs, whereas modes represent a state of being (Young et al., 2003).

1.5.4 Schema Modes

Schema modes are defined as *"moment to moment emotional states and coping responses – adaptive and maladaptive"* (Young et al., 2003, p.37). Schema modes are phenomenological categories of experience that play a role in the process of identifying the behaviour and experience of an individual (Edwards, 2017). They personify and collate a set of EMSs and coping methods. These manifest as systematic variations in a person's behaviour and emotion at different times, triggered by specific antecedents including, but not limited to, sensations, thoughts, and feelings (Arntz et al., 2005). Modes are categorised as: Child Modes, Critic Modes (formally Parent Modes), Coping Modes, and Adaptive Modes (Young et al., 2003).

Table 5

Schema Modes adapted from Edwards (2022); Simpson et al. (2018); Young et al. (2003)

Child Modes	Activated by unmet basic emotional needs.
Vulnerable Child	Feels lonely, isolated, sad, defective, overwhelmed, helpless, hopeless, frightened, anxious, unlovable, lost, pessimistic.
Angry Child	Feels intensely angry, frustrated, impatient, because the needs of the Vulnerable Child are not being met.
Impulsive/Undisciplined Child	Acts on non-core desires or impulses in a selfish or uncontrolled manner to get their own way and often has difficulty delaying short-term gratification.
Happy Child	Feels accepted and loved as their core emotional needs are met.
Coping Modes	Maladaptive strategies that mitigate the effect of unmet needs short-term, however, long-term, cause emotional dysregulation as core needs are unmet.
Detached Protector	Detaches emotionally from people and rejects help; feels withdrawn, pursues distracting, self-soothing, or self-stimulating activities in a compulsive way or to excess.
Detached Self-Soother	Tries to suppress and silence their emotions by compulsively and excessively committing to distracting and soothing activities.
Avoidant Protector	Avoids triggering situations by behavioural avoidance, characterised by interpersonal and situational avoidance.
Overcompensatory	Feels and behaves in inordinately grandiose, dominant, competitive, controlling, attention-seeking way. These feelings or behaviours developed to compensate for or gratify unmet core needs.

Eating Disorder Overcontroller	Functions as a form of overcompensation, whereby perfectionism, achievement, and competitiveness, often focused on the body and eating behaviours, are utilised to provide distance from underlying feelings of vulnerability, generating a self of control.
Self-Flagellating Overcontroller	Involves patterns of self-blame, self-deprivation, and punishment as coping mechanisms
Compliant Surrenderer	Acts in a passive, submissive, approval-seeking, or self-deprecating way around others out of fear of conflict or rejection; tolerates bad treatment; does not express healthy needs to others.
Helpless Surrenderer	A feeling of being dependent, helpless, and needing to be rescued.
Critic Modes	Characterised by internal critical messages that generate disdain towards core emotional needs.
Demanding Critic	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.
Punitive Critic	Feels that oneself or others deserves punishment or blame and often acts on these feelings by being blaming, punishing, or abusive towards self or others; refers to the style with which rules are enforced rather than the nature of the rules.
Adaptive Modes	
Healthy Adult	Nurtures, validates, and affirms the Vulnerable Child; sets limits for the Angry and Impulsive Child modes; promotes and supports the Happy Child mode; combats and eventually replaces maladaptive coping modes; moderates the critic modes.

To measure schema modes, the Schema Mode Inventory (SMI) was developed (Young et al., 2007). It is a 124-item, self-report questionnaire. Many adaptations have been developed, including a shortened version (118-item), which was validated within a sample of Axis and Axis II patients and healthy controls (Lobbestael et al., 2010). In Axis I, the DSM-5 (APA, 2013) includes anxiety, mood disorders, eating disorders and sleeping disorders; in Axis II, the DSM-5 includes personality disorders and obsessive-compulsive disorders. The SMI was primarily developed to measure schema modes in personality disorders.

The SMI has since been developed specifically for eating disorders (Simpson et al., 2018), the Schema Mode Inventory for Eating Disorders (SMI-ED). They examined the original SMI's psychometric features, including internal reliability, factor structure, inter-correlations between subscales, test-retest reliability, and monotonically increasing modes. This used a sample of (N= 863) non-patients, Axis I and Axis II patients. Results indicated a 14-factor structure of the short SMI, acceptable internal consistencies of the 14 subscales (Cronbach α's from .79 to .96), suitable test-retest reliability and moderate construct validity. Certain modes were predicted by a combination of the severity of Axis I and II disorders, while other modes were mainly predicted by Axis II pathology (Simpson et al., 2018). Schema modes are explored further in Chapter Three.

1.5.5 Schema-Based Model of Eating Disorders

According to Waller (2007), schema processes occur in a variety of disorders, but the presence of additional contexts, such as negative comments about weight, food, and appearance, increases the risk of an eating disorder developing. The schema-based model of eating disorders focuses on restrictive and bulimic disorders, with bulimic disorders encompassing AN-BP, BN, and BED. This is because schema processes differ between restrictive and bulimic pathologies. Both are associated with affect regulation; however, the difference is the stage in the cognition-emotion-behaviour cycle where the individual seeks to reduce the experience of intolerable negative affect. This is referred to as primary avoidance of

affect and secondary avoidance of affect. Primary avoidance attempts to avoid the affect being triggered, whereas secondary avoidance attempts to reduce the affect following a trigger (Waller, 2004).

Schema compensation is central to restrictive pathology. In restrictive disorders, a compensatory Unrelenting Standards EMS may be triggered due to the cognitive elements of the Failure to Achieve EMS, thus reducing the risk of the negative emotions associated with failure being activated (Mountford, 2002; Waller, 2004); this is primary avoidance of affect. The behavioural manifestation of this compensation could be calorie restriction or excessive exercise to avoid the activation of the Failure to Achieve EMS and the associated emotions. Whereas schema avoidance is considered central to bulimic pathology and is distinguished from restrictive pathology as the affect has already been activated through the triggering of the EMS (e.g., Defectiveness/Shame); this is secondary avoidance of affect. Following the activation of this EMS, for example, individuals attempt to reduce the associated affect, often through bingeing and purging; these are impulsive acts that serve to block out affect and alleviate feelings of defectiveness.

The schema-based model of eating disorders was driven by theoretical considerations of the clinical observations of clients with eating disorders (Waller, 2004). The model has received empirical support and implies a dichotomy between bulimic and restrictive pathologies; such cases can be explained by amalgamating the schema models with those employing both primary and secondary avoidance of negative affect (Pugh, 2015). The operation of either a primary or secondary avoidance depends on the trigger of schema activation and the strength of the EMS activated, thus, suggesting that it is important to understand the EMS that has been activated, as this can help understand the behaviour behind the EMS.

1.6 Factors that can impact on the development of EMSs and Schema Modes

This section explores factors that are involved in the development and maintenance of eating disorders and how these may influence the development and maintenance of EMSs and

schema modes. There is currently limited research into this. However, the literature reviewed above has highlighted the importance in understanding the factors that can impact on the development of EMSs and schema modes.

1.6.1 Low Self-Esteem

Low self-esteem is viewed as the evaluation of oneself as generally being less worthy (Baumeister, 1999). This can increase the risk for overvaluation of shape and weight, which can subsequently lead to eating-related pathology (Fairburn et al., 2003); leading to symptoms associated with pathological eating, such as aversion to food, reduction calories, and basing one's worthiness on shape and weight (Colmsee et al., 2021). Research has long suggested low self-esteem to be a risk factor for eating disorder pathology (Smink et al., 2018; Welch & Ghaderi, 2013).

Low self-esteem is likely to be a risk factor involved in the development and maintenance of eating disorders. A study has found that those who scored low on a self-esteem measure (Rosenberg Self-Esteem Measure), were increasingly more likely to have a higher score on EAT-26, a disordered eating measure (Mora et al., 2017). This is supported by Colmsee et al. (2021) who found that low self-esteem acts as a risk factor for eating disorders, regardless of the diagnosis, supporting the transdiagnostic approach. The Self-Organising Self-Esteem model (De Ruiter et al., 2017), proposes that low self-esteem manifests due to earlier experiences and influences how a person experiences future situations, much like the concept of EMSs.

The literature on EMSs and low self-esteem in eating disorders is scarce, however, research has found that elevated EMSs (such as Defectiveness/Shame, Failure to Achieve) in those with eating disorders appear to be closely associated with characteristic personality features in those with an eating disorder, specifically low self-esteem (Boone et al., 2013). Theoretically, underlying low self-esteem could be the presence of a Defectiveness/Shame EMS. A systematic review (Nicol et al., 2020) found Defectiveness/Shame to be prevalent in

those with an eating disorder and comorbid depression; both are characterised by elements of low self-esteem. This therefore infers that low self-esteem is likely to be a contributing factor to the development and maintenance of some EMSs, such as Defectiveness/Shame.

The activation of these EMSs is likely to then perpetuate schema modes to cope with the feelings of defectiveness and low self-esteem. It is reasonable to assume that Detached Self-Soother may be activated to alleviate these feelings by binge eating, or Overcontroller mode to alleviate these feelings by engaging in excessive exercise to make oneself feel worthy (Edwards, 2022).

1.6.2 Drive for Thinness

Drive for Thinness (DFT) is characterised by an extreme fear of weight gain resulting in disordered eating and has consistently been hypothesised as a fundamental feature of eating disorders (Levinson et al., 2017). DFT is generally measured by a subscale found in the Eating Disorder Inventory 3 (EDI-3; Garner, 2004) and is known to reliably discriminate people with symptoms of AN from those without (Garner et al., 1983). Lower scores on the DFT subscale are likely to have less severe eating disorder pathology compared to people with high scores.

The DFT is not solely associated with AN and has been found across eating disorders. Those with AN, BN, and OSFED who exhibited higher scores on the DFT subscale have been found to have higher behavioural eating disorder features than those scoring lower (Peñas-Lledó et al., 2015). Although not widely studied, those with BED who experience an excessive concern with shape, were more likely to have higher DFT scores than those who did not purge (Kuehnel & Wadden, 1994).

Jenkins et al. (2013) explored the impact of core beliefs on childhood abuse and eating disorder pathology using the YSQ-SF (Young, 1998). Mistrust/Abuse, Defectiveness/Shame, and Social Isolation EMSs were found to be predictors of the DFT. This is consistent throughout the literature with the Mistrust/Abuse EMS found to mediate the relationship between childhood emotional abuse and the DFT (Maher et al., 2022; Monteleone et al., 2019). It could be

hypothesised that striving for the DFT develops as a coping mechanism (fuelled by an Overcompensatory mode) to compensate for an underlying fear of being taken advantage of.

In a systematic review (Maher et al., 2022) many studies using the Eating Disorder Inventory-3 (EDI-3; Garner, 2004) found that the DFT was significantly predicted by the following EMSs: Mistrust/Abuse (Jenkins et al., 2013); Defectiveness/Shame and Social Isolation (Hovrud, et al., 2020); whilst other studies found that Defectiveness/Shame (Jenkins et al., 2013), Insufficient Self-Control (Hovrud et al., 2020), and Emotional Inhibition (Waller et al., 2002) were significantly correlated with DFT. These findings were found across those with restrictive and bulimic disorders, therefore, supporting the transdiagnostic approach (Fairburn et al., 2003), highlighting the core psychopathology of the DFT shared across diagnoses. The transdiagnostic theory hypothesises that a dysfunctional system for evaluating self-worth is fundamental to the maintenance of eating disorders, likely to be fuelling the DFT. This, therefore, aligns with previous research suggesting that more than half of individuals who receive a diagnosis of AN will subsequently meet the criteria for BN or OSFED (Van Alsten & Duncan, 2020). The results of this systematic review emphasise the concept that eating disorder symptoms and behaviours are frequently driven by similar EMSs, regardless of diagnoses, thus, highlighting the clinical value of a transdiagnostic approach to understanding eating disorders and the role of the DFT.

1.6.3 Perfectionism

"Perfectionism involves high standards of performance which are accompanied by tendencies for overly critical evaluations of one's behaviour" (Frost & Marten, 1990; p.450)

Perfectionism may be a risk factor for developing an eating disorder (Bardone-Cone et al., 2007) and also considered a maintenance factor because it encourages dieting, purging, and binge eating (Treasure & Schmidt, 2013). To assess perfectionism, Frost et al., (1990) developed the Frost Multidimensional Perfectionism Scale (FMPS). This self-report measure assesses four sub-scales of perfectionism. These include concern over mistakes and doubts

about actions, excessive concern with parents' expectations and evaluation, and excessively high personal standards.

When using the FMPS, those with AN and BN endorsed excessive concern about mistakes and doubts about their actions (Boisseau et al., 2013) compared to those without disordered eating. Disorder-specific predictors were also identified. Specifically, individuals with AN were shown to have high personal standards (Wade et al., 2008), whereas those with BN experienced high levels of parental criticism. When comparing scores on perfectionism in those with AN to those with OSFED and BN, similar results were found, suggesting that perfectionism is a common trait amongst eating disorders. Investigations into BED have demonstrated mixed results; Villarejo et al. (2014) observed that women with BED scored similarly to normal-weight or obese controls, whereas Hilbert et al. (2014) found that women with BED had higher levels of perfectionism than control groups. It could be that perfection is more common in AN and BN and less so in BED, which could account for the mixed findings. Or perhaps perfectionism is less researched in BED, which could also account for the variation in findings.

Perfectionism can have both adaptive and maladaptive features. Adaptive perfectionism includes setting high but realistic goals for oneself (Burnam et al., 2014). Maladaptive perfection, conversely, is defined by overly high standards followed by critical self-evaluation and is closely linked to eating disorders (Cella et al., 2020). Those with maladaptive perfectionism may internalise high expectations and punish themselves if these are not reached. For example, with AN, an individual may set a goal of 500 calories per day, and if this is unfulfilled, they may punish themselves by engaging in rigorous exercise to meet these standards. Longitudinal studies have demonstrated the link between maladaptive perfectionism and body image concerns and eating disturbances. Boone et al. (2011) found that maladaptive perfectionism was related to bulimic symptoms through perceived pressure to be thin and body dissatisfaction, thereby demonstrating the consequences of maladaptive perfectionism.

Within maladaptive perfectionism, lie high standards of self. Unrelenting Standards is an EMS that is common in people with eating disorders, it is defined as *"the underlying belief that one must strive to meet very high internalised standards of behaviour and performance, usually to avoid criticism. Typically results in feelings of pressure or difficulty slowing down; and a hypercritical nature towards oneself and others"* (Young et al., 2003, p.17). Short term, this can be beneficial to the person as they may exceed in activities they do. Long-term, however, this can have detrimental consequences; driven by their perceived lack of control, maladaptive perfectionists may develop a rigid focus on eating and exercise, subsequently leading to engaging in an escalating pattern of disordered eating (Hall et al., 2007).

1.6.4 Summary of factors impacting EMSs and Schema Modes

The psychological constructs described are elevated in eating disorders and appear to play a role in developing and maintaining eating disorders, EMSs, and schema modes. However, research into this area is in its infancy. As highlighted, those with an eating disorder share core psychopathology placing an overemphasis on shape, weight, and food concerns (Fairburn & Cooper, 2009). For instance, with low self-esteem, individuals place overemphasis on their shape, weight, and what they eat; this, in turn, exacerbates the low self-esteem, consequently, leading to disordered eating behaviours and perhaps a Defectiveness/Shame EMS. With perfectionism, individuals will often set themselves unrealistically unrelenting high standards, despite the adverse consequences, such as excessive exercise or calorie restriction to attain the desired outcome. Similarly, the DFT overemphasises weight, shape, and food concerns that motivate the drive for the thin ideal. The traits described are all thought to have an impact on the development and maintenance of eating disorders, EMSs, and modes; further research is needed to continue to explore this. As well as exploring the impacting factors, it is important to understand and explore if eating disorders, EMSs and modes have a function.

1.7 Functionality of Eating Disorders, EMSs, and Schema Modes

1.7.1 Do eating disorders have a function?

Authors have previously discussed the functional role of eating disorders (Espíndola & Blay, 2009; Fox et al., 2011). Although the literature is scarce, eating disorders might function as a coping mechanism to provide comfort in distressing situations; for example, one may turn to restriction or excessive exercise when feeling stressed. Participants in Fox et al's. (2011) study reported that their eating difficulties were beneficial as they were a technique they could use when faced with difficulties in life. Participants also explained that they were afraid of giving up their eating difficulties for fear of how they would manage stressful situations, suggesting that their eating disorder also played a role in safety, something that provided comfort.

AN has long been thought to function to regain control (Crisp, 1997), or as a form of self-punishment (Bruch, 1982). Many of the interpretations of the meanings of anorexic behaviour hypothesise motivational constructs, including the need for control. Rather than systematic empirical studies, this is based on theoretical assumptions from clinical findings. The functions of AN include offering a sense of control and identity, and positive experiences (Erikson et al., 2012; Espíndola & Blay, 2009). There is acknowledgement of the negative consequences of AN, particularly in chronic populations. However, it is important to understand the perceived positive functions that eating disorders can have for an individual. Interestingly, the positive side of an eating disorder has primarily been found in qualitative studies, suggesting it is difficult to capture when utilising quantitative measures.

Similarly, with bulimic disorders, research speculates that bingeing occurs due to the function it serves in alleviating the dysphoric mood state (Huff, 2020). For example, people who binge are prone to experiences of aversive self-awareness caused by the perceived failure to meet their own high personal expectations (Heatherton & Baumeister, 1991). Thus, bingeing diverts attention away from the painful awareness, intolerable emotions and into the immediate

surroundings. Bingeing, therefore, alleviates distress and acts as a state of relief; thus, demonstrating the functionalities of bingeing; akin to the Detached Self-Soother mode.

1.7.2 Are EMSs and schema modes functional within the context of eating disorders?

Both EMSs and schema modes can be maladaptive and adaptive (Young et al., 2003). The Unrelenting Standards EMS is elevated in the eating disorder population (Maher et al., 2022), this could be due to its perceived functionality. Theoretically, this EMS could lead a person to believe they are in competition with themselves, thus, bringing a perceived element of control, leading to a sense of achievement, further elevating the maladaptive impact of this EMS. However, for someone with an eating disorder, they may perceive this as being functional if they believe that they are winning against themselves and thus, achieving their high internalised standards.

Additionally, schema modes can be perceived as functional. Detached Protector is elevated in the eating disorder population (Talbot et al., 2015). In this mode, people shut off and detach from their emotions. Within the context of eating disorders, this could be detaching from their emotions by over-eating or purging, suggesting an inability to correctly respond to one's emotional needs. This can be perceived to be functional in that it serves the purpose to stop the individual from being hurt by shutting off emotions; restrictive and compensatory behaviours can function as a form of primary or secondary emotional avoidance, whilst simultaneously generating soothing feelings (Kaye et al., 2013).

Moreover, the Overcontroller mode(s) could be perceived as functional. Encompassed in this mode, there is the Eating Disorder Overcontroller. This mode functions as a form of overcompensation, whereby achievement, perfectionism, and competitiveness, focused on the body and eating habits, are used to generate distance from underlying feelings of vulnerability by creating a sense of control (Simpson et al., 2018). The control element can be perceived as functional as when control is lost in elements of life, controlling one's diet can be seen as a

positive providing a sense of security. However, presently, there is limited research into the functionality of EMSs and schema modes in the eating disorder population.

1.7.3 Summary of functions of eating disorders, EMSs and modes

Despite the negative consequences of eating disorders discussed extensively in the literature, including the negative impact on quality of life, social isolation, and low self-esteem, eating disorders can be perceived as positive and functional. Anorexic behaviour is typically seen as beneficial as it gives individuals a perceived sense of control; when control is lost in other aspects of life, it may be regained through food, as demonstrated by the Eating Disorder Overcontroller mode and Unrelenting Standards EMS. It is this role that may lead to the long-term maintenance of the disorder and the ambivalence around recovery; this will likely make it difficult to recover as many people may not want to give up the behaviours associated with their eating disorder because it is perceived as functional.

1.8 Recovery in Eating Disorders

1.81. What is recovery?

Recovery has been depicted as a place of freedom from food, preoccupation with weight and freedom from the eating behaviours that once controlled the person's life (O'Hara & Smith, 2007). Nevertheless, research portrays poor recovery outcomes, with less than 60% reporting a good outcome (Lock et al., 2010). The reasons why some people fully recover, while others relapse remains unclear. Currently, there is no unanimity on how psychological factors should be assessed and comprehensive evaluation of recovery is rare. Weight gain is quantifiable and is a primary factor in assessing recovery behaviours (Noordenbos & Seubring, 2006). Nevertheless, this fails to consider the cognitive factors that contribute to the onset or maintenance of disordered eating.

There is a wider debate on what constitutes recovery from a personal and clinical perspective. Previous qualitative research highlights the differences between objective and subjective views. Objectively, clinicians view recovery as symptoms being absent, a healthy

BMI, and the absence of restrictive behaviours (Jenkins & Ogden, 2012). Treasure et al. (2003) suggest that the outcome of recovery in AN can be determined objectively; this is because patients' treatment is considered effective when their weight loss has stopped along with a reduction in anorexic behaviours. Whereas a patient's conceptualisation of recovery is significantly more complex in comparison, it is subjective and likely to exist on a continuum. For example, participants in Pettersen and Rosenvinge (2002) study defined themselves as recovered while still experiencing some eating disorder symptoms, further emphasising the subjectivities of recovery. Fennig et al. (2002) found patients with AN restored weight, retained disordered attitudes toward food and still experienced obsessions about food and weight. Therefore, indicating weight restoration does not necessarily constitute a full recovery.

Ambivalence surrounding recovery is a central feature of eating disorders, particularly in those with AN. Patients with AN rarely seek treatment as their motivation to change is often low (Sansfacon et al., 2017), the dropout rate is high (Linardon et al., 2019), and treatment outcomes are typically poor (Fairburn, 2005). The strong resistance to change has been attributed to the function of anorectic symptoms (Serpell et al., 1999). AN patients differ from many patient groups as they often value their symptoms (Fox, et al., 2011), which may explain the low motivation to change and uncertainty around recovery because behaviours become meaningful to the individual.

Following treatment, relapse may occur. In AN, around 31% of people are estimated to relapse in the year after finishing treatment (Berends et al., 2018); in BN, the relapses rates are between 27.6% and 41% within two years after remission (Olmsted et al., 2015). First-line treatment typically has poor outcomes in the treatment of eating disorders (Linardon et al., 2017; Smink et al., 2013), suggesting there is a need for improvement in the outcomes of these treatments and that perhaps a different approach is needed.

1.8.2 Impact of EMSs/Schema Modes on Eating Disorder Recovery

Schema therapy seeks to help an individual reduce their EMSs and their maladaptive schema modes, whilst strengthening their Health Adult mode (Young et al., 2003). The goal is to not eliminate these EMSs or modes, but to enable the client to manage these adaptively. However, some EMSs/schema modes (such as Helpless Surrenderer) may impact a person's recovery. In Helpless Surrenderer, an individual will avoid expressing vulnerability and needs directly, and will instead, seek help passively through withdrawal, compliance, or a quick fix (Simpson et al., 2018). It is hypothesised that Helpless Surrenderer may be linked to certain EMSs: Dependence, Subjugation, Emotional Deprivation, acting as a maintenance cycle for the eating disorder and subsequently, impacting recovery. This mode can also be mistaken for Vulnerable Child mode, which may also hinder recovery as the therapist may be working with the incorrect mode (Simpson et al., 2018).

Default modes may also impact recovery. A default mode remains stable over time and is often a coping mode. Those who spend a significant amount of time in default modes appear to be in their Healthy Adult mode due to the perceived stability; however, this is not always the case as it is often a coping mode manifesting as the Healthy Adult mode (Edwards, 2022). The role of the therapist is to help clients acknowledge that their default mode is a coping mode and not an adaptive way of being (Edwards, 2022); as often, it is the coping mode that can maintain the eating disorder and affect recovery.

1.8.3 Summary of Recovery

In summary, recovery is a broad spectrum that does not have a specific definition and varies across the literature. For example, it could be viewed as maintaining a stable weight or absence of disorder eating. At present, first-line treatment typically has poor outcomes, which could explain why the definition of recovery is varied, suggesting that treatment requires significant depth to uncover the function and origin of the eating disorder to aid in making positive changes in the individual.

1.9 Chapter One Summary

This chapter outlined the psychopathology of eating disorders. It is critical to elucidate factors that predict the future onset of eating disorders and target these in interventions. Eating disorders have clinical outcomes that vary significantly in severity and chronicity; they are a complex phenomenon, requiring a multidisciplinary approach when treatment is involved. Schema therapy explores in-depth the underlying causes of a person's psychological issues. A fundamental aspect of schema therapy is the importance of early childhood experiences, whereby negative life experiences are hypothesised to play a role in the formation of EMSs and maladaptive schema modes. EMSs and modes are two conceptual components in the formulation of a client. Those with an eating disorder are theorised to have elevated EMSs and modes and, in some instances, these can maintain the eating disorder – e.g., a Defectiveness/Shame EMS may contribute to ongoing low self-esteem and maladaptive coping, such as overcompensation by means of excessive exercise to alleviate this feeling– thus, suggesting a schema approach may be beneficial in eating disorders to target underlying core beliefs. Chapter Two explores schema therapy in more detail and also examines the physical, pharmacological, and psychological treatments of eating disorders to provide the context of current treatment avenues, efficacy, and challenges.

Chapter Two: Interventions for Eating Disorders

2.1 Introduction

This chapter explores treatments for eating disorders including pharmacological, physical, and psychological treatments outlined by the National Institute for Health and Care Excellence guidelines (NICE, 2020); these are evidence-based recommendations for health and care in England. It is worth highlighting that the NICE guidelines for eating disorders were published in 2017 but updated in 2020 and as such, the latest guidance is discussed.

Treatment for eating disorders should take a multidisciplinary approach, consisting of a medical doctor, a dietician, a psychiatrist, and a therapist; with involvement of support networks such as family and friends (Gorla & Matthews, 2005). Despite demonstrable need for interventions for eating disorders, there is often a lack of access (Simpson et al., 2010). Considerable research suggests that there has been a paucity of resources and access to treatment of eating disorders (Johns, et al., 2019; Reid et al., 2009). General Practitioners and family physicians frequently feel unequipped to identify and manage eating disorders and prefer to refer to specialist services; however, they are severely under-resourced, overloaded, and frequently unable to accept a high volume of referrals (Diana & Polimeni-Walker, 2004).

Consequently, individuals may be left untreated or face a long waiting list (Tatham et al., 2012), prolonging and possibly worsening their condition. In 2017, Beat (The UK's National eating disorder charity) found on average it takes over eighteen months for people to realise they have an eating disorder, a further year before they seek help and an additional six months to see a clinician and receive treatment. These circumstances are likely to exacerbate the eating disorder and consequently decrease the likelihood of recovery. Research has documented that treating eating disorders can be challenging (George et al., 2004; Keller et al., 2006); individuals rarely seek therapy on their own since their motivation to change is often low (Griffiths et al., 2018); when treatment does occur, the dropout rate is high with 20-51% of

inpatients and 23-73% of outpatients dropping out from their treatment (Abbate-Daga et al., 2013). Therefore, highlighting the need for a wide range of interventions.

This chapter explores the wide range of available interventions used to treat eating disorders, beginning with the pharmacological, moving to psychological therapies and finally, physical interventions such as re-feeding.

2.2 Pharmacological interventions

2.2.1 Antipsychotics

Antipsychotics were initially used to treat those with AN as their obsessions about their weight and shape were thought to be delusional (Bruch, 1973). Early randomised control trials (RCTs) demonstrated a significant improvement in mental state and weight gain after commencing chlorpromazine (Dally & Sargant, 1996) and sulpiride (Vandereycken & Pierloot, 1984); nevertheless, antipsychotics did not modify eating behaviours. Mondraty et al. (2005) found that antipsychotics such as olanzapine were superior to chlorpromazine in reducing anorexic ruminations including calorie counting, consuming food in a specific way, and mirror checking. Bissada et al. (2008) found that olanzapine was considerably more effective than placebo in reducing obsessive symptoms and achieving rapid weight gain in people with AN. Similarly, Mehler et al. (2001) discovered that olanzapine reduced body image issues and anxiety around eating in children and adolescents; in comparison, Boachie et al. (2003) found lower agitation and anxiety and an increase in weight gain.

Powers et al. (2007) found quetiapine to reduce depression and anxiety over a ten-week period, however, there were no significant changes in BMI and the average weight gain was 0.73kg. Furthermore, the use of aripiprazole combined with an antidepressant was found to significantly reduce eating specific anxiety, reduce obsessional thoughts about food, shape, and weight in patients with AN and BN; in those with AN, it was found to restore body weight partially or fully (Trunko et al., 2011). However, Norris et al. (2011) compared patients with AN treated with olanzapine to those not receiving treatment. Those on olanzapine had greater

severity of illness, higher rates of comorbidity, and side effects were reported in 56% of people following completion of treatment. This study suggests that those treated with olanzapine were more likely to present with larger degrees of underlying psychopathology than those who were not; evidenced by lower BMIs at assessment and increased rates of comorbid depression and anxiety. Therefore, given the short-and-long-term side effects of antipsychotics, as well as the fact that weight gain in people with AN does not persist unless it is accompanied by changes in eating attitudes, NICE (2020) guidelines no longer recommend the use of traditional antipsychotics in the UK.

2.2.2 Selective Serotonin Reuptake Inhibitors (SSRIs)

SSRIs have previously been used to treat AN, however, RCTs depict poor results. Fluoxetine was found to have no advantage over placebo for underweight in-patients with AN (Attia et al., 1998; Barbarich et al., 2004). In contrast, Kaye et al. (2001) assigned AN patients either fluoxetine or a placebo following in-patient treatment. After a year, those receiving fluoxetine had substantially lower rates of relapse than those who were given the placebo. Yet, this study had a small sample size (N=13) so the results may be difficult to extrapolate.

Fassino et al. (2002) compared citalopram to a waitlist condition in patients with AN in an RCT, (n=26) in each group. They discovered that while both groups gained weight, citalopram improved obsessive compulsive symptoms, sadness, trait-anger, and impulsiveness in those with AN, therefore, proposing it may be beneficial. Conflicting evidence for the use of SSRIs in AN found that in a larger sample (N=93), there was no difference one year on in relapse rates between those who had the placebo and those who had fluoxetine (Walsh et al., 2006). Across the literature, it is suggested that antidepressants should not be used as a sole treatment for AN, but can be used in conjunction with a therapeutic practice (Marvanova & Gramith, 2018). Pharmacological treatments are often used secondary to psychological interventions (Crow, 2019). Thus, suggesting a combined approach is needed as although medication can help in treating the symptoms, a psychological approach can help uncover the underlying cause of AN.

Only a few studies of antidepressants in children and adolescents with eating disorders have been undertaken as healthcare professionals are usually reluctant to provide medications, particularly SSRIs, to those under 18 years. Medication should be properly monitored due to growing concerns regarding the risk of increased suicidal ideation in young people who take SSRIs. Holtkamp et al. (2005) compared 19 adolescents with AN who had their weight partially restored and treated with SSRIs to a group of 13 who did not receive medication. Their results showed no differences in the eating disorder, BMI, depression, or obsessive-compulsive scores, and therefore, concluded that there was no effect of SSRIs on the eating disorder. This could be due to the small sample sizes or that very few adolescents are treated with SSRIs. However, there is some evidence to suggest that mirtazapine has helped in increasing appetite and inducing weight gain (Schüle et al., 2005). There is limited evidence to support the use of SSRIs for the treatment of comorbid anxiety and depression in adolescents with AN who have are weight-restored (Flament et al., 2012).

The Fluoxetine Bulimia Nervosa Collaborative Study Group (1992) compared two fluoxetine doses (60 and 20mg/d) against a placebo in a large trial (*N*=387). A 60mg dose of fluoxetine was found to be superior to the placebo in terms of reducing bingeing, with a 67% reduction on fluoxetine compared to a 33% reduction on the placebo; similarly, those given fluoxetine at 60mg/d had a greater reduction in vomiting frequency than those on the placebo (56 percent vs. 5%). Fluoxetine was also reported to help with carbohydrate binges, depression, and eating attitudes at this dose. The larger the dosage, the more common the adverse effects, and the average weight loss was 1.7 kg. Moreover, at a dose of 20mg, fluoxetine had an intermediate effect and reduced binge and purge frequency. Although dated, this trial infers that fluoxetine may be beneficial in treating BN.

Furthermore, the impact of a wide range of pharmacotherapeutic treatments on binge eating frequency and weight loss was investigated. RCTs compared placebos with fluvoxamine (Hudson et al., 1998), sertraline (McElroy et al., 2000), fluoxetine (Arnold et al., 2002), and

citalopram (McElroy et al., 2003a) for BED. These SSRIs were linked to a considerable reduction in the number of binge episodes, a lower BMI, and overall clinical improvement. However, many pharmacological trials are short-term interventions (6–16 weeks) with effects investigated at post-treatment, but almost no long-term follow-ups exist. Thus, it is unclear if pharmacological interventions are effective for BED long-term (Ghaderi et al., 2018). Although not all patients with BED may be appropriate candidates for pharmacotherapy, all patients should be considered and educated about pharmacologic treatment options (McElroy, 2017).

2.2.4 Mood Stabilizers and Anticonvulsants

Lithium is known to bring about weight gain in people treated with this medication. Lithium was administered to individuals with AN and compared to a placebo in an RCT. Those treated with lithium gained more weight on average than those on the placebo (Gross et al., 1981). However, using lithium to treat AN is not highly recommended because of the depletion of sodium and fluid which may lead to a reduction in lithium clearance resulting in increased potential toxicity (Flament et al., 2012).

Phenytoin was the first anticonvulsant used as a treatment option. However, early results have not been replicated, due to weight gain being a common side-effect (Carter et al., 2003). Topiramate has also been utilised since it suppresses appetite and causes weight reduction (McElroy et al., 2007b). McElroy et al. (2003b) compared topiramate to placebo in obese outpatients with BED and found topiramate was linked with greater weight loss and reduction of binges, suggesting it could be used in treatment.

2.2.5 Summary of Pharmacological Treatment

Currently, approved pharmacological treatments for eating disorders are limited to fluoxetine for bulimic disorders, however, there are no approved pharmacological treatments for AN alone (Himmerich et al., 2021). Pharmacological treatments have their benefits in the treatments of eating disorders; however, they should not be used as a sole treatment and are

often secondary to therapeutic interventions (Crow, 2019). The NICE (2020) guidelines recommend that medication can be used as an adjunct to psychological treatment.

2.3 Psychological Interventions for Children and Young People

2.3.1 Family-Based Interventions

The NICE (2020) guidelines recommend Family-Based Treatment (FBT) as first-line treatment for children and young persons with an eating disorder. Minuchin et al. (1975) was the first to incorporate families into treatment, yielding positive outcomes with success reported in 86% of patients. The theoretical principles and application of the structural family therapy (Minuchin et al., 1975), along with Palazolli's (1974) work from the Milan Group and Haley's (1976) strategic therapy, served as the establishment for the development of FBT. FBT emphasises the role of parents as resources and encourages families in their efforts to help their child recover (Lock & le Grange, 2005).

FBT has three phases. Phase I is an in-session family meal focused on weight restoration, during which parents are empowered and supported to take responsibility for their child's eating whilst intervening with compensatory behaviours (Murray et al., 2014). Focus on Phase II is given to the impact of the eating disorder on the family and the adolescent's gradual reclaiming of some autonomy over their eating. Phase III addresses individual, developmental, and familial issues, relapse prevention and a reintegration of the young person and their family into normal family activities (le Grange et al., 2012). This phase commences when adolescents can objectively demonstrate varied eating in a range of contexts, whilst maintaining their body weight (Lock & le Grange, 2015).

AN is regularly treated with FBT, with both structural and strategic family therapy being utilised (le Grange & Lock, 2005). Symptoms of AN are sometimes perceived as helping to maintain pathological family processes such as enmeshment and rigidity; thus, interventions, such as a family meal, were developed to enhance parental authority, challenge inappropriate

alignments between children and parental figures, and to encourage sibling subsystem development (Lock & le Grange, 2015).

FBT benefits those with more severe eating disorder psychopathology (le Grange et al., 2012). Dissemination studies (Couturier et al., 2010; Couturier & Kimber, 2015), mediator and moderator studies (le Grange et al., 2012), RCTs (Lock et al., 2010), and meta-analyses (Couturier et al., 2013), demonstrate that FBT is one of the most well-researched treatment modalities in the treatment of eating disorders, particularly AN. By the end of the 12-months, up to 75% of adolescents are likely to have restored their weight. This weight restoration appears to be sustained over time, with a twelve-month follow-up revealing encouraging rates of continued weight restoration. Around 40% of those having FBT report a full remission of cognitive symptomology by the end of the treatment (Lock et al., 2010).

The inclusion of families in treatment yields positive outcomes as families possess skills, commitment, and knowledge to assist their children in recovery (Hurst et al., 2017; Lock 2005). Hurst et al. (2017) found that by having families involved, remission of BN symptoms was achieved, with a cessation of bingeing and compensatory behaviours at the end of treatment. Families felt that their involvement enabled them to improve their understanding of BN and prevented the ongoing, secretive nature of BN as families reported improved family cohesion and communication. The importance of the family dinner session was also recognised as it provided caregivers with the ability to manage BN-related behaviours. This, therefore, lends credence to FBT's efficacy in the treatment of BN (Hurst et al., 2017). Evidence has encouraged the use of FBT when treating BN and has favourable outcomes compared to psychotherapy with 39% of patients abstinent compared to 18% at a six-month follow-up (le Grange et al., 2007), is advantageous to the use of CBT in BN (Schmidt et al., 2007); and has shown efficacy in the treatment of AN (Springall et al., 2022). Indeed, there is consistent support in the literature for FBT. There are, however, limitations.

Firstly, adolescents sometimes do not want their parents involved in treatment. Perkins et al. (2005) had two groups: one group with no parent involved (NPI), and one with parent involvement (PI). The NPI group was older and had had their eating disorder for a longer duration. The most common reason for not wanting parents involved was the perception their mothers held a blaming and negative attitude. This group also said they were responsible for their illness, and it was not their parent's problem to solve, and thus did not want them involved. On the contrary, the PI group included their parents as they were viewed as having an interest and being supportive throughout.

The effectiveness of treatment can depend on the person's family. There has been evidence to demonstrate that those with AN, who come from highly critical families, are likely to drop out of treatment early or have poorer outcomes (le Grange et al., 1992); this is also the case in BN (Hedlund et al., 2003). This implies that family interactions have substantial implications for treatment and can occasionally hinder treatment, for example, if the family is overly critical.

2.3.2 Adolescent-focused Psychotherapy

If FBT is not suitable or ineffective, the NICE (2020) guidelines recommend the consideration of adolescent-focused psychotherapy (AFP-AN). AFP-AN is psychodynamic informed and focuses on enhancing autonomy, self-efficacy, and assertiveness, whilst including collateral meetings to support individual treatment (Hibbard et al., 2012). AFP-AN (previously Ego-Oriented Individual Therapy) theorises that those with AN manifest ego deficits and confuse self-control with biological needs. Clients are taught to identify and define their emotions and learn to tolerate affective states instead of numbing themselves with starvation.

Lock et al. (2010) evaluated the efficacy of FBT and AFT-AN in 24 adolescents in remission of AN. Participants were assessed at baseline, end of treatment, and at 6-and-12-months follow-up. There were no differences between treatments at the end, however at both follow-ups, FBT was significantly superior on the Global Eating Disorder Examination score;

AFT-AN is an important alternative. Although both treatments led to substantial improvement and were comparable in effectiveness in producing full remission, FBT was found to be significantly more effective in expediting full remission at both follow-up points.

To conclude, FBT has beneficial effects on the treatment of eating disorders in adolescents, however, the effectiveness of treatment is associated with the relationship the young person has with their family. For instance, with a critical family, one is less likely to engage; whereas, with a secure attachment, they are likely to engage their family. Treatment for adults is now discussed.

2.4 Psychological Interventions for Adults with Eating Disorders

2.4.1 Maudsley Model of Treatment for Adults with Anorexia Nervosa (MANTRA)

MANTRA is recommended as first-line treatment for adults with AN (NICE, 2020) and is a treatment based on a specific maintenance model of AN, drawing on social-cognitive, personality trait and neuropsychological research (Schmidt et al., 2013) including both intrapersonal and interpersonal maintenance factors. MANTRA also includes a therapeutic style of motivational interviewing, used to increase motivation for change and overcome resistance to treatment.

MANTRA is an empirically based cognitive-interpersonal treatment and suggests four key factors are central to the maintenance of AN: a thinking style characterised by inflexibility, excessive attention to detail, and the fear of making mistakes; impairments in the socio-emotional domain (e.g., difficulties in expression of emotion); positive beliefs about how AN helps the person manage their life, and unhelpful responses of close others, such as over involvement, accommodation to or enabling of symptoms, criticism, and hostility (Schmidt & Treasure, 2006; Schmidt et al., 2015).

The efficacy of MANTRA has been explored in adults, demonstrating significant and stable improvements in BMI, eating disorder psychopathology, low dropout rates, and high treatment acceptability (Schmidt et al., 2016). Maintenance factors are targeted in treatment and

aim to facilitate extensive changes in eating disorder symptomatology and weight. Treatment is primarily formulation-based, with a well-defined therapeutic procedural framework. Individual tailoring of treatment arises from flexibility as to how components of MANTRA are combined and the emphasis they are given. The therapist collaborates with the patient to construct a case formulation, amplifying the patient's strengths (Schmidt et al., 2015). Behavioural change techniques are used to guide the individual towards recovery and close others are invited to participate in sessions as required (Schmidt et al., 2013).

Studies have demonstrated the effectiveness of MANTRA (Schmidt et al., 2013; Schmidt et al., 2015; Startup et al., 2021) with all suggesting that MANTRA has positive outcomes for those with AN. Schmidt et al. (2015) investigated the efficacy of MANTRA, compared to Specialist Supportive Clinical Management (SSCM; the aim being to help the individual recognise the link between their symptoms and abnormal eating behaviour – elaborated in subsequent subsection) in 142 outpatients with AN. Following treatment, both groups improved significantly in BMI, eating disorder psychopathology, psychosocial impairment, and affective symptoms at 12 months; there was no statistically significant distinction between the groups at either 6 or 12 months. MANTRA was rated as substantially more acceptable and credible at 12 months compared to SSCM by patients (Schmidt et al., 2015). MANTRA and SSCM have promise as a first line treatment of AN in adults. MANTRA may have advantages over SSCM such as overall acceptability, credibility, and weight outcomes in patients with a low weight.

RCTs comparing treatment for AN have found MANTRA to have positive outcomes regarding eating disorder psychopathology and BMI. MANTRA was preferred by patients over SSCM and resulted in increasing weight gain, even in those who were severely unwell (Byrne et al., 2017; Schmidt et al., 2012). Zipfel et al. (2015) reviewed evidence from RCTs comparing treatments for AN concluded that MANTRA has a moderate evidence base; demonstrating lasting beneficial effects. Clients valued the approach used in MANTRA and Startup et al. (2021) suggests that MANTRA may support people in their recovery journey.

2.4.2 Specialist Supportive Clinical Management (SSCM)

SSCM is a first-line treatment for AN recommended by NICE (2020). The goal is to develop a positive relationship between the client and the practitioner, to help the client recognise the link between their symptoms and abnormal eating behaviour with the aim to restore weight and improve quality of life. The therapeutic relationship is intrinsic to SSCM and is valued by those with AN (Kiely et al., 2022). The NICE (2020) guidelines suggest allowing the client to decide what should be included in their therapy. This allows flexibility in how tasks are approached and is likely to enhance the client's sense of control, lowering their resistance to treatment (Jordan et al., 2020); treatment is unique to the individual.

Although initially developed as a control treatment for AN, SSCM has evolved as a promising first-line treatment for AN (Kiely et al., 2022; McIntosh. 2015). RCTs have been found to support SSCM as a viable and effective treatment for AN. For example, SSCM has been found to have the same improved treatment outcomes when compared to MANTRA (Schmidt et al., 2012), and MANTRA and enhanced CBT (Byrne et al., 2017), and was found by McIntosh et al. (2005) to be superior to CBT and Interpersonal Psychotherapy. Similarly, when looking at severe and enduring AN, treatment outcomes of SSCM were comparable to that of CBT-AN (Touyz et al., 2013) with significant improvement in both treatments, thus, cementing SSCM as a promising treatment.

If the treatments described above are unacceptable or ineffective, clinicians should consider: one of the treatments they have not had before, or eating disorder focused focal psychodynamic therapy (FPT).

2.4.3 Focused Focal Psychodynamic Therapy (FPT)

FPT is a second-line treatment (NICE, 2020) and ensures that the fundamental psychodynamic aspects of the disorder are the primary focus of treatment. The initial phase focuses on developing the therapeutic bond between the therapist and client, addressing pro-anorexic behaviour and ego-syntonic beliefs, whilst building self-esteem. The second phase

focuses on relevant relationships with other people and how these effect eating behaviours. The final phase focuses on applying therapeutic experiences to everyday situations and addressing difficulties after treatment.

The Anorexic Nervosa Treatment of Outpatients (Zipfel et al., 2014) investigated FPT and CBT for eating disorders (CBT-ED; explored in-depth in the subsequent section). Patients in either the FPT or the CBT-ED groups received an individualised treatment plan based on the treatment manuals (Fairburn, 2008; Zipfel et al., 2014). The data showed that outpatient treatment of people with AN utilising either CBT-ED or FPT resulted in relevant weight gain and an overall reduction in eating disorder psychopathology, with these effects being sustained at a 12-month follow-up; despite positive results, the study's primary hypothesis was not confirmed because no difference in weight increase was identified between the groups. This study demonstrated the effectiveness in various therapies in the treatment of AN in adults; the results exhibited promising outcomes and benefits of FPT.

2.4.4 Cognitive Behavioural Therapy (CBT)

CBT is widely used as a first-line treatment for eating disorders and is recommended by the NICE (2020) guidelines. CBT consists of cognitive and behavioural procedures to develop a regular and flexible pattern of eating that includes previously avoided foods and to learn to reduce concern with body weight and shape. A fundamental principle of CBT is the expectancy that clients learn to alter their cognitive and behavioural patterns by challenging negative automatic thoughts and maladaptive assumptions. Alternative, rational thoughts are generated and reinforced through behavioural experimentation. For example, if someone with an eating disorder believes that something terrible will happen if they eat more than 1000 calories, an experiment may be suggested by the therapist to challenge this. In this instance, it could be encouraging the client to eat a small amount over 1000 calories and have clients monitor their emotions, and feelings when they do this.

Research recognises that rigid thinking styles and behaviours are characteristics of the eating disordered population (Fairburn et al., 2003). An additional prerequisite for CBT is the ability to access one's thoughts and feelings. Young (1994) proposes that individuals with characterological problems often evade painful emotions. Research has previously outlined higher rates of alexithymia in eating disorders (Meneguzzo et al., 2022). Irrespective of the processes that are involved (e.g., avoidance), the higher rate of alexithymia suggests that some clients struggle to recognise certain emotions or cognitions that may precipitate or maintain their eating disorder.

CBT has been found to decrease dysfunctional dieting and have a profound effect on improving the individuals' body image as well reducing binge eating and purging in those with bulimic disorders (Waller et al., 2014). Additionally, CBT frequently improves self-esteem and reduces the level of general psychiatric symptoms with therapeutic improvement well maintained at one-year follow-up and beyond (Linardon et al., 2017). CBT is also useful in the treatment of AN. AN shares core clinical features with BN, including dietary restraint and concern around body shape and weight; these are often successfully treated in BN. CBT has been shown to be effective in treating problems that are idiosyncratic of AN such as resistance to change as it is known to provide well-developed strategies for enhancing motivation to change, and thus can help with this behaviour (Denison-Day et al., 2018).

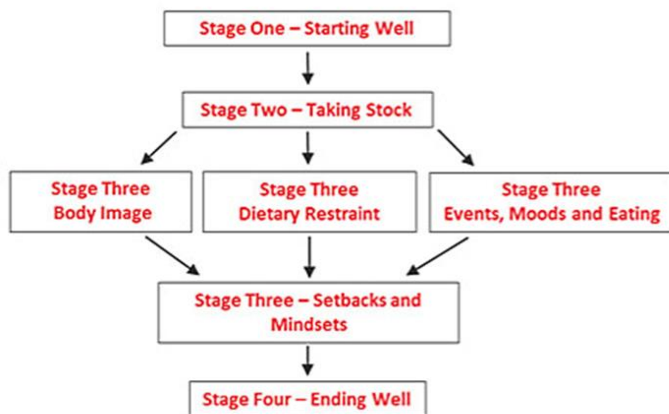
Although CBT has been found to be beneficial in eliminating bingeing and purging in up to 50% of cases of BN (Wilson, 2005), it also has drawbacks. Of that 50%, some demonstrate improvement, however, some do not respond to treatment. Although targeted in CBT, certain traits associated with eating disorders may need more work due to the underlying cognitions; perfectionism, body dissatisfaction, and low self-esteem have all been found to be associated with eating disorders. To further address these underlying cognitions, the enhanced model of CBT for eating disorders was established.

2.4.4.1 Cognitive Behavioural Therapy for Eating Disorders (CBT-ED)

CBT-ED is an expansion on traditional CBT treatment and includes four key stages (Figure 1). CBT-ED has been extensively researched, with RCTs and meta-analyses supporting its efficacy in eating disorders. For example, CBT-ED was found to have substantial and sustained effect in treating eating disorders across a transdiagnostic sample (Fairburn et al., 2015) and has demonstrated improvements in eating disorder attitudes and behaviours including purging and binge eating (Monteleone et al., 2022). Research also suggests that CBT-ED improves the patient's quality of life (Linardon et al., 2017). Additionally, Turner et al. (2015) observed that around 50-60% of patients with AN completed treatment, with medium to large effect sizes on measures of eating pathology and psychiatric symptoms.

Figure 1

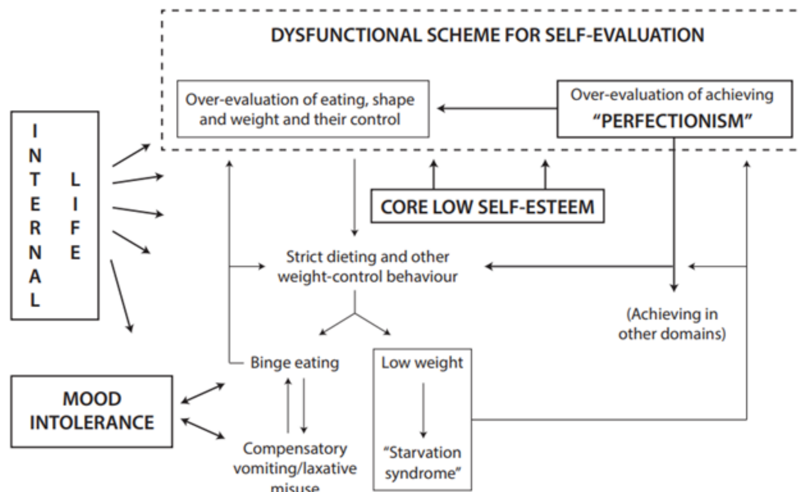
CBT-ED for eating disorders



The CBT-ED model expands on the original model by describing how four additional factors (mood intolerance, clinical perfectionism, core low self-esteem, and interpersonal problems) maintain the disorder’s core factors (i.e., over-evaluation of weight and shape). When using BN as an example, the degree to which the emotion is seen as intolerable is related to the drive to regulate emotions by engaging in disordered eating behaviours. The model depicts adverse mood as disrupting food control and indirectly contributing to binge episodes (Figure 2).

Figure 2

Transdiagnostic model of CBT-ED



The enhanced model includes clinical perfectionism, which refers to a general tendency to set excessively high standards in many areas of life; some people sacrifice personal relationships to guarantee that other aspects of their lives meet this standard. This becomes maladaptive when these ideals are pursued despite major negative effects. The enhanced model suggests that clinical perfectionism maintains BN in two ways, for example, perfectionist standards amplify the detrimental impacts of exaggerating the importance of shape and weight (Lampard & Sharbanee, 2015). Secondly, the negative effects of dietary restraint are exacerbated by perfectionist values in the domain of control of eating.

Core low self-esteem, a pervasive and unconditional negative perception of one's own worth, is also included. Self-worth is a distinguishing characteristic of BN, because it is unduly reliant on weight and shape evaluations. When people with BN attribute their self-worth to these criteria, they are more likely to have low self-esteem, especially when combined with perfectionist weight and shape standards. However, the enhanced model's core low self-esteem differs from this over-evaluation in that it involves persistent, pervasive, unconditional beliefs about low self-worth and self-esteem (Lampard & Sharbanee, 2015).

Finally, interpersonal problems were incorporated into the model and proposed to maintain bingeing and purging through two pathways. Foremost, interpersonal problems can lead to negative mood states, which can perpetuate bingeing and purging episodes to regulate emotions; repeatedly experiencing interpersonal problems further exacerbates and contributes to the development of core low self-esteem. The new additions have influenced the way in which CBT-ED has been applied to the treatment of BN to address the underlying cognitions.

CBT-ED has been demonstrated to be an effective approach for the treatment of BN (Hay, 2013; Linardon et al., 2017). RCTs evaluating this treatment have observed up to 50% of patients experience remission of bingeing and purging following treatment (Agras et al., 2000; Monteleone et al., 2022). Nevertheless, despite additional modules, RCTs have also observed limitations in treatment response to CBT-ED in those with BN. At completion of treatment, trials have reported abstinence rates from bingeing and purging of 42% - 47% (Poulsen et al., 2014) without additional modules; 22.5% (Wonderlich et al., 2014) for focused CBT-ED plus the inclusion of mood intolerance; and 49% (Fairburn et al., 2009) including additional modules. Abstinence rates at the follow-up were similar, ranging from 22.5% - 54% (Fairburn et al., 2009; Poulsen et al., 2014). These rates are noteworthy as they are similar to those found previously, implying that advances in the formulation of BN maintaining mechanisms have not translated into improved treatment outcomes and that more research is needed. Furthermore, 33% of individuals who were abstinent from binge eating and purging at the end of CBT-ED re-initiated these behaviours at follow-up, querying the effectiveness of the additional models (Poulson et al., 2014). It could be that CBT-ED for BN needs further development, there will always be a proportion of individuals who relapse, perhaps, alternative measures or additional sessions could be implemented to help reduce this number.

Indubitably, the enhancement of CBT-ED represents a significant breakthrough in the treatment of eating disorders. Nevertheless, improvements in treatment response are still

necessary, and to achieve this, a greater understanding of the client change process and the therapeutic relationship in CBT-ED is needed.

2.4.4.2 Limitations of Cognitive Behavioural Therapy

Young (1990) recognised the need to expand on CBT and address long-standing patterns of behaviours and emotional problems. A substantial number of people with eating disorders do not respond well to CBT in the long term, especially those who have more complex psychological conditions (Simpson et al., 2010). For instance, Bulik et al. (2007) suggest that the evidence surrounding the support for the effectiveness of CBT in AN is weak, with no clear evidence of improvement. Outcomes tend to be poor as those with AN are often fearful of change as they actively want to retain their eating disorder and some patients have described AN as their friend, providing them with safety (Espíndola & Blay, 2009). Furthermore, the efficacy of CBT is questioned, as approximately 50% of patients with BN continued to be symptomatic at 60-week follow-up following CBT (Fairburn et al., 2009; Waller et al., 2014); with additional research suggesting that approximately one third of individuals with BN continue to meet the diagnostic criteria after completing CBT (Poulsen et al., 2014). Therefore, if the eating disorder is perceived as having a function (e.g., safety) this could be one of the reasons for poor CBT outcomes in both in AN and BN.

Correspondingly, CBT-ED used to treat AN also has disappointing outcomes, including relapsing and reoccurrence of symptoms (McIntosh et al., 2005). CBT models, according to Waller et al. (2007), are solely focused on the maintenance of eating disorders and do not address longitudinal factors such as long-term recovery. Further, maladaptive thought patterns found in individuals with eating disorders often extend beyond dysfunctional attitudes towards weight and body shape (Simpson & Smith, 2019). These findings concur that although CBT is important, it may not be suitable to treat all eating disorders, (Waller & Kennerley, 2003), nor does it consider individual differences within the eating disorder population; this limitation appears to have persevered, despite repeated enhancement of the approach (Pugh, 2015).

CBT rarely focuses on the childhood of the individual and focuses on the present, as opposed to trying to discover why these thoughts are occurring.

Young (1990) places significant emphasis on schema level cognitive patterns as opposed to negative automatic thoughts and assumptions. Those with personality disorders have distinctive psychological characteristics that are distinguishable from Axis-1 cases which may render CBT ineffective (Young, 1994). These traits include diffuse presentations, rigidity, avoidance, and interpersonal problems (McGinn & Young, 1996). Although the presenting difficulties are ill-defined and without any ostensible triggers, they have a substantial impact on an individual's functioning, therefore, indicating that something further than CBT was needed. Thus, schema therapy was introduced.

2.5 Schema Therapy

Schema therapy developed from the notion that children require basic needs to be met to develop into psychologically healthy adults. Young (1990, 1999) developed schema therapy to treat individuals with personality difficulties. Young's schema model is an expansion of traditional cognitive therapy, designed to treat individuals with chronic axis-1 pathology and personality problems associated with axis-2 personality disorders, blending Gestalt, cognitive-behavioural, attachment theory, and psychoanalytic forming a unifying treatment model. The schemas targeted in treatment are self-defeating and enduring patterns that begin in early life. These patterns are comprised of negative thoughts and feelings that have been repeated throughout one's life and can cause problems for one in accomplishing one's goals and meeting one's needs (Calvert et al., 2018).

Currently, schema therapy is not included in the NICE (2020) guidelines, however, this is not because it is not effective, but because there is a lack of research. Schema therapy is included as a second line treatment for bulimic disorders in the Scottish Intercollegiate Guidelines Network (SIGN, 2022) and is emerging as a promising treatment for eating disorders. Schema therapy differs significantly from CBT by conceptualising childhood and

adolescence experiences at the origins of psychological problems (Simpson & Smith, 2019); placing emphasis on the therapeutic relationship, the use of emotion-related therapy strategies and focus on schema-driven maladaptive coping methods.

2.5.1 The Influence of Attachment Theory on Schema Therapy

Attachment Theory, based on Ainsworth and Bowlby's (1991) work, has had a significant impact on schema therapy, particularly on the formulation of the Abandonment schema and the conceptualisation of borderline personality disorder (BPD). The key principle of this concept is that every human being has an attachment instinct seeking to establish a stable relationship with an attachment figure. In both attachment theory and schema theory, secure attachment is fundamental to psychological wellbeing. In attachment theory, the child's secure base is often the mother who serves as the base for independence for them to explore the world (Bowlby, 1969). This therefore, creates a secure attachment, as when the child leaves, they know that their mother is there for them upon their return. However, if this need for a secure attachment is unmet, it may lead to the development of EMSs in the disconnection and rejection domain (e.g., Abandonment). Thus, in schema therapy, secure attachment is the first core emotional need that is addressed (Young et al., 2003).

Ainsworth (1979) elaborated upon the idea of the mother as a secure base from which the infant explores the world and established the importance of maternal sensitivity to infant signals. The idea of the mother as a secure base was incorporated into schema therapy by limited reparenting (Young et al., 2003). The core therapeutic process in limited reparenting is based on a secure attachment between client and therapist. For example, limited reparenting can provide a partial antidote to a patient's Abandonment EMS; the therapist becomes the secure emotional base the patient did not have, within the boundaries of a therapy relationship and seeks to meet the core needs of the patient such as security, stability, and autonomy.

In the schema model, childhood emotional development progresses from attachment to autonomy. Bowlby (1973) proposed that human beings are driven to maintain a dynamic

balance between seeking novelty and preserving the familiar. Often, individuals will misinterpret new information that would correct the falsifications that stem from these EMSs. Instead, they dismiss new knowledge that may contradict their EMSs and seek to maintain their EMSs, for example, a person with an Unrelenting Standards EMS may focus solely on a small negative piece of feedback and ignore the many positive things that may contradict that EMS. Schema therapy aims to help individuals accommodate their new experiences that disprove their EMSs, promoting schema healing. For example, helping someone with an Unrelenting Standards EMS focus on the positives instead of solely the negatives.

Bowlby's (1973) internal working model overlaps with Young et al.'s (2003) notion of EMSs. Alike EMSs, an individual's internal working model is based mostly on patterns of interaction between the infant and main attachment figure. For example, if the caregiver recognises the infant's need for protection while concurrently respecting their need for independence, the child is more likely to establish an internal working model of self as worthy and capable, leading to a Healthy Adult mode. If the child's attempts to elicit protection or independence are consistently rejected, the child may develop an internal working model of the self as unworthy or incompetent, leading to the development of EMSs such as Defectiveness/Shame or Unrelenting Standards (Young et al., 2003).

Attachment theory is not without limitations. Attachment theory focuses heavily on the mother as the primary attachment figure, when in fact, significant others such as the father or siblings can have the same type of attachment (Palm, 2014). Further, people often assume that parents are the main influence on their child; however, Harris (1998) believes a child's peers have a great influence than their parents as children tend to learn from their peers as they want to fit in with them. Children shape their social environments as well as being shaped by them. For instance, some children will be appalled by crime and therefore sever relationships with the offender, whereas others may enjoy it and use it as a way to fit in with their peers. Additionally, children's characters and behaviours also shape their attachments and environments. Resilient

children can reduce the harms of dysfunctional parenting by having the skills to seek help from other adults (Werner, 1995).

Attachment interacts with other factors to impact on a child's growth and capacity to manage their emotions and meet their perceived needs. Although attachment theory provides a solid foundation for the formation of EMSs, it is far from their sole cause. Children raised in the same family and raised in the same manner are yet likely to behave differently, indicating the impact of external variables and personal characteristics on a child's upbringing. If a child continually has unmet needs, this may develop into EMSs or schema modes, schema therapy can help address these.

2.5.2 Goal of Schema Therapy

The main goals of schema therapy are:

- Help clients strengthen their adaptive modes (Healthy Adult and Happy Child);
- Weaken their maladaptive coping modes so that they can get back in touch with their core needs;
- Heal their EMSs to break schema-driven life patterns;
- Have their core emotional needs met in everyday life.

Young et al. (2003) state that psychologically healthy individuals can adaptively meet their own core needs through self-care and close relationships. This involves identifying and reducing maladaptive coping behaviours, which function to perpetuate schemas, reduce the likelihood of schema change, whilst developing healthier, more adaptive schemas and healing unhelpful schemas. This is often a long process, requiring the individual to modify and confront schemas. A good therapeutic relationship is the catalyst in this process.

2.5.3 The Role of the Therapeutic Relationship

The therapeutic relationship is an essential foundation for change to occur. EMSs and schema modes arise when core needs are not met, therapists will aim to identify and meet

these unmet needs by using a variety of techniques including experiential, cognitive, and behavioural strategies, and empathic confrontation. By helping the individual identify missed experiences or unmet needs in early childhood and providing opportunities to address these within a therapeutic relationship, schema therapy serves as an antidote to the early damaging experiences that led to the formation of EMSs and modes. In schema therapy, this is referred to as limited reparenting.

Schema therapists play a vital role in limited reparenting and the development of their clients' Healthy Adult. To date, there are four qualitative studies investigating the perceptions and experiences of schema therapists; none of which specifically look at eating disorders (de Klerk et al., 2017; Pilkington et al., 2022; Pugh et al., 2021; Ten Napel-Schutz et al., 2017). de Klerk et al. (2017) found that therapists and patients with BPD valued the schema model as a conceptual framework, as well as the emphasis on the therapeutic relationship. Imagery was perceived as initially challenging due to the memories evoked; however, this was engaged with positively after time. Ten Napel-Schutz et al. (2017) found therapists valued learning experientially but at times, felt emotionally overwhelmed. Imagery was also perceived as challenging, particularly if the therapeutic relationship had not been established. Thus, suggesting that a good, therapeutic relationship is the foundation in which experiential techniques can be effective.

Moreover, in schema therapy, chairwork is a well-known experiential technique. In chairwork, clients sit on different chairs to represent each different mode and converse with these different facets of themselves. Chairwork facilitates the conversation between modes, often involving a child mode, a coping/critic mode, and the Healthy Adult mode. In an online survey exploring perspectives of chairwork, chairwork was perceived as invaluable by schema therapists (Pugh et al., 2021). Due to the Covid-19 pandemic, therapy was moved to online delivery. This was initially considered anxiety provoking but encouraged therapists to be creative with experiential techniques. For example, therapists described using objects in a

person's room if there were not enough chairs to change modes. This study emphasised the adaptability of schema therapy and suggested that with practice, experiential techniques could have the same impact online as in person. It would be interesting to study how other techniques of schema therapy have been adopted virtually, and to explore how clients experienced being in their own space (e.g., was imagery easier in their own space).

Pilkington et al. (2022) explored schema therapists' perceptions of the influence of their EMSs and modes on therapy using an online qualitative survey. Their findings highlighted: critic modes, overcompensatory modes and child modes to be commonly activated in therapists in sessions. As a result, therapists employed detachment to cope with their limited capacity to be emotionally present for their clients. Emerging research suggests that Detached Protector and Detached Self-Soother are common amongst health professionals (Simpson et al., 2019). Thus, a therapist's capability to reflect on and manage their EMSs and schema modes is an important contributor to the effectiveness of schema therapy (Farrell & Shaw, 2017; Simpson & Smith, 2019; Young et al., 2003). An investment in the therapeutic relationship will be the catalyst driving the motivation to change.

2.5.4 Schema Therapy for Eating Disorders

Schema domains correlate with body image, evaluative concerns, and perfectionism (Boone et al., 2013); however, there are not specific eating disorder subtypes (Dingemans et al., 2006). A key aspect of the schema model is the influence of early experiences in an individual's life such as emotional validation and trauma. It is these negative experiences that are thought to contribute to the development of EMSs and maladaptive coping styles, suggesting that negative childhood experiences could be a risk factor for the development of eating disorders.

There are sometimes difficulties in the treatment of eating disorders as individuals will rarely seek treatment of their own accord as their desire to change is often low (George et al., 2004). There are thought to be a multitude of factors that make this patient group particularly resistant to treatment, including: ambivalence in seeking treatment, distorted thinking patterns

(Mountford & Waller, 2006) and extreme levels of shame and guilt (Muris et al., 2014). The barrier for change in those with an eating disorder may be the presence of an EMS (George et al., 2004). Thus, further influencing the idea that maladaptive schemas play in a role in preventing change.

In a systematic review (Masley et al., 2012), schema therapy had large to medium effect sizes in various psychological conditions such as depression and personality disorders. Calvert et al. (2018) suggests there is increasing evidence for schema therapy use in individuals with eating disorders. Early life experiences are theorised to contribute to the development of schemas, which then drive problems later in life, such as bingeing and restricting (Simpson & Smith, 2019). There has been increased attention in exploring the deeper role of factors such as core beliefs and schemas in eating disorder literature; however, this is still rather limited. The scarcity of research was highlighted by Joshua et al. (2023) in a systematic review with only four studies being included. Yet, despite the small number of studies, they found supporting evidence for the use of group schema therapy in adults with eating disorders, particularly those experiencing severe and enduring eating disorders.

Group schema therapy was first examined in eight participants with eating disorders. Twenty sessions of treatment included experiential, cognitive and interpersonal strategies, with emphasis on behavioural change (Simpson et al., 2010). A clinically significant reduction of the severity of the eating disorder was observed, alongside a reduction in feelings of shame and anxiety from pre-treatment to six months later. Therefore, suggesting the efficacy of schema therapy in reducing the severity of the eating disorder. A clinically significant change in eating disorder severity was found in most patients who completed the programme. After the study, self-report feedback suggested that group factors may catalyse the change process in schema therapy. Simpson et al. (2010) found that group therapy helped by increasing perceptions of support and encouragement to try new behaviours, whilst also providing a therapeutic experience for the client, thus, a promising for treatment for eating disorders. Group schema

therapy is thought to be beneficial as a group environment can facilitate connections between individuals and empower them to address their EMSs and modes. Group therapies are also cost effective and are frequently used in intensive treatment. Additionally, Wetzelaer et al. (2014) suggest that a group format can amplify treatment effects found in individual schema therapy.

Schema therapy is designed to help individuals break negative patterns of thinking, behaviours, and feelings to help develop healthier alternatives. Within current literature, there is limited research regarding schemas and their association with eating disorders and the effectiveness of schema therapy as a treatment. Thus, more research is needed.

2.5.5 Clinical Implications

Research suggests that schema therapy is an effective treatment for personality disorders (Giesen-Bloo et al., 2006) and that over time, the degree of EMSs change. This change over the course of schema therapy predicts symptom relief for personality disorders. The schema model might also be relevant to mood and anxiety disorders and eating disorders, as the maladaptive childhood experiences that are thought to cause EMSs, put people at risk for a wide spectrum of psychological disorders, not only Axis II disorders (Green et al., 2010) and aforementioned comorbidity.

There is strong existing evidence for the use of schema therapy in BPD. Clients with BPD had their perceptions on schema therapy assessed in two studies (de Klerk et al., 2017; Tan et al., 2018), with the former also investigating therapists' viewpoints. Many clients and therapists valued the committed therapeutic relationship, the schema mode model, and experiential techniques used; nonetheless, the number of sessions was a common concern, with many believing that 50 was insufficient. Perhaps tailoring individually may be a solution, but not necessarily practical, particularly with the current strains of the healthcare system. Additionally, clients remarked how they were not provided with information in advance of sessions and felt unprepared when intense emotions arose, namely in imagery exercises, this could be due to emotional dysregulation, which is common in those with BPD (Glenn & Klonsky,

2008). Although experiential techniques were perceived as beneficial, imagery received mixed reviews. This could be attributed to several reasons, but it is likely due to the nature of imagery exercises (revisiting a difficult or traumatic time), that makes this exercise particularly difficult.

Moreover, Tan et al. (2018) collected data from 36 individuals with BPD, (78% women), who received schema therapy for at least twelve months. Clients agreed that the mode model was good and enabled an improvement in self-understanding and an increased awareness of their own emotional processes. Experiential techniques were perceived as emotionally confronting, nevertheless, clients supported its necessity. There was a predominately female sample across each of these studies, it is worth considering if there would be differing opinions with an even distribution of men and women. Nonetheless, schema therapy seems to be a promising treatment for BPD. Due to the high comorbidity of up to 69% between personality disorders and eating disorders (Talbot et al., 2015), one could assume that the effectiveness of schema therapy in BPD is likely to be found in eating disorders too.

Simpson and Slowey (2011) delivered schema therapy online to a woman with symptoms of obesity, binge eating behaviour, restriction, and poor body image. Over 11 weeks, reductions were seen in Global Eating Disorder Examination Question scores with a 77% reduction from pre-treatment to post-treatment in the severity of symptoms and an 87% reduction in global distress. There was also self-reported abstinence from purging behaviour in the final 28 days of treatment. Additionally, to date, only one RCT has explored the effectiveness of schema therapy in eating disorders (McIntosh et al., 2016). In this study, 112 women with BN and BED were randomised to either appetite focused CBT, schema therapy, or CBT. They found improvements in binge eating, eating disorder symptoms and general functioning. No difference was found between groups suggesting that schema therapy is comparable to CBT for treatment of bulimic disorders. These studies propose that schema therapy is beneficial in treating eating disorders.

Moreover, Edwards (2017a; 2017b) and Bowker (2021) both utilised a case conceptualisation approach exploring the experiences of schema modes in those with an eating disorder. Edwards (2017a; 2017b) explored one individual with AN and their schema modes using interpretative phenomenological analysis (IPA); Bowker examined six individuals with a diagnosis of an eating disorder and their associated modes using a primarily qualitative approach (IPA); participants in these studies were women. Across studies, similar modes were found including Punitive and Demanding critic; Detached Self-Soother, Detached Protector, Perfectionistic Overcontroller, Eating Disorder Overcontroller and Compliant Surrenderer coping modes, suggesting that these are elevated in those with an eating disorder, regardless of diagnosis. Vulnerable Child was also found in these studies, whereas adaptive modes such as the Healthy Adult, were not. However, Edwards found that strengthening his client's Healthy Adult mode resulted in a significant increase in their self-worth, therefore providing support for the schema mode model in treating eating disorders. Further, these studies highlighted the idiosyncratic nature of schema modes and the need to adopt a phenomenological methodology to uncover the meanings that modes encompass for people with eating disorders.

More recently, the Specialist Psychotherapy with Emotion for Anorexia in Kent and Sussex (SPEAKS) programme has been developed to avoid difficulties inherent in development of earlier interventions for eating disorders (Oldershaw et al., 2022). SPEAKS focuses on emotional experiences and includes elements of schema therapy into the protocol to treat AN. Thus, schema therapy is gradually being incorporated into treatment for eating disorders and has promising evidence to support its efficacy.

When pharmacological and psychological treatments are ineffective, for instance, if someone has a severe and enduring eating disorder, alternative physical treatments may be utilised, such as re-feeding.

2.6 Physical Interventions

2.6.1 Re-Feeding

Re-feeding is generally used as a last resort and is mainly used to treat those in AN who have a severely low body weight (NICE, 2020). Feeding methods include food alone, using high-energy liquid supplements, nasogastric feeding (NG), and parenteral nutrition (Agostino et al., 2013). Food alone is defined as when the energy and nutrients required are provided through whole food alone (Hart et al., 2013). High-energy liquid supplements are drinks which provide energy and micronutrients in a portion-controlled way. NG feeding distributes the nutrients directly into the gastrointestinal tract with a thin plastic tube through the nose as a liquid formula (Holmes, 2004). Parenteral nutrition provides essential nutrition in a solution, in the form of amino acids, lipids, and dextrose in a solution that is administered directly into the systemic circulation (Mehler & Weiner, 2007). Liquid supplements, NG feeding, and parenteral nutrition have the potential to deliver the recommended daily calorie intake and can be used to provide additional energy to any food that is eaten to meet nutritional requirements and assist with weight gain (Robb et al., 2002).

Hospital admission for medical stabilisation is sometimes required for treatment as weight restoration is important. However, the need to correct weight loss must be balanced against the risk of refeeding syndrome; a rapid increase in calories after a period of undernutrition can cause electrolyte abnormalities including hypophosphatemia, hypokalaemia, and hypomagnesemia, leading to muscle weakness, delirium, and cardiac failure (Agostino et al., 2013). Refeeding syndrome occurs in significantly malnourished patients during the early phase of nutritional replenishment. The Medical Emergencies in Eating Disorders (MEED) guidelines (2022) outlines the features of refeeding syndrome:

Table 6

Clinical and laboratory features of Refeeding Syndrome; adapted from Rio et al. (2013)

Note: Not all features need to be present

1. Severely low electrolyte concentrations:

- Potassium <2.5mmol/l
- Phosphate <0.32mmol/l
- Magnesium <0.5mmol/l

2. Peripheral oedema or acute circulatory fluid overload
3. Disturbance to organ function including respiratory failure, cardiac failure, or pulmonary oedema, raised liver transaminases

The amount of weight loss caused by AN is associated with the risk of refeeding syndrome. A low initial calorie intake (1000–1200 calories per day) and an increase of roughly 100–200 calories per day are advised to help lower the risk of refeeding syndrome, this is known as bolus feeding. However, a review found that restricting calorie intake does not eradicate the risk of refeeding syndrome (Ornstein et al., 2003). For example, a lower carbohydrate load may minimise insulin surges that cause electrolyte imbalances, increasing the chance of developing refeeding syndrome (O'Connor & Goldin, 2011). Additionally, beginning a calorie intake that is markedly below daily requirements will frequently result in weight loss during the first few days of hospitalisation; this could contribute to an increased cardiac risk, leading to a prolonged stay in hospital.

An alternative to bolus feeding is NG tube feeding (Stanga et al., 2008), whereby calories can be delivered continuously, preventing the insulin surges that occur with bolus meals (Ornstein et al., 2003). Slow, continuous feeding should result in reduced abdominal swelling and the associated symptoms. Utilising this strategy can occasionally be resisted because of

concern about the patient's psychological effects. There has been research on this subject, but it only focused on extreme circumstances in which NG was the only option (Patel et al., 2008), therefore results have limited generalisability. Re-feeding is primarily used in patients where their BMI is critically low (<15) and therefore should be used predominately in these circumstances (Kohn & Madden, 2007). Although re-feeding is an effective treatment of AN, it should only be used as a last resort.

2.7 Chapter Two Summary

The NICE (2020) guidelines recommend psychological treatment as a first approach to treating eating disorders, but also approve a combined approach of pharmacological and psychological interventions. The guidelines advise against pharmacotherapy alone. If pharmacological and psychological treatments are ineffective, physical interventions such as re-feeding can be used as a last resort. The treatments described have benefits in treating eating disorders. However, the literature reviewed suggested that there is a gap in addressing eating disorders on a deeper level, particularly for clients with complexities and co-morbidities. Therefore, suggesting a need for a deeper, schema-focused approach with some clients. The results of current and ongoing research suggest that schema therapy can be beneficial in treating eating disorders. The subsequent chapter explores the underlying architecture of schema therapy in greater detail, encompassing an in-depth review of the phenomenology of eating disorders with a focus on schema modes, EMSs, and the eating disorder voice.

Chapter Three: Phenomenology of Eating Disorders

3.1 Introduction

Qualitative psychology research focusses on observable and measurable variables such as behaviours and structured self-reports, while phenomenological explorations focus on descriptions of people's lived experiences. This chapter explores phenomenology in eating disorders, looking at the role of the eating disorder voice, EMSs and schema modes, and the meaning that these have for those with an eating disorder.

3.2 What is the eating disorder voice?

Literature about AN frequently includes reference to the anorexic voice (Morrison et al., 2022; Pugh & Waller, 2016; Tierney & Fox, 2010). The voice is largely described as negative about the individual's body shape and conveys critical messages about the importance of engaging in anorexic behaviours, such as restriction (Williams & Reid, 2012). The voice is experienced as distinct from the self and from ordinary self-criticism, but it is experienced as internal, so it is not an auditory hallucination (Brewin & Patel, 2010; Hare, 1973). Similar 'voice' phenomena are broadly recognised in other non-psychotic disorders, such as obsessive-compulsive disorder (OCD; Gangdev, 2002), PTSD (Brewin & Patel, 2010), and borderline personality disorder (BPD; Hepworth et al., 2013).

Most people with AN begin food restriction as a conscious ego-syntonic decision (perceived as congruent with one's beliefs and values), then, as their AN progresses, many begin to hear a demanding and critical ego-dystonic voice (intrusive and inconsistent with one's beliefs and values) (Reid et al., 2008), driving them to limit their food intake and weight (Noordenbos et al., 2014). Although initially reported for AN, the eating disorder voice is thought to be prevalent across a range of eating disorder diagnoses (Pugh et al., 2018).

Qualitative meta-syntheses suggest that learning to suppress the eating disorder voice plays a role in relapse and recovery, as individuals may relapse due to the increasingly hostile

nature of the voice throughout their eating disorder (Duncan et al., 2015; Pugh, 2016), thus, emphasising the importance of addressing and suppressing the voice. Similarly, quantitative research suggests that internal voices play a consequential role in eating disorders (Pugh, 2018). The voice has been linked with many clinical variables in AN, including negative attitudes towards food, severity of weight loss, and the use of compensatory behaviours, such as purging (Pugh & Waller, 2017). Critical inner voices have been associated with dysfunctional attitudes towards weight, shape and eating; thereby contributing to low self-esteem (Noordenbos et al., 2014).

3.3 The impact of the eating disorder voice

Many individuals view the voice as a positive presence in the early stages of their eating disorder and one that fulfils valued functions, for instance, providing comfort (Tierney & Fox, 2010). However, as the illness progresses, the voice adopts a more hostile persona, resulting in feelings of entrapment (Aya, 2019; Williams & Reid, 2012). For some individuals, this may develop into resistance to the voice and lead to autonomy and recovery. However, altering one's relationship with the voice may also include feelings of loneliness, a fear of life without the voice, and fears about relapse (Pugh et al., 2018). Thus, suggesting that the eating disorder voice contributes to maintaining the eating disorder.

Pugh and Waller (2017) investigated the eating disorder voice in women with AN, examining voice characteristics related to eating disorder pathology and sought to determine if AN patients have different voice experiences. They explored aspects that may explain the clinical influence of the eating disorder voice in the maintenance and treatment of AN. Each participant completed measures regarding the power and nature of their voice and their responses to the voice. The general nature of the voice was found to explain variance in clients' eating attitudes; perceived voice benevolence was linked to more pathological eating attitudes and those with longer duration of AN perceived the voice as being more omnipotent. Those feeling entrapped by the voice tended to have overall lower BMI. It is worth noting that neither

the perceived power of voice nor its perceived malevolence were related to signs and symptoms of AN. Nor were voice characteristics associated with the frequency of compensatory behaviours, suggesting another cognitive mechanism is involved. Hence, the severity of the elements of disordered eating pathology appears to be influenced by appraisals and responses to the eating disorder voice, emulating the literature on psychosis whereby voice-related appraisals and response styles have been shown to interact with severity of pathology (Fielding-Smith et al., 2020).

Within Pugh and Waller's (2017) sample, two subgroups were classified characterised by stronger and weaker voice experiences, where voice 'strength' was a composite of the voice characteristics reviewed above. Stronger and weaker voice experiences were distinguished by levels of voice power, entrapment, and appraisals of omnipotence. Those with strong voice experiences had an increased negative attitude towards eating, more severe compensatory behaviours, an increased chance of having AN-BP, lower BMIs, and a longer duration of illness.

The relevance of perceived voice strength in perpetuating pathology is consistent with findings in the psychosis literature, which link higher levels of voice strength to more pathology in schizophrenic populations (Hayward et al., 2014). Pugh and Waller (2017) suggest that the eating disorder voice is a significant element of the psychopathology of AN. Therefore, addressing the voice may be helpful in increasing treatment outcomes, particularly in situations where the voice is perceived as omnipotent and benevolent. Theoretically, understanding why the voice is there and establishing a constructive relationship, can support better management of the voice. In a qualitative study, Ling et al. (2022) found Voice Dialogue (talking to the voice as if it were separate) to be helpful in exploring the relationships clients have with their eating disorder voice and found it established a more constructive, positive relationship with the voice.

Individuals with eating disorders tend to experience more recurrent and distressing internal voices than non-clinical groups. Noordenbos and van Geest (2017) found that those with an eating disorder had higher levels of self-criticism and experienced higher intensity of

inner critical voices than those without. Furthermore, a BMI <17.5 was also associated with higher levels of a critical inner voice than those with a BMI >17.5. This study demonstrates the association between the strength of the critical voice and the BMI of the individual; with a lower BMI leading to an increase in negative comments about self, possibly encouraging weight restriction behaviours, thereby maintaining the eating disorder. The eating disorder voice may be used to address underlying emotional needs, particularly for those that were unmet in early attachment relationships (Sands, 1991). Thus, maintaining proximity to this alternative internal attachment figure, may limit motivation to change and contribute the maintenance of eating disorder symptoms.

In summary, the literature indicates that the eating disorder voice is related to the nature and severity of the eating disorder, especially for AN. It can have phenomenological reality throughout the duration of a person's eating disorder, it becomes part of their being with many people attributing personal meaning to this entity. Indeed, people with eating disorders sometimes recognise it as part of themselves, it becomes part of their lived reality.

There are similarities between the eating disorder voice and some schema modes, such as critic modes and the Eating Disorder Overcontroller. The subsequent section explores schema modes, this is important as the eating disorder voice could be the manifestation of a schema mode, or modes. Like the voice, modes are separable parts of the self, which may manifest in markedly different ways and at the extreme can involve some dissociation.

3.4 What is a schema mode?

The idea of separable parts of the self can be seen across therapeutic processes from the early 1900s, when Jacob Moreno utilised roleplay in psychotherapy to explore the parts of the self that interacted. From an Object Relations and Transactional Analysis perspective, the concept of ego-states provides a psychodynamic understanding of the phenomenon of multiplicity, that reflect differences and experiences within the individual (Abramowitz & Torem,

2018; Berne, 1961; Ellenberger, 1970). In schema therapy, the parts of the self are referred to as schema modes.

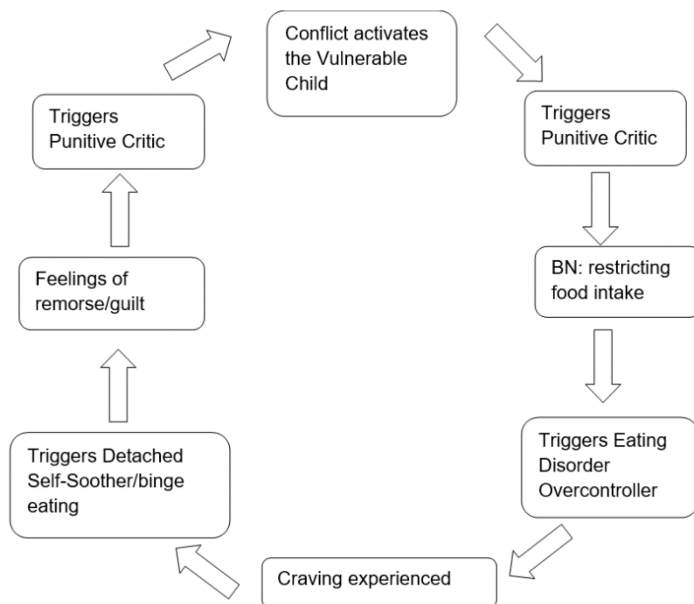
Schema modes compile and enact thoughts, feelings, and behaviours after EMS activation, either enacting schemas directly, avoiding the schema, or producing compensatory, often over-compensatory, responses (see section 3.8). Modes are various states of being to interact with the world in specific ways, often to help the person cope (Broomé, 2016). They are akin to Heidegger's phenomenological concept of disposedness.

Modes were extended specifically for eating disorders by Simpson (2012). The modes of importance for eating disorders are consistent maladaptive response patterns which, at the extreme, can appear to be different personae. Simpson (2019) notes the common clinical experience for clients with complex eating disorders is rapidly switching modes during a therapy session, evidenced by their voice and facial expression rapidly changing. For example, the client may begin in Compliant Surrenderer mode, who presents as an agreeable, smiling, sensible adult that enthusiastically agrees with everything the therapist says, but when the therapist presses for them to actually implement change, they switch to Detached Protector mode, who is unsmiling, avoids eye contact and says very little. Bär et al., (2023), in a systematic review, note a paucity of relevant research and suggest more is needed.

Edwards (2022) developed the concept of mode sequences, whereby a triggering event leads to a sequence of subsequent modes, often coping modes, as a way of managing the trigger, to meet the needs of the Vulnerable Child. Figure 3 demonstrates how mode sequences can work in eating disorders, using BN as an example.

Figure 3

Example of mode sequencing, adapted from Edwards (2022)



In this example, the Vulnerable Child has been activated by a relationship conflict, subsequently triggering the Punitive Critic. In those with BN, this has been internalised and to cope with the Punitive Critic, one restricts their food intake, activating the Eating Disorder Overcontroller to encourage and maintain this restriction. Shortly after, food cravings are experienced, leading to the triggering of the Detached Self-Soother mode and binge eating. This may lead to feelings of remorse and guilt which will then likely trigger the Punitive Critic to further encourage food restriction the following day, perpetuating this cycle. Thus, highlighting the impact coping modes can have in everyday life and the cyclic fashion in which they can work in eating disorders.

Furthermore, Talbot et al. (2015) explored modes in diagnosed eating disorders compared to a community sample. The relationship between schema modes and eating disorder diagnosis was investigated using the schema mode inventory (SMI; Young et al., 2007). Individuals with eating disorders scored significantly higher on 10 out of the 12 maladaptive modes compared to a community sample. The two remaining modes were Bully

and Attack and Self-Aggrandiser. In Bully and Attack, one chooses to humiliate and criticise others whom they perceive as challenging their superiority, and in Self-Aggrandiser, one behaves arrogantly and in a grandiose manner. Both share the commonality of feeling superior and intimidating others (Bernstein et al., 2007). The results suggest that perhaps these modes are less common in those with an eating disorder. Further, Talbot et al. (2015) found that the eating disorder group scored substantially lower on both adaptive modes (Happy Child and Healthy Adult). Voderholzer et al. (2014) had similar findings, suggesting that there are a higher number of maladaptive modes in people with eating disorders.

According to Talbot et al. (2015), eating disorder groups shared comparable patterns of modes, but they also exhibited some noticeable variations. Those with BN distinguished themselves from the community and AN/OSFED sample on the Impulsive Child and Angry Child modes, suggesting that loss of control, impulsiveness, and anger may characterise BN, but not AN or OSFED, therefore suggesting a unique schema contour for BN. This is supported by the literature as several studies have found an association between BN and impulsiveness (Boisseau et al., 2009; Engel et al., 2007; Meule & Platte, 2015) but not for AN or OSFED.

These associations, in conjunction with early success in clinical trials, highlight the notion that a mode-focused approach could be beneficial for individuals with eating disorders (Simpson et al., 2010). The results of Talbot et al. (2015) demonstrate that those with an eating disorder have higher maladaptive modes than a community sample; these conclusions provide support for mode-focused schema therapy in the treatment of individuals with eating disorders. Talbot et al. (2015) suggest that modes may differ depending on diagnosis, but do EMSs?

3.5 Do EMSs differ depending on the eating disorder diagnosis?

Individuals with eating disorders often score higher across all EMSs than those without, with Unrelenting Standards, Defectiveness/Shame, Social Isolation and Social Undesirability being elevated, regardless of diagnosis (Maher et al., 2022). When looking across diagnoses, restricted behaviours and a low BMI are predominantly associated with EMSs in the

disconnection and autonomy domain, such as Abandonment or Defectiveness/Shame (Dingemans et al., 2006). BMI changes are partly attributed to Emotional Deprivation, Abandonment, and Self-Sacrifice EMSs, operating in the context of harmful weight attitudes (Hughes et al., 2006). Lower BMI has been linked to EMSs of Failure, Defectiveness/Shame, Entitlement, Subjugation, Dependence/Incompetence, and Approval Seeking in BN (Unoka et al., 2007). These studies suggest that weight restoration in those with an eating disorder may benefit from schema-focused therapies and interventions targeting specific EMSs.

Research suggests that binge eating is positively correlated with Emotional Deprivation (Hughes et al., 2006), Dependence, Emotional Inhibition, Vulnerability to Harm, Abandonment (Jones et al., 2005), Failure to Achieve, Insufficient Self-Control, Defectiveness/Shame, Mistrust/Abuse, and Social Isolation EMSs (Waller et al., 2001). Howard et al. (2020) suggested that Insufficient Self-Control may be unique to bulimic disorders, possibly due to higher levels of impulsivity in BED and BN, although impulsivity was also seen in AN, it was elevated in bulimic disorders. Emotional Deprivation alongside maladaptive eating attitudes has been revealed as a powerful predictor of binge frequency (Hughes et al., 2006). These results are consistent with schema-focused models that link disordered eating to affective dysregulation; however, Pugh (2015), in a narrative review, note that these interactions have not been identified in all studies. Dingemans et al. (2006) discovered no correlation between core beliefs and binge eating, but found that vomiting, laxative abuse, and restricting to be positively correlated with all domains of core beliefs.

Furthermore, Dingemans et al. (2006) found that purging behaviours are linked to the severity of EMSs. When the severity of the symptoms was reduced, the inability to reduce the frequency of self-induced vomiting was connected to higher levels of pre-treatment Social Undesirability, Defectiveness/Shame, and Social Isolation EMS (Leung et al., 2000). A high Defectiveness/Shame EMS was assumed to be the most reliable predictor of vomiting in BN and has also been found to be a predictor of purging in other bulimic disorders, accounting for

approximately 30% of the variance in vomiting in both BN and AN-BP (Leung et al., 2000; Waller et al., 2000; Waller et al., 2001). Dependence/Incompetence, Insufficient Self-Control, Emotional Deprivation, and Social Isolation EMSs have all been related to bulimic attitudes (Gongora et al., 2004). Limited CBT-induced changes in bulimic cognitions have also been linked to more significant pre-treatment Dependence/Incompetence EMS (Leung et al., 2000).

The studies described emphasise that schema-level intervention may be beneficial in treating eating disorders. As a result, while many EMSs appear to be universal among eating disorder subtypes, there is a general variance in schema presentation. For instance, the way in which someone experiences an Abandonment EMS with AN may lead to overcompensatory behaviours, including restricting food intake as a way of managing their feelings; whereas someone with BN may detach, and Detached Self-Soother may be activated as a way of managing feelings of abandonment. It is worth noting that much of the research is dated, indicative that additional research is needed in this area and is an area of focus.

3.6 What do EMSs, schema modes and the eating disorder voice have in common?

EMSs, schema modes, and the eating disorder voice are similar in two ways. Firstly, they appear to maintain and perpetuate eating disorders and disordered eating behaviour. Secondly, they can be perceived as functional by clients with eating disorders due to the relief and comfort they can bring from stressful situations.

Schema therapy constructs can be considered to underlie eating disorder functions, including EMSs and schema modes, which link to the eating disorder voice. According to cognitive behavioural models, individuals with eating disorders judge themselves in terms of weight, shape, and eating habits, and their ability to control these (Fairburn et al., 2003). These models focus on specific negative thinking patterns linked to eating disorders; such individuals have maladaptive core beliefs and dysfunctional cognitions about shape, weight, or food such as believing they are overweight, when they are underweight, or being fixated on perceived good and bad foods (Dingemans et al., 2006; Waller et al., 2003). These beliefs represent the

deepest level of cognition and reflect an individual's unconditional negative beliefs in relation to their environment.

Schema theory, on the other hand, claims that disordered eating is a manifestation of deeper psychological functions. Disordered eating can facilitate avoidance of harmful effects associated with maladaptive schemas (Waller et al., 2007). For example, restriction facilitates avoidance prior to the activation of the schema, known as primary avoidance, whereas binge eating reduces the affect after the schema activation, this is referred to as secondary avoidance (Pugh, 2015). Schema processes in those with AN-BP, AN-R, and BN were compared by Luck et al. (2005). There were significant schema avoidance and compensation in those with restrictive disorders (primary and secondary), whereas BN was only associated with schema (secondary) avoidance. Spranger et al. (2001) also found greater emotional and somatic avoidance in restrictive types and bulimic disorders in comparison to healthy controls. This suggests that disordered eating behaviours and cognitions can play a variety of different functional roles in coping with the person's deeper psychological issues.

Several studies indicate that eating disorder samples have overall higher EMSs questionnaire scores than controls and are likely to score higher on individual EMS subscales (Dingemans et al., 2006; Leung et al., 1999; Pugh, 2015; Waller et al., 2003). They also score higher than other clinical groups including those with OCD and those with substance misuse behaviours (Pauwels et al., 2013; Voderholzer et al., 2014). Maladaptive schema level cognitions sustained by those with an eating disorder may be significant in the development and maintenance of eating disorder symptoms (Unoka et al., 2007; Waller et al., 2000). There is a relationship between EMS and specific eating disorder behaviours such as the regularity of binge eating and vomiting and the presence of EMS in bulimic disorders (Gongora et al., 2004; Leung et al., 1999). These behaviours are conceptualised as maladaptive coping mechanisms that are related to attachment related distress and negative emotions, including, abandonment,

the most severe form of attachment-related stress, thought to trigger overeating in eating disordered women (Luck et al., 2005).

Attachment disruptions, the emergence of EMSs and maladaptive control strategies can all be considered key risk factors for the emergence of eating disorders. Eating disorder behaviour has been defined as maladaptive coping mechanisms used in the setting of attachment-related distress (Armstrong & Roth, 1989). EMSs are cognitive conceptualisations of dysfunctional internal working models of attachment representations. They misrepresent everyday perceptions of experiences as severe distress of separation or social rejections (Young et al., 2003). Compared to neutral cues, presenting a subliminal abandonment cue considerably increased the amount eaten and presenting subliminal attachment unification information before or after an abandonment cue, substantially reduced the amount eaten among control women (Unoka et al., 2010); the Abandonment schema was found to be related with binge eating and purging behaviours (Waller & Barter, 2005), thus alleviating the pain associated with perceived abandonment. According to research, binge eating is a defence against (Patton, 1992) or a way of coping with the fear of abandonment (Waller & Barter, 2005). The greater the severity of the EMS (e.g., Abandonment), the greater the number of triggering circumstances, thereby resulting in intensely negative emotions and thoughts (Young et al., 2003). It could therefore be assumed that coping modes (e.g., Detached Self-Soother) and the eating disorder voice are subsequently encouraging binge eating, helping to ease the fear of abandonment and thus, reinforcing the schema.

At the time of writing, there is no research into schema modes and the eating disorder voice together. However, it is reasonable to assume that the eating disorder voice could be a manifestation of schema modes such as the Eating Disorder Overcontroller coping mode, Punitive, and Demanding Critic. Perhaps some modes ‘speak’ more than others.

The Eating Disorder Overcontroller mode is linked to the Unrelenting Standards schema, and functions as a form of overcompensation, whereby achievement, competitiveness, and

perfectionism, often focused on the body and eating patterns, are used to provide relief from underlying feelings of distress and vulnerability, creating a sense of control (Simpson et al., 2018). This mode seeks to regulate things in a way that is related to food control to alleviate distress. This mode resembles the content of the eating disorder voice, telling a person to stick to their diet or follow their meal plan thoroughly, which may appear to be adaptive, yet this mode is fixated on rules and rigidity, encouraging the person to do as they are told in terms of food. It is not clear however that this mode necessarily manifests as a voice but there are overlapping qualities.

Critic modes also have commonalities with the eating disorder voice, for someone with an eating disorder, criticisms will be mainly about their weight, shape, and appearance, leading to messages such as: *'no one will love you because of your appearance,'* and *'you are worthless.'* This is likely to be the Punitive Critic. The Demanding Critic mirrors the eating disorder voice too and may say things such as *'I need to run 5k if I eat x number of calories.'* Again, these modes may or may not manifest as a voice.

There are similarities between EMSs, modes, and the eating disorder voice. As well as understanding the commonalities between EMSs, schema modes and the eating disorder voice, it is important to understand their development.

3.7 Trauma, schemas, modes and the eating disorder voice.

3.7.1 Adverse Life Experiences

Child maltreatment, including physical, sexual, and emotional abuse, neglect, and child exposure to partner violence, is recognised as a risk factor for eating disorders (Kimber et al., 2017). The Trauma Dissociation Model of voice hearing suggests that internal voices may embody decontextualised cognitive material developing from early traumatic experiences which encroach upon conscious awareness due to dissociative processes (Longden et al., 2012). Internal voices, therefore, can represent manifestations of traumatic events and early

interpersonal emotional conflicts, much like the concept of schema modes. Indeed, any mode can have a voice, as in chairwork.

Research has identified associations between eating psychopathology and forms of early trauma, with substantial attention paid to the risk factors of childhood sexual abuse (CSA) and childhood physical abuse (CPA) in eating pathology (Fischer et al., 2010). CSA has been linked to multi-impulsivity, binge-purging behaviours, substance misuse, and self-harm behaviours in eating disorders, whereas CPA has been linked to being underweight (Trottier & MacDonald, 2017).

Childhood emotional abuse (CEA) is also a risk factor (Kent & Waller, 2000). O'Hagan (1995) suggested that although similar, emotional, and psychological abuse are often distinguished from one another. Psychological abuse is defined as *"impeding the mental, cognitive, and moral faculties"* and CEA has been defined by O'Hagan (1995, p.456) as *"the sustained, repetitive, inappropriate emotional response to the child's experience of emotion and its accompanying expressive behaviour".* CEA could also be ignoring the child's emotions entirely. CEA is one of the most common forms of abuse yet is one of the least researched.

Although a dated definition, O'Hagan's definition is still applicable today. Schema theory emphasises the impact of emotional invalidation in childhood (Young et al., 2003). An important construct of eating disorders is the emotional invalidation of a child's needs as this can lead to difficulties in emotional tolerance (Rai et al., 2019). Emotional invalidation occurs when an individual's emotions are ignored or responded to incongruently, resulting in the individual believing that their emotions are not valid (Waller et al., 2007). Within schema theory, one could argue that emotional invalidation in childhood could lead to the development of an Emotional Deprivation EMS (the expectation that one's desires for emotional connection will not be fulfilled adequately), with this subsequently leading to the development of a Detached Self-Soother mode (attempting to soothe one's feelings with repetitive or addictive behaviours). Theoretically, in eating disorders, this could manifest as a bulimic disorder as the binge/purge cycle serves to

create relief from one’s emotions, allowing a temporary soothing environment. Research suggest that the Emotional Deprivation EMS is elevated in those with bulimic disorders (Gongora, 2004; Hughes, 2006).

Moreover, Kimber et al. (2017) found a strong link between CEA and eating psychopathology. The causal links between CEA and eating pathology are unclear; however, cognitive-behavioural models infer that early abuse may lead to the development of negative core beliefs about self, others, and the world (e.g., EMSs), increasing vulnerability to psychological disturbance in later life, including eating disorders. Emotional invalidation is a fundamental component in the development of eating disorders (Waller et al., 2007) as well as EMS severity (Brown et al., 2016). A systematic review and meta-analysis exploring adverse childhood experiences and EMSs in adulthood, found that the Emotional Deprivation EMS was consistently correlated with all types of adverse childhood experiences (CPA, CSA, CEA). Interestingly, the presence of emotional invalidation in childhood was the most salient predictor of EMSs in adulthood (Pilkington et al., 2021), particularly Emotional Deprivation. Although not specific to eating disorders, the review suggested that the Emotional Deprivation EMS and CEA are important targets for treatment.

Constant criticism, insults, or attacks on a child's character are examples of emotional abuse; children will internalise criticism over time and may even believe it to be true, this in turn, could lead to the development of a critic mode. Those who have suffered adverse childhood experiences may not recall criticism about their body or appearance, yet the eating disorder voice will place primary focus on the individuals’ weight, shape, and food (Pugh et al., 2018).

Additionally, it is probable that emotional withdrawal in infancy may have an influence on the development of eating disorders and is a form of CEA. Ignoring a child is invalidating and will likely have an impact in adulthood due to the ruptured attachment, which may lead to maladaptive coping to manage. It could be that the eating disorder is a response to unmet emotional needs and ruptured attachment during childhood (Simpson, 2019). For example,

bingeing, restricting, and purging can be used as coping strategies to numb painful emotions they have experienced in the past. These behaviours are subsequently reinforced and become self-perpetuating.

3.8 What are the coping styles according to schema theory?

3.8.1 Introduction

The schema model proposes that EMSs are maintained by schema processes and maladaptive coping styles. Coping styles and responses often originate in childhood as an attempt to manage life's challenges, however, despite their initial value, they often become maladaptive. Coping styles are broad tendencies to cope with EMS activation using surrender, avoidance, and overcompensation, whereas coping responses are the ways in which these tendencies manifest (Rafaeli et al., 2010). Young et al. (2003) contend that the ability of humans to "fight" (overcompensate), "flight" (avoidance), or "freeze" (surrender) in the face of danger, suggests that the three coping styles may have evolutionary roots.

3.8.2 Schema Surrender

Schema surrender is where individuals do not fight the schema activation; they behave as if the schema is true and try to maintain that schema, leading to cycles of dysfunctional schema driven patterns of behaviour. These behaviours are used to make the person feel safe, however, prolong the time that they are in the associated EMS. People with this coping style often work hard to earn people's approval, subjugating themselves and sacrificing their own needs (Rafaeli et al., 2010). This coping style is often associated with EMSs in the Other-Directedness domain such as Approval Seeking, Self-Sacrifice, and Subjugation. The types of surrenderer modes include Helpless Surrenderer and Compliant Surrenderer.

3.8.3 Schema Avoidance

Schema avoidance seeks to avoid the schemas that have been activated. If an EMS becomes activated, attempts are made to block out the associated effects. The avoidant coping style can manifest in a variety of coping responses. Young (1999) suggests that individuals will

use emotional, cognitive, or behavioural (such as binge eating) methods to avoid the thoughts, feelings and emotions associated with the triggered EMS. These avoidance methods are regarded as beneficial in the short term because they minimise the likelihood of the schema being triggered; however, they often serve to maintain the schema because it has not been disconfirmed (Young, 1990). Schema modes associated with an avoidance style coping are Avoidant Protector, Detached Self-Soother, and Detached Protector. Dissociation could be considered a form of avoidance; this is discussed in section 3.9.

3.8.4 Schema Overcompensation

Schema overcompensation describes the process whereby people try to counteract an activated schema by feeling, thinking, and acting as if the opposite were true. Overcompensation, according to Young et al. (2003), can be viewed as an attempt to challenge the EMS that has been triggered; it can also be viewed as an exaggerated response that perpetuates the activated schema. For example, a person who felt worthless as a child may try to be perfect as an adult.

Overcompensation was proposed by Young (1999) to be a single construct, but has since been elaborated upon (Edwards, 2022; Lobbestael et al., 2007; Simpson et al., 2018) whereby there are many subsections of Overcompensatory modes, including: the Perfectionistic Overcontroller that focuses on perfectionism to obtain control and prevent criticism (Lobbestael et al., 2007). As highlighted in Chapter One (Section 1.6.3), perfectionism is strongly associated with the eating disorder population. Additionally, the Suspicious Overcontroller focuses on vigilance, seeking malevolence and controls others out of suspiciousness (Lobbestael et al., 2007). This mode could be interpreted as individuals being suspicious of people trying to control their food or making them gain weight.

Simpson et al. (2018) developed the Overcontroller mode further and added the Eating Disorder Overcontroller. The aforementioned Eating Disorder Overcontroller is where perfectionism, competitiveness, and achievement, focused on the body and eating patterns, are

used to protect vulnerability. This mode has parallels with the Perfectionistic Overcontroller. There is also the Self-Flagellating Overcontroller that involves patterns of self-blame, self-deprivation, and punishment as coping mechanisms (Edwards, 2022). This mode serves a variety of purposes, one of which is to help the client feel a sense of belonging with their family because they are frequently told they are a burden. The ability to relieve pain is another perceived benefit. For example, someone with AN may use self-deprivation and deprive themselves of food or other enjoyable activities, thus numbing the emotional pain. They may also exercise on an injury for pleasure or punish themselves by eating food from the floor or even consuming raw food as a way of earning deservingness.

3.8.5 Summary of Coping Styles

Maladaptive coping mechanisms develop in childhood to adapt to EMSs that are associated with distressing emotions. Distinct from untreated EMSs, an individual's coping style remains stable; they may engage in various coping modes in response to the same EMSs in different situations and at different periods in their life. For example, one may have an avoidant coping style but may use a Detached Self-Soother mode to cope with a Defectiveness EMS or an Avoidant Protector to cope with an Abandonment EMS. Coping strategies become maladaptive if continued. Another coping response, although not specific to schema therapy, is dissociation.

3.9 Dissociation

3.9.1 Introduction

Central to Young's theory is the concept of the schema mode model. However, one facet that has received less empirical attention is the notion of dissociation in the organisation, maintenance, and operation of maladaptive schema modes. It could be argued that dissociation is an extreme avoidant coping style. Dissociation is understood in terms of experiences, a breakdown in integrated processing or a structural organisation of the personality (Steele et al., 2009; Van der Hart et al., 2006). It is a disturbance of the normal, subjective integration of one

or more aspects of psychological functioning in an individual, including: identity, memory, perception, consciousness, and motor control (Spiegel et al., 2011). Young et al. (2003) do not give a formal definition of dissociation; however, it is congruent with Janet's (1907) divisions of the personality.

According to Janet (1907/1965), dissociation is a reaction to a traumatic experience in one's life. Memories and thoughts linked with the trauma may become separated from conscious awareness, resulting in a fragmented mental organisation (Lightstone, 2004). Individuals who have experienced trauma, such as emotional abuse, sexual assault, or witnessing the death of a loved one, are more likely to develop severe dissociative symptoms (Pugh et al., 2018; Watson et al., 2006). Dissociation can take many forms, ranging from mild types such as daydreaming, to more serious forms such dissociative identity disorder and may be linked to psychiatric disorders such as PTSD, bipolar disorder, and eating disorders (La Mela et al., 2014). Dissociation may develop as a psychological defence mechanism helping an individual escape from awareness of threatening emotions (Everill & Waller, 1995); whereas other evidence suggests that early trauma does not predict the development of dissociation (Johnston et al., 2009). However, because the sample size in this study was small (N=30) and comprised people with BPD, it should be interpreted with caution.

3.9.2 Dissociation in Eating Disorders

Exposure to problems in attachment history, as well as neurobiological factors, may trigger the onset of dissociation (Jepsen et al., 2014). People with eating disorders may dissociate due to experiences of CEA (Farrington et al., 2002; Kong & Bernstein, 2009). Dissociation can manifest itself in differing ways and degrees of severity (mild to severe; Seijo, 2015). For example, psychoform dissociation refers to the separation of mind aspects such as thoughts, sensations, and emotions (Van der Hart et al., 2006). It consists of symptoms related to the mental functions such as memory, consciousness, and identity.

Another type of dissociation in eating disorders is somatic dissociation. This is regarded as the most common. In this state, the body is no longer perceived as their own, but rather as an enemy against whom they must fight, creating a conflict of embodiment. These sensations, which the individual experiences as real, reflect depersonalisation due to the upset they cause (Nijenhuis et al., 1996). According to Waller et al. (2003), somatic dissociation is a defence mechanism against emotional overloading. The intensity of somatic dissociation appears to be associated to the degree of dissatisfaction about the individual's own body; the sensitivity about one's own body image could be connected to bulimic behaviour. This type of dissociation may identify people who purge and engage in other compensatory behaviours from those who do not (Nilsson et al., 2020).

As such, bulimic behaviour may be a way to produce a dissociative state to create an escape from unwanted experiences; known as avoidant coping, which could be perceived as either Detached Self-Soother, Detached Protector, or Avoidant Protector schema mode. Dissociation fluctuates during the binge/purge cycle and may be interpreted as episodically linked to the eating disorder rather than to the general psychopathology; negative affect and dissociative experiences, caused by an interpersonal situation, for example, could trigger a bingeing episode (McShane & Zirkel, 2008). The eating behaviour offers the person with a concrete experience of reality. Therefore, the dissociation and binge eating would have a function for affect regulation (Hallings-Pott et al., 2005). Thus, the purging process may be a way of getting back to reality from a dissociative state.

Compared to non-clinical samples, those with eating disorders have reported increased psychoform and somatoform dissociation (Nilsson et al., 2020). Analyses found a correlation between degree of dissociation and severity of eating disorder symptoms; however, no differences in dissociation were found between the eating disorder subgroups. Therefore, concluding that eating disorders appear to be correlated with presence and severity of

dissociative symptoms and that those with an eating disorder are more likely to experience dissociation than individuals without.

Dissociation is viewed as a defence mechanism and a natural response to stressful and distressing circumstances (Nijenhuis & Van der Hart, 2011; Nilsson & Svedin, 2006). This is akin to the function of schema modes.

3.9.3 Are Schema Modes Dissociative States?

Maladaptive schema modes in BPD are assumed to be 'facets of the self' that have not yet been incorporated into a cohesive personality structure and thus, operate in a dissociative manner (Young et al., 2003). The constant movement between maladaptive modes, facilitated by their dissociative structure, is responsible for the patterns of instability in emotions, interpersonal relations, and impulse control that characterise BPD (Johnston et al., 2009). Therefore, without the personality being organised in a dissociative way and without dissociated maladaptive schema modes – the characteristics of the 'borderline' structure, rigidity, or mode shifting would not occur. The more dissociated these schema modes are, from one another and from the healthier aspects of self (i.e., Healthy Adult mode), the increasingly maladaptive they become (Young et al., 2003). Dissociation is seen as being central to the degree of mode pathology and therefore, the degree in pathology present in BPD; as mode pathology increases, so does the dissociative structure of the personality.

Johnston et al. (2009) hypothesised that maladaptive schema modes would predict dissociation based on two assumptions. Firstly, in BPD, maladaptive schema modes exemplify sub-divisions of the 'borderline' personality that become progressively more maladaptive as they become increasingly dissociated, and secondly, increasing dissociative division in the structure of the borderline personality is evidenced by a related increase in dissociative symptoms (Young et al., 2003). They found that participants who scored highly on the Angry and Impulsive Child and the Abandoned and Abused Child modes predicted higher dissociation scores, whereas childhood trauma did not. The findings of the study support the schema mode model of

BPD and clinically support the emphasis on the integration of maladaptive parts of the personality in working with people with BPD (Young et al., 2003). Thus, suggesting that the more maladaptive schema modes present, the more dissociative symptoms a person is likely to experience.

Additionally, Barazandeh et al. (2018) proposed that dissociative processes in schema modes can explain mental shifts in patients with BPD. Using various quantitative measures including the Psychiatric Diagnostic Screening Questionnaire (Zimmerman & Mattia, 2001), DSM-4/ICD-10 Personality Questionnaire (Ottosson et al., 1995), SMI (Young et al., 2007), and Wessex Dissociation Scale (Kennedy et al., 2004), they conducted a regression to explore the extent of these associations and found strong correlations between dissociation and the following modes: Detached Protector, Angry Child, Impulsive Child, Punitive Critic, Demanding Critic, and Vulnerable Child. Schema modes explained 58% of the variance in dissociation. Detached Protector and Impulsive Child were found to significantly predict dissociation in BPD patients, thus, suggesting that schema modes are associated with dissociation. In Detached Protector, one detaches emotionally from the world, others, and self, a process that mirrors dissociation. Regarding Impulsive Child, one may become so angry that they behave in such a way whereby they have no control of their actions, resulting in a dissociative state. However, at present, this research has only been conducted in those with BPD and is thus, may not be generalisable. While people with less complex mental health problems may also have modes, or elevated scores on a mode questionnaire, it is unclear to what extent their modes were caused by maltreatment or trauma and unclear to what extent their modes are dissociated from each other.

Specifically, there is no literature investigating schema modes as dissociative states in the eating disorder population. However, due to the high comorbidity in eating disorders and personality disorders, it could by hypothesised that by drawing on inferences from previous research, those with an eating disorder who dissociate when they binge or purge and are in a

detached mode (Talbot et al., 2015). Dissociation is common across eating disorders (Farrington et al., 2002) and has been found by Pugh et al. (2018) to be related to experiences of childhood trauma such as CEA and was partly mediated by dissociation.

3.10 It is complex and confusing, so how do people with eating disorders and their therapists view their eating disorder voice?

Qualitative research highlights individuals with AN frequently report experiencing a non-psychotic, critical, inner voice that is focused on eating, weight, and shape (Graham et al., 2019). The eating disorder voice has been reported to facilitate emotional avoidance and generate a sense of identity, which may explain treatment ambivalence (Pugh, 2018). Emotion-Focused Therapy addressing the voice, yielded promising results in treating eating disorders (Brennan et al., 2014); similarly, Voice-Dialogue is promising in addressing the eating disorder voice (Ling et al., 2022).

Graham et al. (2019) was the first to analyse clinicians' thoughts on the eating disorder voice using 15 semi-structured interviews. When using the eating disorder voice as part of motivational work, clinicians reported being able to challenge the voice's messages by using chair-work; clinicians also reported attempting to undermine the voice directly by providing a compassionate narrative to the client. The clinicians' interpretation of the voice was consistent with the client's description; its perceived companionship functions reflect the predominance of insecure attachment styles among people with AN.

Working with the voice was seen as a way for clinicians to promote compassion. This links into the model of compassionate action, which entails seeing, appraising, feeling empathetic concern, and reacting to an individual's suffering (Atkins & Parker, 2012). Compassion is perceived as an active response to suffering. Consistent with the first stage of the model, clinicians described countering the eating disorder voice as a demonstration of client courage, due to the critical nature of the voice. The latter element of the compassionate model is appraisals that determine whether one has an empathetic emotional response to suffering

and the acts to alleviate it (Atkins & Parker, 2012). In Graham et al. (2019), all participants demonstrated compassion towards clients and the eating disorder voice. Thus, encouraging clients to be more compassionate to themselves.

Clinically, the eating disorder voice could be used to encourage compassion among healthcare professionals in supervision and formulations, and to develop self-compassion among service users with whom it resounds. The findings of Graham et al. (2019) suggest that studying the voice can be useful in developing and sustaining compassion when working with those with an eating disorder.

3.11 What interventions are available?

Cognitive and relational elements, such as power imbalances, are addressed in interventions. Cognitive models of psychotic phenomena may be an approach to explore the link between eating disorder voice and eating pathology (Mawson et al., 2010). Cognitive frameworks emphasise the importance of power and the nature of the voice. Voices that are viewed as more powerful than the self are frequently linked to depression and increased distress in the individual, although that effect is moderated by the voice's nature; in particular, its malevolence or benevolence (Birchwood & Chadwick, 1997). Cognitive behavioural interventions for the voice include techniques such as re-evaluating the content of the voice through cognitive modification and behavioural experimentation, addressing the malevolence of the voice, and developing a de-centred perspective on the internal dialogues the voice creates (Mountford & Waller, 2006).

Voice dialogue and emotion-focused therapy, for example, were designed to encourage a relational approach to internal voices (Corstens et al., 2012; Ling et al., 2022). The eating disorder voice is often referred to as a critic (Brennan et al., 2014) and can be challenged during chairwork using voice dialogue (Stone & Stone, 1989). This is commonly used in schema therapy. Voice dialogue uses direct communication between client, therapist, and parts of the self to increase awareness and understanding of the voice. Preliminary results by Ling et al.

(2022) suggest that voice dialogue can be helpful in supporting the individual to separate from their voice; akin to separating from maladaptive schema modes and encourages the individual to work with the voice in a positive way. Ling et al. (2022) found voice dialogue to be beneficial in helping individuals establish a constructive relationship with their eating disorder voice.

To add to this, chairwork techniques have been used in various settings, including in CBT (Pugh, 2019) and compassion focused therapy (Bell et al., 2020). Within schema therapy, chairwork aims to modify EMSs, maladaptive schema modes and coping styles whilst simultaneously developing the client's Healthy Adult mode (Pugh & Rae, 2019). Chairwork is utilised to study the functional basis of the eating disorder voice, stimulate boundary setting, and cultivate more affiliative and compassionate internal dialogues. Because the eating disorder voice is experienced in a dialogical fashion, chairwork is a natural fit (Pugh, 2019). This interaction generally generates one of two outcomes; either the severity of the voice decreases because of the client's healthy self or adaptive rage is used to encourage the individual express themselves in reaction to the inner critic, suggesting promise in working with the voice.

Schema therapists play an active role during chairwork; by immersing themselves in the dialogue and connecting with the parts of their client, they can create a sense of agency to maximise the effects of chairwork (Pugh & Rae, 2019). Sometimes, the therapist will remain silent when the client is engaging in chairwork to ensure that it reaches a therapeutic end; this can further strengthen the therapeutic relationship as it is demonstrating to the client that the therapist is present if things do become distressing. Thus, chairwork is promising and is yielding traction in becoming a positive technique for challenging and working with the eating disorder voice in schema therapy.

3.12 Chapter Three Summary

EMSs, modes, and the eating disorder voice are important research areas in eating disorders. The evidence suggests that they may be important in maintaining an eating disorder due to the meaning attached to them by the client and the purpose they have served, for

instance, a way of coping. Typically, the eating disorder voice is thought to have some positive characteristics, such as being reassuring, providing company, and managing distress in the early stages, yet becoming progressively antagonistic throughout the development of the eating disorder; much like maladaptive schema modes. Akin to the eating disorder voice, modes could be thought of as maintaining the eating disorder.

The voice plays a significant role in the maintenance of the eating disorder; this could be due to the fear of relapse and loneliness. It is often the case that those with an eating disorder will want to get better, yet when in the depths of the eating disorder, the voice is hostile and may tell them such things as *'you are worthless, you need to lose weight'* leading to further distress and ambivalence around recovery. Therefore, when working with the eating disorder voice, clinicians should aim to address the content of the voice and how individuals are responding to the voice; in the same way modes are addressed in mode work. The eating disorder voice could be argued to be a form of mode specific to eating disorders.

Following an extensive literature review of the literature, a gap was identified to explore the phenomenological experience of schema therapy in those with an eating disorder, with focus on modes and the eating disorder voice, and to explore schema therapist experiences of delivering schema therapy to those with an eating disorder. The following chapter explores the chosen methodology.

Chapter Four: Research Approach, Methodology and Research Issues

4.1 Introduction to Research Approach

All knowledge is gained from a particular viewpoint or a form of experience with the world (Merleau-Ponty, 1962). Philosophical worldviews have an impact on the research process, so it is important to identify these from the beginning. They are a set of principles held by the researcher that guide action and research, based on pre-existing factors and past experiences of the researcher, for the researcher's knowledge and experiences influence the choice of research approach (Guba, 1990).

4.1.1 Research Paradigm

A paradigm for conducting research includes the following: Ontology, Epistemology, Methodology, and Axiology (Guba & Lincoln, 1994). Ontology is the study of being and refers to the nature of our beliefs about reality (Hudson & Ozanne, 1988). Researchers have assumptions about reality and what can be known about it. The chosen ontological approach for this thesis was Pragmatic Realism. Pragmatic Realism assumes that there really is an objective lived experience; it is not created by writing or talking about it, it would exist even if it the person who experienced it never discussed it. Epistemology is concerned with the nature and forms of knowledge. It describes how researchers come to know the reality (Kivunja & Kuyini, 2017); in this thesis, this was through a realist epistemology. Realism suggests that unobservables are to be taken at face value as they are describing the truth about an unobservable reality (Papineau, 1985). Unobservables generally refer to aspects of an experience that cannot be directly observed. For example, mental occurrences such as consciousness, emotions, thoughts, and cognition cannot be observed but are inferred through reflection on experience. Thus, a phenomenological methodology is needed to uncover individual meanings and unobservables.

The research design, methods, and processes utilised in a research study to address the research question are referred to as methodology (Keeves, 1997). Quantitative research assumes that there is a reality that exists apart from society and holds that the best way to

accurately model reality is to measure the ways in which different variables can have a cause-and-effect relationship. Alternatively qualitative researchers hold that the best way to accurately model reality is through methods such as interviews and focus groups (Mason, 2017). As described in the literature review, much of the research into schema therapy and eating disorders is quantitative (e.g., Simpson et al., 2010; Simpson et al., 2019; Talbot et al., 2015) with little qualitative research exploring this phenomenon (but see Bowker, 2021; Edwards, 2017a; Edwards 2017b), suggesting that further qualitative research is needed. The methodology used in this thesis was Interpretative Phenomenological Analysis (IPA). Lastly, the final part of a research paradigm is axiology. This refers to the ethical issues considered whilst planning and designing the research (Krauss, 2005); these are explored later in the chapter. Many paradigms have different assumptions and views. It is important to have a clear and cohesive paradigm to conceptualise a research project.

IPA was chosen as the methodology as it interprets and amplifies research participants' lived experiences; it is an experiential psychological approach with theoretical roots in critical realism (Bhaskar, 2013), drawing inspiration from phenomenological philosophy and hermeneutic theory. IPA encourages researchers to engage with its theoretical and epistemological underpinnings whilst recognising that they are not philosophers and that often, their research will be driven by pragmatic concerns. It is therefore in keeping with my own ontological and epistemological position, which I would describe as Pragmatic Realism.

IPA, phenomenology, and the research aims, and issues will now be explored in-depth. I will intermittently write in first person, discussing my own experiences and reflexivity.

4.2 Methodology and Research Issues

4.2.1 Introduction

Hepworth (1994, p.179) emphasised the importance of qualitative research in eating disorders, describing the lack of such research at the time as *“a weakness in developing theory and clinical practice”.* A growing number of qualitative studies of eating disorders have been

conducted since then (Bouguettaya et al., 2019; Fox & Diab, 2015; Nordbo et al., 2006; Pemberton & Fox, 2013). However, compared to the number of quantitative studies, these are scarce and have limitations. For example, since such research often utilises structured reporting methods, participants can only comment upon what they are asked, which may produce a *'disjointed picture.'* Considering this, and in order to best address the research needs of this study, it was decided to use a primary qualitative approach with supplementary quantitative measures with client groups to provide additional qualitative prompts (*e.g., you scored highly on x EMS, do you recognise this in yourself?*). Such approaches have the advantage of allowing for in-depth and extensive investigation of phenomena that are difficult to quantify such as understanding the experiences of schema therapy.

Qualitative research has two main approaches. The phenomenological approach explores individual experiences, and the social constructionist approach explores how understandings are socially constructed via language. Phenomenological approaches are concerned with examining the individual, whereas social constructionist approaches aim to generalise their findings to the society, or social group, being examined. Strictly speaking, social constructionism should only be used when there is a definable social group to study with a shared language and vocabulary. People whose only commonality is having the same health condition may or may not constitute such a social group, yet grounded theory is widely used in qualitative health research. On the one hand, perhaps the experiences of interacting with health care services create suffice to produce a shared language and vocabulary. On the other hand, this risks pre-categorising people by their status as patients.

4.2.2 Choosing IPA

Before choosing IPA, I also considered Grounded Theory, Thematic Analysis and Narrative Analysis. Grounded Theory was developed to give researchers a clear, systematic, sequential guide to qualitative research and employs devices such as constant comparison, data saturation, and theoretical sampling to generalise findings of the emerging theory to a

wider population (Glaser & Strauss, 2017). But it is more of a sociological approach, drawing on convergences within a larger sample, ideally a social group of some kind, to support conceptual explanations at a wider level (Willig, 2003). IPA is more psychological and idiographic, which is a better fit for researching eating disorders, which are not a group activity.

Thematic Analysis was also considered and is *“a method for identifying, analysing, and reporting patterns (themes) within data”* (Braun & Clarke, 2006, p. 79). However, Thematic Analysis is under-theorised compared to IPA and there is a risk of the themes extracted being relatively simplistic or superficial. The aim of Thematic Analysis is to identify patterns across cases, whereas IPA is more idiographic and more in keeping with the aims of the research.

Narrative Analysis was developed from social constructionism and is fundamentally about analysing qualitative data as stories that have objective content and discernible commonalities across people. As with literary criticism, the stories are potentially open to multiple interpretations. In contrast, as will be discussed shortly, IPA attempts to establish the idiographic meanings underlying people’s stories and to analyse the commonalities of meaning, rather than the commonalities of the narratives.

Therefore, IPA was the chosen methodology. In this dissertation, IPA is committed to the examination of how clients made sense of their experience in schema therapy and their understanding of schema modes and the eating disorder voice, and how schema therapists made sense of their experience delivering schema therapy to people with eating disorders. IPA has previously been used in studies with individuals with an eating disorder (Fox et al., 2011; Mulveen & Hepworth, 2006; Taborelli et al., 2016), but until recently, has seldom been used in understanding experiences of schema therapy (Bowker, 2021; Edwards, 2017a; 2017b). Further methodological rationale for the use of IPA can be seen in section 4.4 of this chapter, but first, phenomenological psychology is explored.

4.3 Phenomenological Psychology

4.3.1 Introduction

Edmund Husserl's distinction between the Körper and the Leib is used by Merleau-Ponty (1962) to explore the lived body. The Körper refers to the body as an object, a physical entity that occupies space in the universe, whereas the Leib refers to the lived body as a collection of abilities that allow experience. The fundamental structure of an experience is its intentionality; it is being aimed towards something as it is an experience about an object. An experience is directed toward an object by virtue of its content or meaning together with appropriate enabling circumstances. Phenomenology is the study of structures of consciousness and experiences from the first-person perspective (Smith, 2007).

4.3.2 Phenomenology

Phenomenological philosophy is important as it offers beliefs about how to examine and understand lived experience, which is unique to the individual's personified relationship to the world (Larkin et al., 2006). What individuals perceive and what they carry throughout their lives at some fundamental level of their being is the relationship between embodied selves and the world. Thus, perception is neither a subjective nor objective phenomenon. It is prior to the reflexively constructed ideas of an objective and subjective world, suggesting that perception is not fixed, but is multidimensional.

Fundamental to phenomenology are the lived experiences of the person and the meanings placed on these experiences. In order to achieve this, Husserl stated that the researcher must use phenomenological reduction, known as bracketing, or epoché. This approach seeks to bracket off one's preconceived ideas regarding the phenomena and thus, opens oneself up to discovering the phenomenon in the way in which the participant experienced it. Husserl argues that bracketing is essential as it allows researchers to detach as observers and encounter *"things as they are in themselves"* independent of any pre-conceived ideas (Husserl, 1913, 2012, p.163). However, it is debatable how much someone can truly

bracket off. Husserl believes experiences are transcendental and relates to the belief that a person can step outside their experience and view the world from above, in a transcendental state, thus stating that epoché is possible and one can completely *'bracket-off.'* Husserl suggested that researchers can arrive at a *'transcendental ego'* and can bracket off and become *'absolute mind.'* Then, the researcher can engage in phenomenological reduction and concentrate on the essence that is being studied.

Whereas Merleau-Ponty believes experiences to be existential and that humans exist through *'being-in-the-world'* and can only perceive things through this subjective being and thus, believes it is not possible to completely achieve epoché. Existential psychologists suggest we exist in a world with others; as a result, all experiences transpire in relation to others. Heidegger (1962) argued that as researchers, our *'being-in-the-world'* that we are attempting to research means that complete separation from it is impossible. He proposed the idea of the 'lived world' in which we have some investment that will always influence our description of it. He argued it is difficult to separate ourselves as researchers from our object of study as we are already embedded within this and therefore, make interpretations of what we experience.

Hermeneutics, the art of interpretation, is employed in phenomenological psychology (Smith, 2007). Within phenomenological research, a double hermeneutic is used, in which the researcher is making sense of the participant making sense of their experience (Smith & Osborn, 2003). However, it is imperative to remember the idiographic nature of experience; each person's experience of phenomena will be different, therefore, it can be argued that there is no correct interpretation. According to Finlay (2003), phenomenological research is a co-creation between the researcher and participants and the meanings they bring to the data. This involves recognising the important role of the researcher and their fore-understandings in the interpretation of the research, whilst concurrently acknowledging the need to remain open to the insights of the participants' experience (Smith, 2007).

4.3.3 Phenomenology in Eating Disorders

Human beings are embodied agents; they are expressive and meaning-making, embedded in a world that is loaded with significance. The term embodiment is intended to capture the idea that humans are intrinsically connected to the world in multifaceted and irreducible ways (Moran, 2013) and suggests that the mind and body are one. It is an abstract concept, referring to the role of one's own body in their situated life. This subsection introduces phenomenology within the context of eating disorders.

To have sight is the physical fact of being able to see, whereas having vision is to have a sense of the perceptual field in which we see ourselves (Merleau-Ponty, 1962). The ability to view ourselves as others see us is anticipated by the fact that we are aware of others as we can see them (Burkitt & Sanz, 2001). Perception, on the other hand, is bound up in our belonging to both a perceptual field and a social environment. However, from this perspective, the conceptualisation of AN is questioned, as AN is the result of invalid logic or perception (Burkitt & Sanz, 2001). Those with AN can often experience a conflict of embodiment.

A common distinction in phenomenology is between the body as experienced from within (the subject body - Leib) and the body as experienced from without (the object body - Körper). This can lead to a conflict of embodiment between the Leib and Körper. The anorexic conflict of embodiment arises in early life, where the body becomes an object of another's gaze, leading to the belief that their body is simply an object and does not belong to them (Fuchs, 2022). It is not only others who gaze at their body, but also, they themselves too. Indeed, people with eating disorders often critique their body in what may be strange detail to someone without an eating disorder (e.g., *nobody will love me in this body,* or *I did not do well in an exam, therefore, I need to punish my body*). Although the gaze of others starts the process, the person with AN takes the lead on objectifying their body.

Objectification therefore results in conflict of embodiment, whereby the person with AN initially attempts to comply with the concept of ideal body image for their Körper, whilst

simultaneously seeking independence from the Leib, fighting against their dependency on their body and its overpowering nature, particularly hunger cues. It could be argued that someone with AN is a dualist thinker and views their body as something that belongs to them, rather than 'being them,' leading to disembodiment. This disembodiment results in a dualism of mind and body whereby the anorexic begins to pursue the ideal of an asexual and disappearing body, aiming to exert control over one's body as an object. They, therefore, seek to be in complete control of their body, *"the body I am, becomes the object I have"* (Fuchs, 2022, p.110). Thus, the person with AN views their body as an object, something they can control or discipline in any way they choose. From this perspective, AN is a fundamental disturbance of embodied self-experience (Fuchs, 2022) whereby AN results in alienation of self from body.

A phenomenological approach has rarely been used to explore schema therapy in those with an eating disorder. Edwards (2017a; 2017b), and Bowker (2021) are the first such studies, with both using one and six case studies respectively, to explore schema modes. Edwards (2017a; 2017b) used IPA on clinical transcripts to examine schema modes, the relationship between them and developed group experiential themes reflecting the nature of, and the relationship between the modes in an individual. Whereas Bowker (2021), adopted a case conceptualisation of six cases looking at how participants experienced schema modes and how they subsequently influenced behaviour. Therefore, suggesting that although in its infancy, IPA is looking to be a promising methodology when exploring this phenomenon. Indeed, Edwards (2017b) proposes that the primary investigatory tool for modes should be phenomenological, as it allows researchers and clinicians to investigate the dynamic aspects of modes that are important to clients, suggesting that this approach can also be applied to explore other experiences of schema therapy too.

To truly understand experiences of schema therapy from client and therapist perspectives, a phenomenological approach is required, thus, this thesis utilised IPA across three studies. The rationale and methodology are explored in turn. Each study chapter includes

a methods section specific to that study, the following sections will cover general methodological and research issues focusing on IPA.

4.4 Methodological Rationale

4.4.1 Interpretative Phenomenological Analysis

IPA is concerned with trying to understand the individuals' personal perception of an experience instead of attempting to produce an objective record of the experience (Merleau-Ponty, 2013). IPA examines the lived experiences of individuals and explores the meanings, understanding, and significance of these experiences within their lives (Smith & Osborne, 2003; Smith et al., 2009; Smith et al., 2022). In the examination of how a phenomenon appears, the researcher offers an interpretative account of what it means for the participants to experience these (Larkin et al., 2006).

IPA connects with hermeneutics in that phenomenological examination is an interpretive process. The capability to reflect on experience from multiple layers of awareness of an experience is a cognitive process involving memory, attention, and meaning making (Smith et al., 2009). IPA offers psychology an important methodology, integrating multiple layers of experience through an inductive process centring on *"the value of complimentary micro analyses…which may enrich the development of more macro accounts"* (Smith et al., 2009, p. 202). Thus, IPA offers a combination of the various aspects of phenomenological experience grounded in the individual experiences of participants, whilst simultaneously acknowledging how these relate to the broader theoretical positions in the development of psychological knowledge.

IPA originated in the field of health psychology and has been applied extensively in the field (e.g., Newson et al., 2023; Smith, 1996), but its value has since been demonstrated in clinical psychology (Beattie et al., 2019). This methodology has also been used to address questions in eating disorder research, such as Mulveen and Hepworth's (2006) study of participation in a pro-anorexia website, Fox et al's. (2011) study of participants' personal meanings of eating disorder symptoms and to explore the perceptions and experiences of living

with chronic AN (cAN) while an inpatient on an Eating Disorders Unit; IPA has also been used in case studies of schema modes by Edwards (2017a; 2017b) and Bowker (2021).

In defining this epistemological position, Heidegger (1927) explored the emergence of a person's conscious experience through his ontological conceptualisation of human existence as *'Dasein',* which translates as *'being-in-the-world',* in which existence is brought to awareness through meaningful and intersubjective relations. Within psychology, the most widely known example of this type of theory is the work of J.J. Gibson and those he influenced (e.g., Gibson, 1966). This *'being-in-the-world'* constitutes to human level (Varela et al., 2017) which is formed by interacting with the world whereby people learn from doing. For example, regarding eating disorders, Fox and Diab (2015) explored client experiences of cAN. Several clients highlighted how the self becomes entwined with cAN, therefore, making it very difficult to perceive a life without cAN. Thus, their being in world is formed by their experiences with cAN as a part of them.

Furthermore, IPA aligns with Heidegger's (1927; 1963) notion of phenomenon emerging into meaningful awareness through interpretation, highlighting how the investigation into events and understanding that emerges is situated within an assumptive world because researchers' worlds are shaped by their own knowledge and experience. Thus, interpretation of discourse and text can be biased by the researcher's own assumptions and perspectives on the world. Heidegger suggested that the way to manage this was to be aware of biases and to examine them to understand their influence on our interpretations.

> "The important thing is to be aware of one's own bias, so that the text can present itself in all its otherness and thus assert its own truth against one's own fore-meanings." (Gadamer, 1975, pp. 271-272).

It is therefore important to focus on reflexivity throughout the duration of IPA research as this allows us as researchers to acknowledge the ways in which our fore-structures may bias interpretations and assumptions. I maintained a reflexive diary throughout the process to

maintain a reflexive self-awareness between my interpretations and assumptions (Appendix H for summary).

As IPA is interpretative, Larkin and Thompson (2012) contend that validation strategies such as member-checking may be inappropriate. The combined effects of participant narratives, the researcher's interpretation, the passage of time since the interview, and the time constraints on participants can make member-checking counter-productive. Member checking further relies on the assumption that there is a fixed reality that can be accounted for by the researcher and confirmed by participants. IPA utilises a double hermeneutic, whereby the researcher interprets the participant's interpretation of their experience. With these factors in mind, member-checking was not carried out in this thesis. Internal validity and reliability were enhanced through reflection. I maintained a diary of my own experiences during the research process to be aware of my own frames and potential influences. Interrater reliability was achieved by cross-referencing themes with my supervisory team. The following section will explore the elements of quality in qualitative research as set out by Yardley (2000) and how this thesis sought to satisfy those elements.

4.5 Trustworthiness, Quality, and Reflexivity

The quality of qualitative research needs to be assessed in ways that understand the research aims; it needs to be assessed on its ability to interpret and present the experiences of participants coherently and accurately. My approach to the design and analysis of this thesis followed criteria proposed by Yardley (2000). Yardley emphasised the sensitivity to the context of phenomenon observed, the commitment and rigour of engagement with the research process, transparency of the data analysis, and coherence of the design and findings of the study, and the subsequent impact and importance in presenting the findings. These are explored in turn.

4.5.1 Sensitivity to Context

The emphasis given by Yardley (2000) to sensitivity to socio-cultural contexts suggested a refinement to this area of trustworthiness which extended beyond engagement with context (Lincoln & Guba, 1985). Sensitivity to context is established through demonstrating sensitivity to the existing literature, theory, the socio-cultural setting of the study (Yardley, 1999) and the data obtained (Smith et al., 2009).

The theoretical review of schema therapy in this thesis highlights the importance of contextual factors in the experience of schema therapy, including the socio-cultural context of experiences and the importance of the therapeutic relationship for facilitating the therapy from both client and therapist. Yardley's emphasis on context therefore suggested a good fit to the aims of this thesis where consideration of the intersubjective context of the therapeutic relationship was to be explored in relation to experiences of schema therapy. Sensitivity to data has been established through conducting and describing an in-depth analysis with supporting arguments supported by verbatim extracts; thus, giving participants a voice and allowing the reader to assess the interpretations being made (Smith et al., 2009).

4.5.2 Commitment and Rigour

Commitment and Rigour are important in conducting qualitative research; this element requires in-depth engagement with the topic at hand. This involved a prolonged engagement with the topic, from the continuous review of the literature to the data collection for each of the three studies, my own experiences with AN, to the depth of the analysis. As demonstrated in the subsequent chapters, I believe this thesis has achieved commitment and rigour to the topic area. Completeness of the data was achieved with in-depth interviews of a total of 22 participants across the three studies, creating 27 interviews, and through the subsequent analysis. IPA has many levels of interpretation ranging from the linguistic to the conceptual; this is established in the subsequent chapters and demonstrates how rigour and commitment were achieved through analysis. Thus, Yardley's wider trustworthiness criteria matched well to the

IPA methodology where the commitment and rigorous depth of analysis would allow participants' meanings associated with their lived experience with schema therapy to be fully explored and articulated.

4.5.3 Transparency and Coherence

This subsection is concerned with the clarity of the argument, the use of transparent methods, data collection - including presentation of data - the fit between theory and method, and reflexivity (Yardley, 2000). This thesis utilised IPA across three studies. Each step of data collection was adhered to (Smith et al., 2009); please see subsequent chapters for detailed description of each study's data collection and analysis.

Within IPA, it is important to consider the co-construction of knowledge and understanding as the researcher brings their own experiences, values, and assumptions to the phenomenological experience of a participant. Langdridge (2007) suggests that the researcher's assumptions can influence the qualitative research process from the initial decisions to the data collection and analysis. Given this possible influence the researcher has on biasing the research at several points during the inception and completion of the research, it is important that strategies to promote trustworthiness and research quality are provided throughout the research endeavour.

To ensure the quality and trustworthiness of the research and findings, I utilised reflexive and bracketing processes throughout the planning, implementation, and interpretive analysis stages of the study through a reflexive diary (Appendix H). Willig (2013) highlighted the importance of awareness of fore structuring of knowledge, experience, and professional and personal positioning in relation to the research. The ways in which this provided me with the opportunity to reduce the influence of my existing assumptions at the theoretical, clinical, or personal level is elaborated upon below.

4.5.4 Reflexivity

Reflexivity is important in assessing qualitative research (Secrest & Thomas, 1999; Willig, 2013) and can be thought of as addressing issues of sensitivity and rigour. Reflexivity involves the researcher acknowledging the way in which their own biases, the subjectivities of the participants and how the relationship between the participant and researcher shape the research (Finlay, 2008). I will be bringing together my experiences with people who discussed, in detailed ways, their experiences with schema therapy, their understanding of schema modes, the eating disorder voice, and the implications for their eating disorder, and schema therapists' experience. This section explores my experience on a personal, epistemological, and practical level. I will be discussing how I believe I have informed the research, and how the research has informed me. I will further consider the practical experiences of conducting this research online and the implications this may have had for my research.

4.5.4.1 Personal Reflexivity.

Personal reflexivity involves acknowledging the ways in which the I influenced the research and ways in which the research influenced me; whilst simultaneously not deflecting from the participant's experience (Willig, 2001; Willig, 2013). In order to understand the ways in how I may have impacted the research, I will introduce myself as the researcher. I am a 29-year-old female living in the UK. I have lived experience with AN and was treated with CBT at ages 16 and 19; however, have not had personal experience with schema therapy for AN. I am now ten years into recovery.

Throughout this research process, I maintained a reflexive diary noting anything I felt may have influenced my interpretation of the participant's accounts during the analysis process and vice versa (Appendix H). I was careful to not disclose my past with AN to participants. From my own experience, I am aware of how competitive eating disorders can be, and with initially being unaware of how far my participants were in their recovery journey, I did not wish to hinder their recovery in way, thus chose not to disclose this. I also did not want to take away the focus

from the participants by talking about my history as it was their experiences in which I was interested.

In terms of epistemology, as my PhD studies progressed, I became increasingly influenced by the Pragmatic-Realist approach. I perceive eating disorders as existing on a continuum. I believe that they are phenomena that anyone, regardless of age, gender, may experience, often as an interaction between biological, psychological, and social factors. Regarding theoretical orientation, I would describe myself as integrative and acknowledge the influence of a wide range of models and theories on my thinking, including cognitive, transdiagnostic, and psychodynamic.

For many years of my life, I have been aware of the prevailing pressures from society on people to look a particular way and follow body trends portrayed by the media. My interest in psychology and eating disorders developed in my teenage years and solidified from my own personal experiences with AN after being diagnosed at the age of 15. My interest developed further when I began my recovery journey around ten years ago (aged 19), and in part, influenced my decision to develop the studies involved in this thesis.

Furthermore, during my PhD, I became increasingly aware of my own EMSs and schema modes. I completed the YSQ-2 SF (Young, 1998) and SMI-ED (Simpson et al., 2018) at approximately six-month intervals. Being aware of my own EMSs provided me with insight into experiencing these EMSs. Unrelenting Standards was consistently high for me. I view this as a positive for it provided me with the drive and determination to complete my PhD. I also consistently scored highly on Overcontroller, Detached Self-Soother, and Healthy Adult modes. I identified with this and did not perceive these scores to be maladaptive, for functional people still have some elevated schema and mode scores. For example, schema therapists are trained to identify and work with their own schemas and modes. I think awareness of my scores helped me to understand how participants who experienced these EMSs and modes were feeling.

Prior to conducting the research for this thesis, I had no particular stance on schema therapy, which was new to me. However, I had quite an in-depth knowledge of eating disorders, particularly AN, through my own experiences and the treatments available. Thus, I did not have pre-conceptions regarding schema therapy as a treatment for eating disorders.

My understandings of schema therapy in the early stages of my PhD were limited. I was aware that schema therapy combined various approaches, including, psychodynamic, cognitive-behavioural and gestalt, for example, to make its own, unique therapy. I also understood that it used an array of techniques such as chair-work and imagery rescripting to help people delve into their past. My understandings grew substantially through reading the literature, attending workshops, conferences, and networking. Although I had engaged in necessary reading before carrying out data collection, it was not until I analysed the data that I could really try to understand participants' experiences with schema therapy and the implications on their eating disorder. Prior to this thesis, and to my knowledge, there was minimal research on experiences of schema therapy in eating disorders, from both client and therapist perspective, thus emphasising the importance of this research.

4.5.4.2 Epistemological Reflexivity.

Epistemological reflexivity involves reflecting on the ways in which the methodology influences the findings (Willig, 2001). I entered my PhD as a novice researcher; I had completed my Master's degree in 2017 and thoroughly enjoyed my research project *'Muscle Dysmorphia, The Quest for Body Satisfaction'*; it was this that peaked my interested in pursuing a PhD and further my passion for conducting research in eating disorders. I have been working full-time throughout my part-time PhD, initially as a phone crisis counsellor, then in my fourth year, secured a role as a Research Fellow and believe I have developed my skills as a researcher including interview techniques and understandings of different methodologies. As mentioned in section 4.2.2, IPA was chosen over other methodologies for a variety of reasons and because it allowed me to capture the idiographic, in-depth experiences of participants.

4.5.4.3 Practical Reflexivity.

Practical reflexivity is a form of existential questioning; it can take place in the present, or retrospectively. It allows us *"to understand ourselves, our ways of relating to others, and how to participate in our social world"* (Cunliffe & Easterby-Smith, 2004, pp. 35-36). Due to the COVID-19 pandemic, data collection for this thesis took place entirely online via Zoom. This in many ways has been advantageous as it allowed me to recruit and speak to participants on a global scale. Participants were reminded they did not need their camera on if they did not wish to and I believe this enabled the participants to feel at ease, particularly when talking about a sensitive topic.

Regarding limitations, with the research being online, the primary limitation was not being able to build a rapport as well as I could have done in person. Sometimes, it is easier to demonstrate empathy in person, less so online, particularly if there are internet difficulties and a time lag. However, this did not seem to impact me too much and I was able to build a rapport with my participants online. At times there were internet connection difficulties, but this was easily managed.

4.5.8 Impact and Importance

Finally, Yardley (2000) emphasises impact and importance in qualitative research. Qualitative research should be useful to the intended audience, enrich theoretical understandings of the topic and have sociocultural and practical impact. This thesis drew on empirical data to present a novel perspective to experiences of schema therapy from both client and therapist perspective, opening new ways of understanding the topic.

Throughout the journey of the PhD, elements of this thesis were submitted to conferences for poster and oral presentations. Chapter Eight includes dissemination of research (Table 17) and a quote from a conference attendee who found the research in Study One (Chapter Five) to be helpful, providing them with hope as they started their own journey with schema therapy for their eating disorder, thus, indicative of impact.

4.5.9 Summary of Methodology

Nizza et al. (2021) published a paper discussing the indicators of good IPA research. These include constructing a compelling unfolding narrative, developing a rigorous experiential and/or existential account, close analytic reading of participants' words, and attending to convergence and divergence. This is explored further in the discussion chapter (Chapter Eight) of how I believe that this thesis has achieved these markers.

Given the awareness of my positioning to the research, my lived experience with AN, the use of reflexive analysis within a research journal was an important part of regularly reflecting on my own assumptions and represents my reflexive ability to hold and bracket my fore-structuring whilst construing the sense-making attempts of the participants.

Heidegger (1927) suggests that interpretation and meaning develop through the relationship between the phenomenon and the individual in an interpretive hermeneutic circle and not through objectively isolating the observer from the phenomenon. From this viewpoint, it is during the interpretation process where the researcher engages with phenomenon by *"bracketing preunderstandings and exploiting them as a source of insight"* (Finlay, 2008, p. 1), this fore-structuring, therefore, adds to the depth of interpretive validity. Within this research, the use of reflective journaling provided this interplay between bracketing the fore-structure and the identification of developing meanings in the participants' narrative during the hermeneutic circle of interpretation. This process added to the commitment and rigour of the interpretative process by acknowledging and holding contact awareness of the influence of my own presuppositions whilst simultaneously allowing meanings from the participant's accounts of their lived experience to develop.

It is also important to consider how participants' felt following the research process and the effect it has had on them. The following sections address ethical considerations.

4.6 Ethical Considerations

Ethical approval was granted through the University of Hull Ethics Committee for each study in this thesis (FHS167; Appendix B).

4.6.1 Informed Consent

Informed consent from participants was ensured through providing a Participant Information Sheet, setting out the information about the study, including the purpose of the research, what participation would involve, who would have access to the data, and how it would be stored following completion. Potential participants could take as long as they needed to consider this information before deciding to make contact.

Before meeting with the participants, I ensured they had read and understood the contents of the information sheet they were provided. If they wished to continue, they were asked to complete the consent form and provide written consent before being interviewed. Participants kept a copy, and then sent one back to me.

To ensure participants did not feel obliged to take part, it was emphasised that they were under no obligation to do so. Participants were also informed that they could withdraw their data from the study (up to two months following interviews), without needing to provide a reason for doing so. Individuals unable to give informed consent were excluded from the study. Inclusion/exclusion criteria is listed in each individual study.

4.6.2 Confidentiality

Participants were informed about confidentiality and its limits, that is, that I would share information with appropriate services if I thought that they or somebody else was at risk of harm. They were fully aware that although direct quotes would be used in the write-up for thesis and conferences/journal articles, all identifying information – such as names and places – would be removed from the transcripts and write-up. They were aware that my supervisors would look at the anonymised transcripts. All participants consented to their anonymised verbatim being used in this thesis and other outputs.

4.6.3 Potential Distress

Informed by my experiences of working with people in distress and in crisis, I endeavoured to conduct the interviews as sensitively as possible. Participants in each study were provided with a debrief following completion detailing support should they require it following the interview. Participants in the client studies also had the option for myself to email them a week after to check in and reiterate available support.

There was a risk that taking part may be distressing to participants. This was addressed by providing information beforehand about what taking part would entail and the topics to be covered. This was so potential participants could make informed decisions about taking part. Participants were made aware that they could ask for a break at any time and had the right not to answer any questions if they so chose. They were also informed that it was their right to withdraw from the study at any time, without having to provide a reason.

There was also a risk of distress to myself as I am in recovery from AN. To address this, I maintained a reflexive diary and after every interview, I noted my thoughts and reflected on how I believe I impacted the research and how I believe the research impacted me. I had the support from my supervisory team who were available if I needed to discuss anything. For the years I have been in recovery, I have developed coping mechanisms that I can turn to when needed. I believe my recovery in part has driven my enthusiasm for this research.

The following chapters explore the three studies conducted as part of this thesis.

Chapter Five: Clients' Experiences of Schema Therapy

5.1 Chapter Introduction

This chapter first discusses the recruitment of the steering group for the study, whose purpose was to help refine the qualitative questions and complimentary quantitative measures for the following client study. After which, the methodology, results, and discussion of Study One are detailed. Throughout the chapter, I write in the first-person to explore my reflections.

5.2 Steering Group, Methods, and Results

The steering group took place over two groups online on Zoom with a total of (N=7) participants who were recruited through an eating disorder charity. Professor Marie Reid and I facilitated the online steering groups. Participants were given draft quantitative and qualitative questions to review with the aim of helping to refine these for the following client study. See Appendix A for draft qualitative questions and D for quantitative.

5.2.1 Participants

5.2.1.1 Recruitment and Sampling.

Participants had lived experience of an eating disorder; their mean age was 33.28 years (SD=16.64). Information was emailed to the manager of an eating disorder charity to share with potential participants explaining the premise of the study; those who expressed interest were given the information sheet and consent form prior to participation. Participants were recruited on a voluntary basis. Consent was obtained to record the session; participants were informed that they did not have to use the video but were requested to use their audio for discussions.

5.2.1.2 Inclusion and Exclusion Criteria.

To be eligible for the steering group participants were required to:

a) Be aged 18-65,

b) Have lived experience with an eating disorder,

c) BMI > 15

Table 7

Steering Group Demographics

Participant*	**Eating Disorder**	**Age**	**Treatment received**	**Gender**
Henrietta	AN	22	CBT	F
Abby	BN	23	CBT	F
Claire	AN	22	CBT	F
Jerome	AN	25	Nil	M
Gina	BN	25	Awaiting CBT	F
Harper	Atypical AN	55	CBT/Psychoanalytic	F
Celeste	BED	60	CBT	F

*Pseudonyms were generated via a name generator online to conceal participants' identity.

5.2.2 Procedure

Participants were asked to complete and comment on the questionnaires and qualitative questions that were to be asked of participants as part of the research. The following subsection explains these measures.

5.2.2.1 Eating Disorder Inventory 3 (EDI-3; Garner, 2004).

The EDI is a diagnostic tool designed to assess the presence of an eating disorder in an individual. The latest revision is the EDI-3. It is a self-report questionnaire comprised of 91 items, including statements such as: *'I think my stomach is too big', 'I feel ineffective as a person'*. These are rated on a scale of: always, usually, often, sometimes, rarely, and never. The higher the score, the more disordered eating. It is split into four sub-scales: eating disorder risk scale, eating disorder risk component, psychological scale, and psychological composite.

This questionnaire was used to understand participants' disordered eating behaviours, to assess severity of eating disorder and provide additional demographic details (e.g., BMI).

5.2.2.2 Young Schema Questionnaire 2 Short Form (YSQ2-SF; Young, 1998).

The YSQ-2 SF is a 75 item self-report questionnaire consisting of self-statements related to a range of schemas, including: *'I must be the best at what I do', 'I don't fit in'*. The mean is calculated, providing a score for each schema. In a research setting, a mean score of greater than 3 is considered clinically relevant (Waller et al., 2001). This was chosen over later versions as it is the most widely known and used in research and in accordance with Young's original classification, 16 EMSs are identified (Rijkeboer, 2012; Young & Brown, 1994).

5.2.2.3 Schema Mode Inventory for Eating Disorders (SMI-ED; Simpson, 2018).

The SMI-ED consists of 190 items that were found to best represent and distinguish 16 schema modes within eating disorders (e.g., Vulnerable Child, Punitive Critic, Eating Disorder Overcontroller). It is a self-report questionnaire containing statements such as: *''if I lose control of my eating, I feel unsafe.'* Participants were asked to rate these on a scale of 0 (never, almost never) to 5 (always). The mean score for each mode was calculated. In previous studies (Brown et al., 2016; Talbot et al., 2015), using the SMI by Young et al. (2007), any schema mode with a mean score of 3 is clinically significant and those of 4 or above are considered high in a clinical setting. This scoring was applied to the SMI-ED.

5.2.2.4 Qualitative Questions.

Participants also helped to refine the proposed qualitative questions for the research study to ensure it was fit for purpose in such a way that was comprehensible for individuals with lived experiences of an eating disorder. Participants were not required to have had experience of schema therapy themselves and were provided with an explanation of schema modes and the eating disorder voice to understand the nature of the qualitative questions. Simpson et al. (2018) included those with lived experience with an eating disorder, with no prior knowledge of schemas, in their development of the SMI-ED and thus, it was felt appropriate to do so in this

study to aid psychological safety of participants. A further justification was to demonstrate the receptiveness to schema modes – e.g., do participants with no prior knowledge understand the concept of modes, do they relate to them?

5.2.3 Feedback

5.2.3.1 Quantitative Measures.

The quantitative measures can be found in Appendix D (SMI page 373; YSQ page 375, and EDI page 377). For both the SMI-ED (Simpson et al., 2018) and YSQ-SF (Young, 1998), participants said they provided them with time to reflect on their eating disorder journey. No concerns were raised with these questionnaires. Whereas with the EDI-3 (Garner, 2004), some participants did not find the questions about weight to be helpful, *"I struggled with that section as I don't regularly weigh, if I start weighing myself it triggers me, it even triggers me knowing other people's weight, so, I couldn't fill in that section" (Abby, 33 – 35).* There were no concerns with the remainder of the EDI-3. The questionnaires provided information for use in the subsequent interview process, informing and structuring the questions. An example is *"you scored highly on Unrelenting Standards; do you recognise this in yourself?"* Whether or not the participant agreed, this allowed further discussion of how they saw themselves in schema terms.

5.2.3.2 Qualitative Questions.

The steering group was generally happy with the draft qualitative questions and only minor changes were made with the following exceptions. The question *'when you were diagnosed, how did you feel?'* generated discussion around the word diagnosis, with many stating it was too clinical. There were also queries about what diagnosis meant. For example, who were you diagnosed by, was it a professional or self-diagnosis? It was recommended to change the wording to *'when did you first notice a problem with food?'*

Proposed questions about the eating disorder voice also created discussion. Participants understood this concept but felt referring to it as a voice was too stigmatising, *"I refer to it as the force instead of a voice. The voice kind of comes from me myself kind of trying to stop myself*

rather than in my head…I would not be comfortable calling it a voice" (Gina 586 – 590). It was decided to reword the question and instead, participants were asked if they had a specific name for it and if they did, it was referred to as such throughout their interview.

The final questions asked about recovery. Participants felt the concept of recovery was ambiguous due to its subjective nature. Instead of asking *'how do you see your recovery now?'* it was advised to funnel this question to include topics of quality of life and the impact of the COVID-19 pandemic. Participants said that the pandemic had disrupted their routines, *"lockdown made recovery worse (…) I'd go to the same places on a set day a lot got closed cos of lockdown" (Jerome, 256 – 258),* thus, highlighting the importance of asking about it.

The comments were taken into consideration and appropriate changes were made to the interview schedule as discussed above (Appendix A contains the qualitative questions that the group were asked to review and Appendix E consists of the final interview schedule used), thus demonstrating the impact of the steering group in the development of the design of the first study of this thesis. Participants were emailed a debrief, following completion and sent a copy of Breaking Negative Thinking Patterns (Jacob et al., 2014) for their participation. Following the steering group, Study One was developed. The method, results, and discussion are presented below.

5.2.4 Reflexivity

Following the steering group, Professor Reid (principal supervisor) and I met to discuss the possible changes to be made to the questions. Feedback was received for both the quantitative and qualitative questions and appropriate changes (as detailed above) were made to the qualitative questions. The questionnaires were retained as they were, but it was agreed to inform participants that they did not have to answer any questions they did not feel comfortable doing so in the questionnaires. From a phenomenological perspective, it was important to have involvement from people with lived experience to ensure that the questionnaires and qualitative questions were suitable for purpose and not triggering. I was mindful of time management

during the steering group, this was discussed in supervision as it did over-run, something to bear in mind when conducting interviews to ensure they are not too short or too long.

5.3 Study One Introduction and Method

This study sought to explore experiences of schema therapy in those with an eating disorder using a phenomenological approach. The primary ethos of IPA is to allow full detailed consideration of each participants' individual experiences. There are no rules pertaining to sample size. Pietkiewicz and Smith (2014) suggest number of participants depends upon depth of analysis of individual cases, richness of individual cases, how the researcher wants to compare cases, as well as practical constraints the researcher may experience.

This study sought to address:

- Are schema modes and the eating disorder voice experienced as being separate from the self?
- Is the eating disorder voice another way of describing schema mode(s) in action?
- How do people with eating disorders identify schema modes and the eating disorder voice?
- To what extent are the voice and modes experienced as discrete personalities?
- What positive and negative functions do they experience?

5.3.1 Participants

5.3.1.1 Recruitment and Sampling.

Participants were recruited via clinicians who provided schema therapy for eating disorders and were active in specialist social media groups for schema therapists. Clinicians referred participants using the eligibility criteria, which were also checked at the start of the online interview. A volunteer sample was used. Participants were invited to respond to an email with an attached poster explaining the research that was sent out to them via their therapist

(Appendix C). Interested participants contacted the researcher and subsequent information was sent.

5.3.1.2 Inclusion and exclusion criteria.

Participants must:

a) Have a self-disclosed diagnosis of an eating disorder,

b) Be aged between 18 and 65

c) Have a BMI of >15 during the study,

d) Be being treated with schema therapy.

5.3.2 Interview Schedule Development

Open-ended questions in a semi-structured approach help participants to explore their own lived experiences of the phenomenon under investigation (Smith et al., 2022). Interviews move between sequences that are narrative and descriptive; starting with a question to allow the telling of a descriptive experience to promote comfort in the participant. A copy of the interview schedule can be found in Appendix E.

Open-ended questions provided participants with a phenomenological map to allow them to begin exploring their own lived experiences with their eating disorder and schema therapy. The funnelling of questions across the interview schedule allowed participants to provide narrative across their whole schema therapy experience, whilst being careful not to lead the participants during the interview.

Following Smith et al's. (2009) approach to interview construction, participants were provided a series of open questions that provided flexible context for them to explore their own experiences of schema therapy. A series of prompting questions were also created for each main interview question to aid exploration of the experiences. Following completion of the interviews, participants were sent the debrief and if they were happy to share their address, a copy of *'Breaking Negative Thinking Patterns'* (Jacob et al., 2014) was sent to them. One participant was randomly selected in a raffle to receive a £100 Amazon Gift Voucher.

5.3.3 Procedure

In-depth semi-structured interviews were conducted online via Zoom; a topic list was constructed after steering groups and discussions with the research team, which comprised researchers with academic backgrounds and clinical expertise. Alongside each interview, participants were asked to complete three questionnaires the YSQ2-SF (Young, 1998), SMI-ED (Simpson et al., 2018), EDI-3 (Garner, 2004) (Appendix D). The quantitative measures were chosen as supplementary information to explore participants individual EMS, schema modes, and their eating disorder.

Confidentiality and anonymity were explained. Participants were informed they did not need to answer any questions they did not feel comfortable with. Professor Reid was present in the first interview for training purposes due to the sensitive topic of the study. Participants consented to their verbatim quotes being used in dissemination of research.

5.3.4 Data Analysis Process

The core principle of IPA is the focus on participants' attempts to make sense of their experiences, identifying patterns and themes (Smith et al., 2013). Due to the idiographic nature of IPA, each case is examined in depth to look for themes to highlight similarities and differences in perceptions of participants (Allan & Eatough, 2016). The researcher transcribed the interviews to fully become immersed in the data. Analysis aims to give credence to participants' perceptions as well as acknowledging researcher's sense making, thus moving between emic and etic perspectives (Pietkiewicz & Smith, 2014).

Analysis of the interviews followed the guidelines described by Smith et al. (2009). The initial phase of analysis involved listening to the first audio recording in conjunction with an initial reading of the transcription. Initial notes were made to provide a contextual understanding of the interview for the researcher and their relationship to the research, allowing a reflexive noting of their own impressions, whilst returning attention to the participants own lived experience.

The second stage involved a deepening of engagement with participant narratives and begun with an exploratory reading of the data, noting of impressions and comments on the data; looking at descriptive content, linguistic style, and conceptual interrogation. Descriptive comments allowed the identification of key phrases, descriptions, and emotional responses. In making linguistic comments, the researcher paid specific attention to pauses, repetition, pronoun use, and the use of similes and metaphors as this allowed the researcher to interpret meanings behind these linguistic devices. Conceptual comments included developments of questions about meaning, e.g., if a metaphor or an idiom was used, why did this participant use that? What is the significance of this? Stage three of analysis involves collating the comments to develop Experiential Statements for each participant to capture significant aspects of participant’s accounts. Patterns and relationships were explored by organising these statements into meaningful clusters that represent participant’s experiences. Theses meaningful clusters represent Personal Experiential Themes (PETs) – stage four. For example, if a participant had themes of bullying and abuse in their narrative, they would be clustered together under a possible PET of Adversities. The original transcripts were frequently checked to ensure interpretations were grounded in participant’s words.

Stages one to four were repeated across all participants and once all transcripts were analysed, they were compared to identify patterns across cases. This involved looking at the PETs for each participant and clustering them into Group Experiential Themes (GETs); emphasis was paid to the claims, concerns, and experiences of participants in an effort to ground the analysis in their phenomenological reality. It is worth noting that Smith et al. (2022) suggest calling what were ‘superordinate themes’, GETs; in the studies of this thesis, they are referred to as the latter. This is the final stage of analysis. It is at this point of analysis that theoretical understanding can help interpretative convergence whilst simultaneously ensuring this convergence is within the participants’ individual understanding of the concepts (Smith et al., 2009; Smith et al., 2022).

5.4 Study One Results

The mean age of participants was 33.2 years (*SD=9.82*). It was believed that an adult sample would have the advantage of having longer life histories from which to draw self-narratives, in addition to being able to consent for themselves. Self-reported BMI of participants ranged from 17 to 45 with the mean being 26.08 (*SD=9.69*) this may be skewed as (*n*=3) declined to provide this information (Table 8). Interview times ranged from 35 minutes to 120 minutes; participants were prompted if it was felt additional information was needed.

Participants were requested to provide their height and weight measurements to calculate their body mass index (BMI). A normal BMI is between 18.5 and 24.9. A BMI of 12-13.5 can be life threatening and can lead to organ failure. Taking this into account, and to not exclude those who were underweight (BMI <18.5 but >13.5), it was decided that those with a BMI of <15 were excluded from the study. However, some participants did not wish to disclose their weight as they did not weigh themselves due to finding it triggering. Participants agreed in the consent form to alert myself if their BMI was <15.

Of the (*N*=10) participants in this study, (*n*=9) were from the UK and (*n*=1) from Australia; (*n*=8) had undergraduate degrees and (*n*=2) had National Vocational Qualifications.

Table 8

Client Demographics

Participant*	Diagnosis	Age	Gender	Height (CM)	Weight (kg)*	BMI
Anne	BN	26	F	170	Unknown	Unknown
Billie	BN	26	F	168	68	24.2
Clare	BN/BED	41	F	Unknown	Unknown	Unknown
Diane	AN	28	F	165	52	19.1
Emma	BED	56	F	157	127	45
Fiona	AN	31	F	163	56	21.3

Participant*	Diagnosis	Age	Gender	Height (CM)	Weight (kg)*	BMI
Gertrude	AN	24	F	165	40.3	17
Harriet	AN	23	F	Unknown	Unknown	Unknown
Ian	BED	40	M	172.7	107.9	36.2
Jane	AN	37	F	165	54	19.8

*Some participants declined to provide their weight; pseudonyms were used; names were provided that were not linked to participants in any way

Table 9

Client Highest EMSs and Modes at Time Point One

Participant	Highest EMSs	Clinically Significant Modes (3+)	High Modes (4+)
Anne	Emotional Deprivation, Abandonment, Defectiveness/Shame, Subjugation, Enmeshment, Self-Sacrifice, Unrelenting Standards, Entitlement	Angry Child, Punitive Mode, Compliant Surrenderer	Demanding Mode, Healthy Adult, Detached Self-Soother, Helpless Surrenderer
Billie	Abandonment, Mistrust/Abuse, Social isolation, Defectiveness/Shame, Subjugation, Self-Sacrifice, Unrelenting-Standards, Insufficient Self-Control	Happy Child	Compliant Surrenderer
Clare	Abandonment, Emotional Deprivation, Mistrust/Abuse,	Compliant Surrenderer,	N/A

Participant	Highest EMSs	Clinically Significant Modes (3+)	High Modes (4+)
	Social Isolation, Defectiveness/Shame, Vulnerability to Harm, Self-Sacrifice, Unrelenting Standards	Detached Self-Soother	
Diane	Emotional Deprivation, Abandonment, Self-Sacrifice, Unrelenting Standard	Healthy Adult, Happy Child	N/A
Emma	Emotional Deprivation, Abandonment, Failure, Defectiveness/Shame, Subjugation, Self-Sacrifice, Unrelenting Standards	Vulnerable Child, Happy Child, Healthy Adult, Detached Self-Soother	Demanding Mode, Eating Disorder Overcontroller, Compliant Surrenderer
Fiona	Emotional Deprivation, Mistrust/Abuse, Social Isolation, Defectiveness/Shame, Self-Sacrifice, Emotional Inhibition, Unrelenting Standards, Entitlement, Insufficient Self-Control	Undisciplined Child, Happy Child, Detached Protector, Self-Aggrandizer	Eating Disorder Overcontroller
Gertrude	Emotional Deprivation, Abandonment, Failure, Enmeshment, Subjugation, Self-Sacrifice, Unrelenting Standards	Vulnerable Child, Happy Child, Demanding Mode	Compliant Surrenderer

Participant	Highest EMSs	Clinically Significant Modes (3+)	High Modes (4+)
Harriet	Emotional Deprivation, Mistrust/Abuse, Social Isolation, Defectiveness/Shame, Failure, Vulnerability to Harm, Subjugation, Self-Sacrifice, Emotional Inhibition, Unrelenting Standards	Vulnerable Child, Punitive Mode, Detached Protector, Self-Aggrandizer	Demanding Mode, Compliant Surrenderer, Detached Self-Soother, Eating Disorder Overcontroller,
Ian	Emotional Deprivation, Social Isolation, Defectiveness/Shame, Subjugation, Emotional Inhibition, Unrelenting Standards, Insufficient Self-Control	Vulnerable Child, Demanding Mode, Healthy Adult, Compliant Surrenderer, Helpless Surrenderer	Detached Protector
Jane	Abandonment, Social Isolation, Defectiveness/Shame, Failure, Dependence, Enmeshment, Subjugation, Self-Sacrifice, Emotional Inhibition, Unrelenting Standards, Insufficient Self-Control	Punitive Mode, Helpless Surrenderer	Vulnerable Child, Demanding Mode, Compliant Surrender

Note: clinically significant and high schema modes are calculated using the mean; a mean of 3+ is clinically significant and 4+ is high. EMSs were calculated using the mean of the scoring on the YSQ2-SF (Waller et al., 2001). Regarding the EDI-3 (Garner, 2004), participants had elevated scoring on many

of the subsections including perfectionism, maturity fears, low self-esteem, drive for thinness and body dissatisfaction.

Table 9 portrays the highest scoring EMSs and modes across participants. Participants scored highly on similar EMSs/modes. For instance, high scoring EMSs included: Unrelenting Standards (10), Self-Sacrifice (8), Defectiveness (8) and Emotional Deprivation (8); these were high across all participants, regardless of diagnosis. Further, highest scoring modes (including high scoring and clinically significant) were: Compliant Surrenderer (8), Demanding Critic (6), Vulnerable Child (5) and Happy Child (5). Similar to EMSs, these modes were elevated in participants across diagnoses. Thus, as suggested by the transdiagnostic approach there may be common underlying mechanisms contributing to the maintenance of participants' eating disorder. The impact of EMSs and modes on the development and maintenance of participants' eating disorders is discussed further in the results and discussion of this chapter.

Following an interpretative analysis of participants' accounts, four GETs and ten subthemes were developed (Table 10). The themes relate chronologically to one another, 1. 'Adverse Experiences' looked at the development of coping mechanisms/modes and the psychological functions participants attributed to food and eating. 2. 'Interpersonal Relationships' explored relationships and highlighted the importance of a good, therapeutic relationship; 3. 'Self-Awareness' explored participants' journey and their developing insight into schema modes, the eating disorder voice and how they identify with them. Lastly, 4. 'Recovery' explores participants' journey.

Table 10

Client Group Experiential Themes and Subthemes

Group Experiential Themes	Subtheme
1) Adverse Experiences	1a) Trauma and Maltreatment
	1b) Detachment and Dissociation

Group Experiential Themes	Subtheme
	1c) Psychological functions of food and eating
2) Interpersonal Relationships	2a) Difficulties in Family Relationships
	2b) Importance of the Therapeutic Relationship
3) Self-Awareness	3a) Attunement to Modes
	3b) Identifying the Eating Disorder Voice
4) Recovery	4a) Finding Inner Child
	4b) Managing Emotional Needs
	4c) Ambivalence

Themes and sub-themes will each be explored in turn. Line numbers are denoted in parentheses after each quote and refer to the individual transcripts.

5.4.1 Group Experiential Theme: Adverse Experiences

This theme explores how participants made sense of their experiences in early life. Participants described an awareness of the development of their schema modes and the eating disorder voice. Often, participants recognised this development occurring after an adverse life event (e.g., abuse, bullying), suggesting that modes and the eating disorder voice are internal mechanisms that have developed to manage the challenges they face. Detachment and dissociation encapsulate participants' experiences of modes on a continuum from being used as a metaphor in their lives to dissociation from the healthy parts of the self. Finally, participants described the psychological functions of food and eating with all participants experiencing the eating disorder voice to a degree.

Sub-Theme: Trauma and Maltreatment.

This subtheme suggests that modes may develop from adverse early life situations to help cope with these events at that time, often leading to significant yet maladaptive roles in

adulthood. Fiona said, *"she wasn't really a mum; she was always too busy" (171)* and *"I always had a bad relationship with my dad…he worked a lot, as did my mom so they were never at home, so I just used to go and not eat, cos no one, no one cared, so I got away with it…" (40 – 44)*; implying neglect or even abandonment. Moreover, *"just used to go and not eat"* suggests use of this to mitigate emotional deprivation, while *"got away with it"* means seeing this as a bad thing. Fiona's eating disorder began when she was young, around the time she began competitive swimming and her relationship with her parents began to deteriorate.

Further, Fiona describes her mother an enemy, *"I felt she was against me and wanted to make me fat cos she was the one feeding me when it all came out so the voice in my head was telling me she was the enemy" (172 – 174)*. Linking back to *"got away with it,"* Fiona feels she is being punished by her mother whereas, prior to this, she was the one punishing herself. *"When it all came out"* highlights the secrecy of eating disorders and follows up on her earlier comment of *"getting away with it;"* suggesting that Fiona did want someone to care, however, believed her mother was the enemy.

Moreover, there was evidence in Anne's narrative that she was the victim of trauma and physical/emotional abuse from an ex-partner, *"I was terrified…he was a violent guy" (184)*. Initially, she remarks how she felt confronted and unintentionally restricted her food intake as he would frequently make comments about her appearance, *"you'd be so much more attractive if you lost weight or had a boob job" (22 – 23),* following the end of the relationship, she received positive comments from those around her, not about leaving the relationship, but about her weight loss, *"when I finally broke up with him everyone was like you've lost so much weight, you look amazing, blah, blah, blah, and I hadn't noticed" (28 - 30).* She states she did not notice, indicative of how unaware she was of her behaviour, it is likely her ex-partner's actions subconsciously fuelled her desire to look a particular way and believed this could be achieved by restricting food intake.

Clare discussed past trauma, *"I was raped when I was nineteen and um, we're also finding something might have happened to me when I was a kid as well" (243 – 244).* This trauma seems to have led to the presence of strong punitive messages from the dragon, *"I have a very loud critical parent which we call the dragon, which is an absolute bitch that just has a go at me" (211 – 213)* she further explained how derogatory the dragon is *"you fat bitch, you disgus…oh it calls me a slut and stuff like that as well" (331)*. Traditionally, the dragon is a symbol of evil and the embodiment of chaos and untamed nature.

Exploring this further, Clare disclosed that the dragon was a personification of her mother. She surrenders to the dragon as she sees it as her mother, and she wants to have her needs met by her mother thus, appeases accordingly in a Helpless Surrenderer mode, as reflected below:

> I just roll over and I'm like YES, but I've actually gotten better at that, trying to deal with it but it depends how hard it swoops sometimes it just takes over and scares off my child completely and the healthy adult sitting there and it's all a bit of a disaster.
>
> (Clare, 317 - 320)

Maltreatment was further expressed by Billie, *"no-one wanted me in school, and I'd go home, and I'd feel like no-one wanted me cos my mom was shouting at me all the time, my brother didn't wanna know and my dad was completely emotionally avoidant" (221 – 224).* There is a sense of abandonment and hopelessness. Due to feeling this way, Billie reflected how she has used food to self-soothe to manage these feelings *"I basically learned to use food to self-sooth as a kid" (110 – 111).* Similarly, Ian utilised food in this way, *"it's just vulnerable little Ian comes out all the time and just tries to soothe himself with food" (297 – 298)*; parallel to Billie, this has likely developed as a coping mechanism in response to bullying from his father in response to his weight gain *"tact isn't my dad's strong point shall we say and you know he just said you know we're very concerned that you're putting on weight and I'm sure he referenced what neighbours would think of it…yeah…was very car crash way to handle it" (70 – 73).*

Brustiengh et al. (2018) suggest that childhood trauma, maltreatment, and its associated perceived loss of control, is a suspected mechanism underlying eating disorders, as the eating disorder symptoms are an attempt to regain control. Many of the participants experienced maltreatment and trauma in their early lives, which may have led to the development of EMS, such as Abandonment, Mistrust/Abuse, Defectiveness/Shame, and Emotional Deprivation. These EMSs were notably common among all participants (Table 9).

Sub-Theme: Detachment and Dissociation.

Modes are facet of the self, involving schemas or coping responses, which have not been fully integrated with other facets. A schema mode, therefore, is a part of the self that is separated, to some extent, from other aspects of the self. Participants in this study experienced detachment to varying degrees, *"an Orb state…I'd go dead behind the eyes, and I was under water and everyone else was on the surface" (Anne, 411 - 413).* Anne referred to herself being in an *"Orb state,"* although she is physically present, she emotionally detaches; thought to mirror the Detached Protector coping mode. The feeling of being *"under water"* is a feeling of being trapped and indicates she would like to be rescued by those on the surface. Anne oscillates between Detached Protector and Vulnerable Child in that she has responded in the initial way of an *"Orb state"* and has since attached back to reality and needs her Vulnerable Child to be rescued. Everyone else being on the surface, emphasises the loneliness and isolation. This is likely to have developed as a coping response to difficult situations Anne has encountered.

This was too, encapsulated by Billie, *"sometimes I would go to therapy and would be dissociated before I got there (…) almost knowing I knew I was about to have to deal with something quite scary (…) it's like my brain leaves my body it's like I'm not there at all which is kind of scary but it's to stop feeling the pain" (579 – 584).* Billie has psychologically detached from her surroundings to prevent traumatic memories and reduce activated schemas. This can be perceived as a Detached Protector mode, as it allows for the avoidance of feelings through psychological detachment to lessen overpowering emotions. Billie describes feeling afraid in this

mode but understands its purpose. By entering this mode, she prevents the triggering of her Mistrust/Abuse schema, reducing the possibility that this will happen again. Billie identifies with her Detached Protector mode through dissociation and understands its function to protect her.

This uncertainty and fragmented experience may have resulted in avoidant coping strategies and disconnecting from self-awareness, a strategy discussed by Ian, *"Detached Protector for me, up until a year ago was come home, roll a spliff and now binge eat" (272 – 273).* Previously, he would misuse substances to detach from his emotions, now, he states he binge eats as a coping method. Throughout schema therapy, he was encouraged by his therapist to *"change things up in the moment, you know, go for a walk, or exercise that isn't binge eating…to sort of snap yourself out of that mode and to snap your mind out of it…I find that challenging, I won't lie" (273 – 276).* The repetition of 'snap' suggests that this mode causes Ian to be in a trance like state and he is unaware of how he is behaving. Clare expressed similar views *"I have a Detached Protector that is queen of everything I am so good at just turning off" (260 – 262);* suggesting this coping mechanism allows her to switch her negative or stressful emotions off. 'Queen' infers that this mode is the primary way in which Clare manages her feelings and suggests it can take precedent over other, perhaps more adaptive modes.

This coping mechanism was also illuminated by Harriet:

> My dad especially very much kind of stiff upper lip, not being emotional and I think because of that I've always kind of perceived showing emotions as being vulnerable or being weak that kind of like leaves you open to criticism and being hurt…
>
> (Harriet, 219 – 222)

The idiom *"stiff upper lip"* suggests that even when faced with adversities, Harriet should not show emotions as it is considered weak and thus, detaches emotionally. Being told that vulnerability is a weakness in childhood has manifested the development of an Emotional Deprivation schema and a subsequent Detached Protector mode. Once this maladaptive coping was entrenched, it resulted in the exacerbation of her eating disorder as a primary way of

coping. She said *"all my friends know me as the girl who never cries" (255)* as though it would be perceived as weak if she cried. Stating she never cries could also be operation of an Avoidant Protector mode whereby she avoids situations that are emotionally triggering. This extract highlights how Harriet understands her detached modes and to be anything other than detached from emotions is considered *"weak."*

She conveys a sense of caution around expressing her emotions but later emphasises how she can be overly emotive:

> I become like over emotion, like I've gone past that barrier of suppressing emotion and gone into kind of properly like out of control like suddenly really angry and tantrum like. (Harriet, 264 – 266)

Although Harriet states she never cries, when her emotions build up, she becomes angry at her needs not being met. The display of a tantrum could be due to the fact she has been told to repress her emotions, *"my parents not necessarily being there for me either physically or emotionally…like been brought to kind of…be…self-sufficient" (276 – 278).* 'Tantrum like,' infers she has not had the skills to communicate how she is feeling effectively and therefore, acts in this manner to have her needs met. It is likely this expression is how Harriet relates to the Angry Child mode, in that by acting in this manner is the only way she will get the needs of her Vulnerable Child met.

This sub-theme captured participants understanding of detachment and dissociation. Throughout, we see participants articulating the function that these two behaviours have had in their lives, they are demonstrating awareness and phenomenological reality of their coping modes, thus suggesting schema therapy has allowed them to articulate these parts of themselves. Participants clearly articulated a state reminiscent of the Detached Protector, which could either simply be detached, or be detached to the point of dissociation from the current situation. Clients identified with and strongly recognised the presence of detached modes.

Sub-Theme: Psychological Functions of Food and Eating.

Food was viewed as a source of comfort or distraction, and it was sometimes restricted as a means of coping with mental discomfort:

> I've been quite an emotional eater you know so like we all have ups and downs in life, when that, when that happened, erm…I would naturally eat my way out of it.
>
> (Emma, 33 – 35)
>
> .I remember feeling really stressed whilst I was revising one night and I just ate, and ate, and ate.
>
> (Gertrude, 33 – 34)

Both Gertrude and Emma described eating as a mechanism to self-soothe. Emma describes eating her way out of a situation suggesting food provides comfort. The use of the word 'naturally' implies this is something she has done from a young age and has subsequently developed into a coping mechanism in adulthood. Additionally, prior to Gertrude's comment, she had found out upsetting news about her father and became overwhelmed that she used food to soothe herself. The repetition of 'ate' highlights the amount of food consumed, suggesting that if she ate more food, it would assuage the upset she was experiencing. Based on this, it is likely this process is the coping mode Detached Self-Soother to alleviate the distress. However, shortly after, Gertrude states:

> .Disgusted in myself that I ended up purging for the first time and I was disgusted in myself and so scared of it ever happening again, so I thought ok, restrict, make sure that doesn't happen cos you'll lose all control from there.
>
> (Gertrude, 35 – 37)

There appears to be a distinct shift between Detached Self-Soother and Demanding Critic. Although feeling disgusted, Gertrude utilised food to ease her stress, leading her to soon regret this and shift into Demanding Critic mode, feeling as though she has eaten too much. The need for control is paramount with Gertrude and highlights the fear of losing control. Disordered eating behaviours appear to be coping mechanisms and demonstrate participants

understanding of their relationship with food. Following this, participants explored their relationship with the eating disorder voice and the psychological purpose it serves them.

Participants explained the voice as a positive presence in the early stages of illness and one which fulfils valued functions, for instance, providing comfort (Pugh & Waller, 2017). This voice can behave in a way that makes people with eating disorders feel they cannot live without it, providing them with a sense of safety and security:

> .I guess part of me always hides the fact I don't want to let go of this voice telling me I can't eat that cos I can't live without it.
>
> (Fiona, 618 – 620)

The voice provides a sense of safety and control when she states she cannot live without it; yet simultaneously, is critical towards her and has been personified as the devil, *"he is like the devil that morphs into everything and all about food and I know it's him I just want to flick him off half the time" (319 – 321).* The devil is typically an embodiment of evil and is often a destructive force. By calling the voice him, it seems she has mirrored this voice on her father, which is reasonable to assume in her description of his actions, *"he used to hit me, my dad" (208)*. She feels as though she cannot live without the voice in the same way she cannot live without her father, as despite the negatives there are positives, as it provides Fiona with a sense of control and safety.

The identification of the voice was further expressed by Billie:

> .I bought a five guys milkshake cos I really fancied it (…) I said to myself I'm not going to finish it because otherwise I feel, I finished cos I was obviously hungry and then I googled how many calories were in and it had a 1000 calories in it and I started panicking all over(…)I live in a house share and I couldn't use my bathroom cos someone was in and I couldn't use the next cos someone was in it so I had to use someone else's bathroom on the third floor to go and get rid of it just

because…the…stress of it being inside of me was ten times worse than the process of getting it out.

(Billie, 309 – 318)

Prior to consumption, Billie has told herself she will not finish it, suggestive of an internal battle with her eating disorder voice. She leaves the sentence *“otherwise I feel…”* incomplete, indicative of the guilt if she were to finish it. She appears to be justifying herself, *“I was obviously hungry”* as though she needs to explain her consumption of the milkshake. After checking the calorie content, she experiences physical symptoms of distress. Purging could be utilised to make her feel safer; by removing the threat of food from her body, she is removing the fear and generating a sense of security, creating psychological safety. This is likely to have developed as a way of coping with her overwhelming feelings of defectiveness and shame, likely resulting in the exacerbation of her eating disorder and amalgamating of her EMSs.

Additionally, Anne discussed her understanding of the eating disorder voice:

Being aware of it and for so long it was like this insidious erm…a bit like how my ex-boyfriend would talk to me, you couldn’t quite call out what was wrong with it but because it was so persistent it wouldn’t go away.

(Anne, 624 – 627)

‘Insidious’ suggests that the build up with the voice was gradual, subtle, with negative effects. The mention of her ex-boyfriend could be interpreted she has based the eating disorder voice on him, he was critical and emotionally abusive, in the same way the voice is. Similarly, throughout her narrative Anne states how critical her mother was *“you were mental, she said to me if we had you first, we wouldn’t have had another kid” (367 - 368).* It is likely that Anne has internalised these comments which have exacerbated the development of the eating disorder voice and associated EMSs such as Defectiveness/Shame, and Emotional Deprivation (supported by Table 9). Anne is the youngest child, there is no mention of her siblings, which

may have stemmed from this comment and led to Anne comparing herself to them, and consequently, not feeling good enough.

Moreover, participants' experiences with the power of food were so persistent that some described it as an addiction:

> When I would get the urge to binge, it would be like a heroin crack addict.
>
> (Anne, 278-279)
>
> On bad days especially, you have a cupboard full of crack, well your version of crack.
>
> (Billie, 879 – 880)

Anne speaks of her urge to binge in the first person, whereas Billie utilises the second person pronoun 'you,' as to distance herself from this addiction, suggesting she feels shame for this. The use of the simile to liken the urge to binge to an addiction, highlights the difficulty in surpassing this urge. The comparison to an addiction highlights the relief these behaviours bring to Billie and Anne from the distress they were feeling – akin to Detached Self-Soother. Though this behaviour is dangerous and can have detrimental effects on one's life, they cannot live without it. Thus, suggesting food was used in a way of fulfilling that unmet need.

This subtheme encapsulated participants' experiences of the psychological functions of food and eating, namely on the different ways in which food has been used and the subsequent meaning this held for participants, both positive and negative. Food and the associated actions (e.g., binge eating, restriction) were perceived as providing participants with psychological safety, protecting them from hurt experienced and providing comfort, relief in times of distress. This subtheme also introduced the concept of the eating disorder voice and the psychological functions that this serves for participants.

Table 11

Prevalence Table Example for GET: Adverse Experiences

Group Experiential Theme: Adverse Experiences	**Prevalence n (participant names)**	**Extracts provided n (participant names)**
Subtheme: Maltreatment and Trauma	9 (Anne, Billie, Diane, Emma, Gertrude, Clare, Fiona, Harriet, Ian)	5 (Fiona, Anne, Clare, Billie, Ian)
Subtheme: Detachment and Dissociation	9 (Clare, Anne, Fiona, Emma, Billie, Diane, Gertrude, Harriet, Ian)	5 (Anne, Billie, Harriet, Ian, Clare)
Subtheme: Psychology of food and eating	10 (Emma, Gertrude, Clare, Fiona, Billie, Anne, Harriet, Jane, Ian, Diane)	6 (Emma, Gertrude, Clare, Fiona, Billie, Anne)

5.4.2 Group Experiential Theme: Interpersonal Relationships

This theme explores participants' experiences with their interpersonal relationships; looking at the difficulties faced and the importance of the therapeutic relationship.

Sub-Theme: Difficulties in Family Relationships.

It is important to note that participants describing difficulties with family does not mean that families were responsible for participants' eating disorders. Participants explored their family relationships throughout their lives and the difficulties they faced with those close to them. Fiona had a traumatic response when she told her family about her eating disorder, *"my dad*

went mental…he put a load of food on the table and just started shoving it in my mouth" (54 - 56) which later on, led to Fiona feeling low and misunderstood she tried to take her own life, *"I used to cut myself, I took three overdoses…and ended up in hospital with it" (71 – 75);* with this self-harm possibly suggesting the operation of a Detached Protector mode developed as a way of coping with the emotional deprivation and abuse evident in her father's actions towards her. It could be reasonably assumed that once this maladaptive coping pattern was embedded, it resulted in the exacerbation of her eating disorder and the solidifying of her EMS's. She has developed a strong Detached Protector mode to shield herself from the pain; she finds it difficult to trust people due to this experience and has subsequently developed a Mistrust/Abuse schema driving her Detached Protector mode.

Anne expressed her own frustrations:

Mom is a therapist, and I was like mom I'm doing this.

(Anne, 106),

My mom's a therapist.

(Anne, 222/223),

My mom's a therapist.

(Anne, 224),

Her being a therapist but also not her figuring it out.

(Anne, 348),

You'd think as a therapist, she'd know.

(Anne, 355)

She surmises she has been let down by mother for not helping her when it is her job to help other people. This has triggered an Angry Child mode in Anne; the repetition of this reiterates her frustration at her mother which could have been reinforced by Anne's Enmeshment and Entitlement EMSs. She is frustrated that her mother did not help her and further states, *"I basically have to be the mom which, I find hilarious with her being a therapist"*

(735 - 736). This could be interpreted in two ways, firstly, it could be Anne implying she is now in a Healthy Adult mode and able to help herself in an adaptive way. Alternatively, it could be perceived as Anne being in Angry Child mode, using humour as a way of coping; the needs of her Vulnerable Child were not met and thus, she felt she had to accept the role of the parent.

Moreover, Ian described his mother as *“quite a cold woman growing up” (574 – 575),* with his parents displaying *“an uncaring, coldness attitude” (665).* To manage these feelings, Ian said he *“just tries to soothe himself with food” (298).* He refers to himself in the third person, as though he wishes to detach from this behaviour and his environment. This is indicative of operation of a Detached Self-Soother mode to meet his unmet needs as a result of emotional inhibition. This was a common occurrence for Ian and something he developed from a young age to have his needs met. Detached Self-Soother was described throughout his narrative *“you know what f*** it what does it matter, actually, I need to binge cos I need to soothe this…” (379 – 380)* suggesting that bingeing provides safety and soothes his triggered EMSs such Emotional Deprivation. The use of a profanity highlights the stress just before a binge and how it provides him comfort in that moment; however, it could also be interpreted as frustration, in that he needs to binge to meet the needs of his Vulnerable Child.

Detachment was further evidenced by Clare and was likely influenced by her childhood relationships:

> I just shove a…erm and then the other one, just totally detaching, just like, I don’t want to feel anything so I’ll eat to make sure I can’t feel.
>
> (Clare, 504 – 505)

‘Shove’ implies fast pace and that she is eating very quickly to ensure she cannot feel the subsequent schema or mode that is triggered. Clare experienced a traumatic background, so it could be that this has developed as a coping mechanism. The process of binge eating for Clare could be in frustration for her needs not being met, Emotional Deprivation, for instance. Therefore, she is fuelling her need for love and emotional security through food. The use of food

as a coping mechanism highlights the importance of being understood, particularly in childhood, and how adverse childhood experiences can lead the development of food as a coping mechanism when EMSs are activated (Trottier & MacDonald, 2017). As a child, Clare was placed on a diet and had a mother who was fixated on weight, which has subsequently, skewed her relationship with food:

> I was put on a diet at six, food was always my go to thing, um, when my parents went out we'd have the baby sitter and I'd eat all the biscuits um and blame the baby sitter and my brother kinda did the same we weren't allowed food, like um kinda naughty food as you might call it, in my house um, very often and only kinda if you were given it, so we used to steal it, you'd put bags of crisps in your arm thing and run upstairs.
>
> (Clare, 42 – 48)

She describes the food she is not allowed as *"naughty food;"* it is as though she is eating this food quickly so it cannot be taken off her and to not feel the subsequent feelings of guilt and shame. Clare describes using food as a soothing mechanism from an early age, *"at school I got right into the puddings, I just used food from a very early age" (52 – 53).* This behaviour was secretive, cementing the belief of naughty food.

Throughout her interview, Clare described a turbulent relationship with her mother, when she saw her mother, her weight fluctuated. Her fluctuations in weight could be thought to mirror her fluctuating relationship with her mother, *"I gained two stone every two months and lost two stone every two months I just went [moved hands up and down] like that and I saw my mom and that was, like, if I saw her, I lost the two stone and then I gained it before seeing her…it was a mess" (99 – 102)*, it is reasonable to assume that the feelings before seeing her mother are ones she did not want, thus, she ate to detach from this, supported by her earlier narrative of using food as a soothing mechanism.

When she told her mother about her eating disorder, she said, *"my mom reacted incredibly badly and was like why are you telling me? *laughter* and she was just worried that*

my best friend's mom knew about it" (155 – 158), further emphasising the difficulties Clare experienced. This sub-theme explored participants' difficulties with those who were close to them; exploring their feelings and the impact this may have had on the development of modes.

Sub-Theme: The Importance of the Therapeutic Relationship.

Schema therapy and the therapists were felt to be very helpful, *"she has saved me massively" (Anne, 757), "I can see that she's working and she's involved and it's responsive and she's part of that journey" (Gertrude, 102 – 103)* and *"I think she's just incredibly compassionate and works very relationally and I think it's her rather than schema but I think it's both" (Clare, 150 – 151)*. However, some participants felt they had not been understood in previous therapeutic settings, *"I had to get it so bad before things were picked up" (Gertrude, 493),* emphasising the necessity of being understood and a good therapeutic alliance.

The importance of a good therapeutic relationship was also described by Harriet, *"I feel like with CAT I could kind of…it was like the right ballpark…but like…I didn't get on with my therap…my therapist was like, we just didn't gel very well" (437 – 439)*; the idiom *"right ballpark"* implies that CAT was beneficial in that she could work with the model, however, she did not develop a therapeutic relationship. Harriet was apprehensive when talking about this, demonstrated by the breaks in speech, further emphasising the significance of the therapeutic relationship and the importance of *'gelling.'* Harriet was also treated with Group DBT:

> I don't do like fluffy things *laughter* and kind of like, and I did my, I did a whole research on DBT and if anyone comes near me with DBT I'm like walking out.
>
> (Harriet, 104 – 106)

Harriet appears to be in Detached Protector mode, she does not engage with '*fluffy things*' (interpreted here to mean feelings), because engaging with feelings is threatening. Throughout her interview, she states she has been brought up to be independent and not show weakness which is likely to explain Detached Protector mode. She later states that schema therapy has challenged this view:

I've allowed myself to be more vulnerable…erm…and it's like schema therapy is almost like a place to practice that, it's almost like…erm…like…a safe space…I hate saying that…a safe place.

(Harriet, 338 – 340)

Schema therapy has encouraged Harriet to access her vulnerable side and practice it safely. She has not been allowed to access this side of her growing up, or to feel vulnerable as this was perceived as weak; hence, the evidence of a strong Detached Protector mode in her interview. The ellipsis emphasises her hesitancy. She repeats the words *"safe space,"* her tone is one of disgust at this phrase. This could be interpreted in two ways, firstly, because Harriet has never had a safe place to be herself before, or acknowledge her own vulnerability, it is something unusual and possibly scary to have, and everything is telling her to detach. Secondly, it could be interpreted that Harriet is emotionally hurt because she did not have a safe space growing up, whereas now, she has freedom to allow herself to be vulnerable in this safe space.

Moreover, participants emphasised the role of schema therapy in allowing them to grow and nurture themselves and compassion experienced:

The actual nurturing side of stuff…cos I've never learned anything like that, so it was teaching me how to do stuff.

(Fiona, 95-96)

The way [therapist] reacts to it is so compassionate and not freaking out, there's no pressure from her, whereas I have felt pressure in the past.

(Clare, 608 – 609)

For both, there is a sense of security. Fiona states how she had not learned to nurture herself as a child; due to schema therapy, she has been able to access her inner child and learn how to do this, emphasising the importance of the therapeutic relationship. Clare expresses a sense of relief as it seems her current therapist is the caregiver that she needed; she previously described negative past experiences with therapists who had mirrored her mother, *"psychologist*

just like my mom, incredibly critical" (109 – 110), suggesting Clare was seeking a safe, non-critical environment. By having this therapeutic relationship, she does not feel pressured and can work on developing her Healthy Adult mode at her own pace. *"Freaking out"* suggests she felt pressure to recover in the past, illustrated here: *"she [previous therapist] said you've been with me for this time why aren't you better" (610 – 611)*; this attitude towards Clare is a direct contrast to how her current therapeutic relationship is.

Similarly, Gertrude spoke of the importance of the therapeutic relationship:

> With schema therapy, it's like we're both involved in the, I don't know, I feel as though someone is there with me, guiding me through the textbook.
>
> (Gertrude, 106 – 108)
>
> She'll [therapist] put me in a scenario and then she brings in the other modes and that's really important cos I've built up, it's almost like a TV show where I know the characters, you can predict what they're gonna say and visualise it.
>
> (Gertrude, 340 – 343)

In contrast to previous support, Gertrude states she does not feel alone and feels supported in her current therapeutic journey. She highlights the importance of understanding the sides of herself and the visualisation process, she can talk to her other modes and bring in her therapist as a Healthy Adult to guide her.

Emma also emphasised the importance of this support:

> Having that relationship with someone who does treat you like you matter and doesn't treat you like…and does treat you like you matter maybe does help undo some things like maybe it wasn't my fault and I deserve love and it does have benefits as well.
>
> (Emma, 301 – 305)

The repetition of *"you matter"* opposes what Emma was taught throughout her childhood that she did not matter; supported by the way in which her mother spoke to and treated her, *"if you did something you didn't realised was defying them [parents], you got a wallop for it" (455 -*

456). She appears to be distancing herself from her childhood and past, by referring to herself in the second person. Her therapist was a male and throughout her interview, she stated that she felt more able to trust men, possibly due to her turbulent relationship with her mother. Her father passed away and this was a significant life event for Emma, which could be why she feels more able to trust male therapists more as she sees them as father figures.

This subtheme was common in several participants and highlights how important feeling safe and nurturing the Vulnerable Child is. Schema therapy has enabled a safe place for participants to explore their vulnerabilities.

5.4.3 Group Experiential Theme: Self-Awareness

This GET illustrates participants growing self-awareness around their modes and eating disorder voice. We see participants articulating and understanding their schema modes and the eating disorder voice, exploring experiences of the positives and negatives. The two subthemes capture the impact of schema therapy on this increased understanding.

Subtheme: Attunement to Modes.

Schema modes are strategies that have helped a young person to cope with adversities in life. They are often overgeneralised in adult life to situations and interactions where they are not needed or are counterproductive. During their journey of schema therapy, participants expressed how they have been able to identify with schema modes:

> I can recognise when the Vulnerable Child is triggered, I don’t always give a s**t, you know, sometimes it’s like shut up for God’s sake.
>
> (Clare, 436 - 437)

Preceding therapy, she was unaware or unable to accept that she had a vulnerable side; whereas now, she is aware of her Vulnerable Child, yet chooses to ignore her at times, perhaps due to the hurt she is experiencing. The expression *“for God’s sake”* infers frustration, telling her inner child to shut up, could be indicative of how she was spoken to as a child and that she is

not supposed to be expressing her vulnerability. However, it is this awareness that alludes Clare has attuned to schema modes.

She described her modes as working as a team:

> I have a team of, um nurturers, who are some are fictional so Mrs Weasley from Harry Potter cos I'm a big Harry Potter fan even though I'm not the biggest fan of JK Rowling right, but hey, but Mrs Weasley is there, one of my friends, (…) another lecturer who was really kind to me and I've got my protectors, which is like Arnie when he was in the Terminator 2 days with his oozie and this boxing guy from my Nintendo Switch game and um Hagrid and you know, then you have the wise people like Dumbledore and other people.
>
> (Clare, 649 – 657)

The people listed are people she has not had in her life and thus, is assigning this team to fulfil her unmet needs. By beginning with nurturers, it is indicative that Clare has not had the experience of being nurtured in her life and is thus, seeking people she can call on when her child modes are activated. She has listed people who have all had a positive impact in her life, interestingly, her family members are not there. The protectors are characters who are likely to represent healthy coping modes there to protect Clare's vulnerable side. Clare experienced trauma in her life, thus, it is understandable where these protectors have originated from. Her schema modes are discrete personalities; they are the parts she needs to meet her needs, inferring phenomenological reality as they are part of Clare's reality.

This concept was also demonstrated by Billie:

> Creating a team of people, a support group in your head, we had one like was really caring…like a mom that would hug and support you and one that was a fighter and fight your battles and she wore a lot of leather and one that was wise, and we had to create those characters and they still live in my head.
>
> (Billie, 619 – 623)

It is interesting how two participants have likened their schema modes to teams of people in their head. The description of a support group demonstrates that the modes are there to support Billie. One being *"like a mom"* suggests her mother was not there emotionally for her, possibly exacerbating feelings of abandonment. Billie states how she was dismissed as a child and left to fight her own battles with bullies in school, therefore, she has created a fighter; wearing *'leather'* indicates how strong she is. She does not go into detail about the wise one in her team which could mean the wise one is one she does not use often but is there if required. The idea of a team is a positive concept of schema modes that Billie has articulated.

Billie further said she found the concept of schema modes helpful and able to relate to them, *"they're there to protect you" (519)*, proposing a constructive function of schema modes as a means of protection. Similarly, Harriet voiced how without having her inner critic, she would not be where she is today *"critic and stuff has got me to where I am today and like…it has pushed me to do well in exams (…) got me into [university] and like so without that like…I just don't think I'd where I am today cos that's what gives me that drive and determination is the kind of controller" (317 – 320).* Harriet explains how she views schema modes, particularly the inner critic and Overcontroller as positive aspects in her life; both of those modes have provided determination, likely fuelled by her Unrelenting Standards schema, demonstrating the positive attributes schema modes can have.

Diane felt she did not identify strongly to the concept of modes, *"I don't really think in relation to it so much, I don't get round thinking, that's you know Detached Self-Soother or anything" (131 – 133)* and found the most helpful part of schema therapy to be learning to nurture herself, *"treat myself like I would treat a small child, so not to hurt myself, to treat myself with kindness, like I deserve love and respect. Um…to recognise ways of behaving rather than just going along with them, the unhelpful ways of behaving…" (277 – 281)*. Although Diane does not think so much in schema terminology, her narrative infers a strong connection to her Vulnerable Child and her Healthy Adult, in that she has the tools to nurture her Vulnerable Child.

Similarly, Emma does not use schema terminology. When asked about her modes, Emma lists her scoring on the SMI-ED *"Dysfunctional Parent, Happy Child, Vulnerable Child, Healthy Adult"* (567) and follows with *"defences made to get you through life, self-sacrifice was a defence used which was useful at the time but is not so helpful now" (568 - 569).* The use of *'you'* indicates she is not applying these to herself and is generalising them, she does not state, 'I have…' and refers to her modes in the second person. It could be due to Emma being early on in therapy, or she does not identify with the concept of schema modes. It is thought-provoking how she focuses on Self-Sacrifice, which is a schema, rather than a mode, throughout her narrative, she tells how she has often put others first *"only one thing I regret (…) I worked on ITU and was going to go to [city] and do the course but we hadn't been married that long and he wasn't that keen" (669 – 671)* at the expense of her own happiness. It could be that Emma identifies more with the concept of EMSs than she does with schema modes.

Throughout narratives, participants identify with the positive aspects of schema modes, for instance, enabling them to cope when feeling vulnerable or helping them to achieve goals. However, when discussing their relationship with food and associated schema modes, there were primarily negative connotations. The negative side tended to focus on the individual's weight, appearance, and food. This was captured by Ian and Billie, respectively:

> My inner critic, and you know particularly in the gay world if you're anyway overweight, you're fat, you're disgusting, you're horrible, this is the inner critic going do do do do. (Ian, 375 - 377)

Although Ian has been able to identify positives with schema modes, the inner critic has negative attributes. In contrast to other modes, this mode focuses on Ian's appearance and his weight in a largely negative way. Generally, the inner critic is an echo from the past, thus, it is likely, Ian has internalised negative comments he has received. The words used associated to the critic are generally negative, highlighting the impact it has when activated. Ian perceives the critic to be triggered in *"the gay world,"* following on from his earlier comment *"as a teenager*

because I was like forcefield up, I have this dirty secret, I have to block my emotions" (236 – 237) his speech was mildly pressured, demonstrating how quickly he had to put the forcefield up to protect himself. The forcefield is likely to be operation of his Detached Protector.

Previously, Billie spoke of her modes as being part of a team, whereas her critic is not part of this:

> I get very hangry as well, I get very panicky about not eating, when, if I get really hungry my eating disorder mindset kicks in and the anorexia voice is there and the self-hatred voice is there.
>
> (Billie, 915 – 918)

Each mode described had both positive and negative functions for participants, e.g., Detached Self-Soother helping soothe unmet needs but can also be maladaptive long-term, leading to emotional dysregulation. However, the inner critic had primarily negative connotations and often caused ambivalence for participants. Some described their critic as the eating disorder voice, this is subsequently discussed.

Sub-Theme: Identifying the Eating Disorder Voice.

Each participant interviewed identified with the eating disorder voice some identified it as an inner critic and some as the Overcontroller mode. It could be argued that the voice is an amalgamation of critic and overcompensatory modes due to the critical and overcompensatory nature of the voice. Participants were able to recognise when this voice was activated and whilst working through schema therapy, some have been able to challenge the voice.

Every participant expressed being able to identify with and understand the concept of the eating disorder voice and experienced it often as the inner critic:

> I did find though with my inner critic, although I haven't got a name for it, when it starts going, I go *points* that's my inner critic!
>
> (Ian, 390 - 391)

Through his narrative, Ian progresses from feelings of low self-worth, to recognising and challenging his critic. Ian's critic was particularly harsh regarding his weight and appearance. By acknowledging his inner critic, he can understand why it is triggered and the underlying schemas, such as Defectiveness/Shame and Social Isolation. He expressed how at times he felt particularly isolated, and this triggered his inner critic. His highest schema mode was Detached Protector; thus, it is reasonable to assume that this mode comes into operation when his inner critic is activated. Ian points to his head when this mode is triggered and recognises the callousness of this mode, allowing him to challenge this.

Billie described the role of her eating disorder voice in a way that appears to mirror the Eating Disorder Overcontroller:

> I broke…I broke down… down into tears…I realised I actually loved her; you'd think you would be like I hate you, you're a demon, but I'm emotional, I cried a lot, this little person in my head is literally trying to save my life and doing everything she can to make sure I'm not excluded from the world…
>
> (Billie, 719 – 724)

This was a highly emotive realisation from Billie highlighting her awareness of the eating disorder voice. The voice bares similarities to the Overcontroller mode in that it is *"doing everything she can,"* to cope with social isolation and exclusion. It could be that this mode has intensified her eating disorder to protect her from being alienated from her peers, *"didn't have any friends at school and I was being bullied and that feeling of no-one wants you cos you're fat and I was going home, and they were basically all against me" (113 – 115).* This suggests that this mode has developed subconsciously to protect Billie from being excluded and in her words *"save my life,"* with her believing that if she is not 'fat,' she will not be excluded. Billie is consciously aware of her Overcontroller and identifies with this mode as a source of protection. Referring to the voice as 'her' infers that Billie sees this mode as a female figure in her life.

As schema therapy has progressed, Billie demonstrates a realistic vulnerability as she experiences a freer way of thinking:

> Freedom to allow yourself to do whatever you wanna do and think we all have within us enough nutritional knowledge to know what's good and bad…not good and bad, but what a balanced diet should look like to be healthy, but that freedom from your brain…is like the shackles… [came off]
>
> (Billie, 976 – 980)

It is interesting how she retracts almost immediately, *"what is good and bad,"* indicating how this new way of looking at food has changed her perception. Billie likens her lived experience with an eating disorder to being shackled and trapped; *"the freedom from your brain"* suggests Billie is working to detach herself from the eating disorder voice and learn to live without these metaphoric shackles that are currently holding her, suggesting she is challenging her critic to free herself.

Throughout therapy, participants emphasise becoming increasingly aware of the role of the eating disorder voice; demonstrating insight and exploring the functions it plays; albeit positive or negative. For instance, Diane's eating disorder voice was critical and negative, akin to the Punitive Critic mode, *"I didn't need certain things, that things were too high calorie, that other people could have them and I couldn't, that I didn't deserve fresh food and should have mouldy food" (189 – 192)*. It is likely that this is in past due to the use of the word '*didn't*;*'* whereas she states that because of schema therapy, she has learned to focus on what her inner child needs, thereby, challenging her inner critic mode, *"focusing on that Vulnerable Child and how you'd treat a child was the main thing that sort of stopped me from restricting food as much cos I wouldn't wanna do that to a child" (167 – 171).*

Jane echoed similar thoughts, *"I couldn't justify spending money on nicer food cos it's just for me and that was a bit of waste" (111 – 112).* Her eating disorder voice is likely to be operation of a Punitive or Demanding Critic, an internalisation, that she does not feel worthy of

'nice' food. This is perpetuated by her Defectiveness/Shame and Unrelenting Standards EMSs, whereby, she is depriving herself of 'nice' foods due to feeling defective. There is also the operation of the Overcontroller mode in that Jane is not allowed to have the foods she wants as it is perceived as a waste. However, later in her narrative, *"I am now seeing the problems and actually trying to find a solution to them as opposed to before I'd give in to them and not buy anything or buy the lowest calorie thing I could find" (709 – 711),* inferring that she is able to identify and recognise her Punitive Critic and challenge the associated feelings with this mode.

Anne reflects upon how her challenging of the eating disorder voice has led to her seeing herself as human, indicative of identification with this part:

> I didn't see myself as human before I just kinda seen myself as a walking failure (…) and now like you're a whole person and taking it all into account and really thinking it's a lot less accusative…and it's a lot more nurturing and nourishing and being more forgiving and seeing myself as human and I've don't think I've done a huge amount wrong, obviously I've done things what are wrong but I haven't killed anyone.
>
> (Anne, 770 – 777)

This quote highlights the extent of the eating disorder voice and suggests in this instance, it is her Punitive Critic. Prior to being able to challenge the critic, Anne did not view herself as human and referred to herself as a *"walking failure"* – this is likely due to repeated messages from her inner critic that she was a failure. The fact she states that she has not killed anyone, suggests how critical this voice can be, but equally, could be the role of dark humour. Whereas now, Anne is demonstrating a realistic vulnerability, accepting that she has done wrong in the past, but realising that she is human, and it is ok to make mistakes. It is likely that given by the words used, the inner critic was how Anne perceives the eating disorder voice; she states it is now nourishing and nurturing, whereas, before, it was not.

Each participant interviewed identified with the eating disorder voice some identified it as an Inner Critic and some as the Eating Disorder Overcontroller and some felt able to name it

and confront it. Participants were able to recognise when this voice was activated and whilst working through schema therapy, some have been able to challenge the voice, indicative of a developing Healthy Adult mode.

5.4.4 Group Experiential Theme: Recovery

As participants engaged in schema therapy, they experienced a change in themselves. Through this lived experience, we are witness to the autonomy they experience in their journey to recovery. This theme explores the elements of recovery important to participants.

Sub-Theme: Finding Inner Child.

Participants described a growing sense of control and personal agency throughout their journey and explored the connections to their inner child; described by Ian *"the importance of being vulnerable and being vulnerable in a healthy way" (332 – 333)* signifying he is allowing himself to sit with feelings of vulnerability. It is through the therapist's acknowledgement of his experiences that he starts to feel safe in exploring his vulnerability and soothing his inner child, *"in my head they're set identities, so we talk about Vulnerable Child and Healthy Adult Ian and about trying to…get vulnerable Ian healthy Ian thinking when these events happen" (289 – 291)*; highlighting the importance of understanding schema modes and how expressing these can lead to catharsis.

Conversely, Ian simultaneously reports he is finding it difficult to connect to his inner child, *"little Ian was scared, vulnerable, had a wall up and now as an adult, is finding it quite hard to connect with that child so erm…one of my homework is that I have to get lots of pictures of me as a child and put them on my fridge and it's about trying to emotionally connect again" (534 – 537).* The metaphor of having a wall up is important as though the wall is there to block the emotional connection between adult and little Ian. He is distancing himself from how he was a child, and it is likely that he still has that wall up now between adult Ian and little Ian. However, he appears keen to identify his inner child and is working towards building an emotional connection with him.

In schema therapy, chairwork has been used as a method to help clients identify what their inner child needs, *"we gave them names…we sat them on a chair and worked out why they were there" (Billie, 516 - 517)*. *'We'* establishes the importance of the therapeutic relationship and how vital it is in working towards finding Billie's inner child. Naming modes is significant as this enables Billie to identify and work with the modes in her life and emphasises that they are part of her. By doing this, Billie has been able to create a scenario in which she can talk to each mode and work out their role; this has been beneficial in helping her find her inner child and acknowledge what she needs.

Similarly, Harriet explains how chairwork has enabled her to become familiar with her inner child, *"the corner chair is the Vulnerable Child" (396);* however, the idiom of putting her in the corner is suggesting that her Vulnerable Child is naughty. The Vulnerable Child is being punished for being active; as noted earlier in her narrative, she sees it as weak to feel vulnerability. The Vulnerable Child is separate from her other modes and is taking a metaphorical back seat when it comes to mode work; often being in a corner is a situation that is difficult to get out of. Harriet is acknowledging her Vulnerable Child, nonetheless, feels the need to banish her to the corner.

Nevertheless, later in her narrative, Harriet explains how schema therapy has enabled her to understand herself and acknowledge her schemas, *"understand myself some more just by kinda like finding out about different schemas and like identifying them and then in turn like because that's kinda allowed me to be more open and more vulnerable I think it has improved relationships…" (550 – 553)*. She is sceptical when discussing schemas and her vulnerable side; the repetition of *'kinda'* implies she is still struggling to acknowledge that she has a vulnerable side. Evidenced by the fact her Vulnerable Child has the corner chair. Yet, by exposing her vulnerable side to others, she has noticed an improvement in interpersonal relationships; through the development of her therapeutic relationship, she has been able to find her inner child, bring out her vulnerability, thus, strengthening the Healthy Adult mode.

Moreover, Gertrude identifies with her inner child, *"I think Happy Child is when I'm, um, when I'm not even conscious of my train of thought she's like, it's like true joy, whereas Vulnerable Child she, she gets joy from the things she learned to get joy from (…) when I do well on a test" (214 – 217)*. When referring to Happy Child, Gertrude refers to her in the first person, in the present tense, whereas Vulnerable Child is referred to in the second person; suggestive she is becoming more attuned to her Happy Child and distancing herself away from her Vulnerable Child. She is still aware when both are active and can distinguish them.

Sub-Theme: Managing Emotional Needs.

Participants highlighted how schema therapy had enabled them to acknowledge feelings that they may have previously inhibited, thus leading to a greater understanding of their own emotional needs, *"it's been incredibly helpful to understand my little side (…) we worked out my little side is about eighteen months (…) we've been working with her to try and self-sooth" (Clare, 171 – 172; 284 - 285)*. She describes the ways in which she soothes her little side, *"I have um, a massive elephant (…), I literally go, if I'm really overwhelmed, I will go and lie on my bed and hug this elephant and then we got to the stage of adding a dummy cos I still suck my thumb" (285 – 288).* The mechanisms used are consistent with the age of her little side. This demonstrates that Clare is working with and soothing her Vulnerable Child by recognising these uncomfortable feelings, whereas previously, *"my Vulnerable Child, I'm aware when she's around now um, I wasn't really before" (305 – 306);* however, throughout her narrative, she vacillates between Helpless Surrenderer mode and adaptive modes, for example when she spoke of surrendering to the dragon earlier in her narrative.

Previously, Clare expressed feeling detached from her Vulnerable Child, *"recognising vulnerability of little side trying to help her because, I get so rejecting and NO I DON'T CARE, F*** NO, I don't care" (415 - 416).* The use of a profanity suggests how strongly she feels in terms of rejecting her little side; juxtaposing "*the more I do on focusing she's alright and telling her it's ok, um that's when things go better, I think with food*" *(415 - 418)* therefore,

demonstrating the benefits of schema therapy in enabling Clare to sit with and explore her vulnerability. This appears to have been difficult as she described a "*Detached Protector that is queen of everything*" *(261).* Referring to this mode as a 'queen' demonstrates how strong this mode is for Clare and how fighting against it has enabled her to access her little side.

Correspondingly, Diane spoke of how schema therapy had enabled her to address how she would treat a child, "*I found some things helpful like not wanting to hurt a vulnerable child, not wanting to harm a child, not wanting to starve a child of food*" *(97 – 99).* This alludes to a strong Healthy Adult mode in that she has recognised that her previous coping modes were primarily maladaptive. She repeated this throughout her interview at multiple intervals, inferring that she no longer utilises maladaptive coping; evidenced by her answers in SMI-ED (Simpson et al., 2018) where she scored highest on two adaptive modes (Table 9).

Ian spoke in detail of how he has learned to find his inner child and acknowledged the feelings this brought:

> These are schemas that you've developed as a child that you then…you're a child and you dunno how to deal with the world so you just develop these schemas to look after yourself, it's how you get through, then you become an adult, you don't need to look after yourself in that way…you're skilled enough in life to do it…but you still hold on to these schema erm…that you have because that what you learned as a child and that is just…that linkage for me.
>
> (Ian, 350 – 356)

Ian begins by addressing schemas in second person *"you've developed"* and uses past tense until the last sentence. Although he can identify his schemas/modes and their origin, he is distancing himself from the boy he once was by referring to himself as 'you' and talking in the past tense. He has been able to create the connection between the past and present. It is this linkage that has enabled Ian to understand his emotional needs. When he described the link,

Ian placed his hands together on the video recording symbolising bringing Little Ian and Adult Ian together, allowing them to meet; suggesting that Adult Ian is looking after Little Ian.

Gertrude echoed this:

> Healthy Adult Gertrude was sat on the couch with perfectionist Gertrude, she was sat in like a business suit wanting to be thin, wanting to have the perfect hair, wanting to be perfect, and little, child Gertrude was sat on the floor, playing, as a child, and just being able to have that dynamic as us being two parents looking after that child, what we would want for the best for that child and how to go forward.
>
> (Gertrude, 349 – 354)

Through her narrative, we can see Gertrude begin to acknowledge her healthy side and the dynamics between her Healthy Adult and Overcontroller mode. She refers to her modes in the third person, detaching from them and viewing them as separate parts to herself and putting herself in the position of the child. It is likely that she has mirrored her healthy and perfectionist modes on herself and sees her true needs as the child playing on the floor. By doing this imagery, she has been able to view things from an alternative perspective and manage the emotional needs of her inner child in this way.

This sub-theme captured the ways in which schema therapy has enabled participants to understand their emotions; thus, leading to management of emotional needs in a primarily adaptive way.

Sub-Theme: Ambivalence.

Ambivalence and uncertainty around client's eating disorder recovery was experienced by all. Ambivalence was experienced in terms of eating disorder behaviours and overall perspectives around recovery, creating an internal battle, life with an eating disorder versus life without an eating disorder.

Ambivalence around recovery was consistently expressed throughout interviews, *"food was my worst enemy but also my best friend…I wanted to starve myself and be as skinny as I*

possibly could but bingeing all the time" (Billie, 48 - 50), inferring a Compliant Surrenderer mode in which she is appeasing the Overcontroller by engaging in these behaviours, despite feeling she is in a battle. Referring to food as her best friend is interesting, as early in her narrative she remarks how she was bullied and did not have a best friend at any time in her life; inferring she used food as a way of managing this, which could explain the ambivalence around letting go.

Ambivalence was further echoed by Clare:

> You can't hold on to this and the feeling after throwing up for the first time after a long time gives you a kind of mania, I always find I feel really powerful so, there's that oh God I don't wanna do this but on the other hand that was really great.
>
> (Clare, 597 – 600)

Clare begins with the pronoun *'you'* and is detaching herself from the experience of purging; opposing to where she switches to first person and identifies as feeling *'powerful.'* This change in dynamic is interesting as although feeling powerful, she suggests that being unable to hold on to the urge she is experiencing infers a loss of control. The use of the words *'power,' 'mania'* and *'great'* are positive connotations associated with the purge and how Clare feels afterwards. However, she is conflicted as she does not want to purge, nevertheless, is overcome by the compulsion to do so. There is an internal battle between her Eating Disorder Overcontroller and Detached Self-Soother; her Detached Self-Soother is triggered, and it is this that leads to the binge.

Moreover, Harriet reflected on her journey, *"I can see the path I just haven't started the path yet" (403).* The metaphor of a path suggests that this path is new, it would be easier to walk on the old path that she knows; each step on the new path will be challenging and requires motivation to keep going. The new path is in the distance, nevertheless, is reachable and it is evident that Harriet wants to start this new path although, is apprehensive. She follows on by discussing her Vulnerable Child, *"allowing, letting that internal dialogue to actually be heard and it's almost like giving it permission" (417 – 418)*; by allowing her Vulnerable Child to be heard

and guide her down this new path, she is recognising the importance being vulnerable can bring. Yet, Harriet does refer to her Vulnerable Child as *'it,'* almost detaching from her. There is some ambivalence around this new path Harriet is looking towards as she is apprehensive about acknowledging this side of her. However, by giving this side permission, she is allowing herself to feel vulnerable and accepting this side of her that she has not previously had.

Both Jane and Fiona expressed their experiences with ambivalence:

> I don't think I'm quite there yet…if you were here and said let's go to the café, I fancy a bit of cake, do you want some? For me to go aye I'd have some, whereas I'd panic and before and I can't do that cos I haven't factored that into everything I've had, and I'll have to skip something.
>
> (Jane, 726 – 729)
>
> It's more management rather than full recovery cos I just, I'm just not sure that's programmed into us as people what have *pause* issues with food, I don't like to say problems cos I think they get easier, and you change, you learn, and different times in your life you learn…it can impact you more, but I'll never say never.
>
> (Fiona, 637 – 641)

For Jane, recovery is having freedom with food, she is striving for this, yet simultaneously, reflects how she is finding this challenging. Fiona talks about living with her eating disorder; the use of the word *'programmed'* infers it is difficult to change her mindset and that she is learning to manage her behaviours, not completely eradicate them. However, she does state, *"I'll never say never,"* suggesting promise and hope. Both Jane and Fiona articulate how their eating disorder can impact them in different situations in their lives, however, it is how they respond to these situations that suggests that they are challenging their eating disorder. This sub-theme was present in all participants as everyone discussed positively working towards recovery, but highlighted ambivalence around this.

5.5 Study One Discussion

There were marked diversities within the study group who may not have been representative of people with eating disorders in general. One participant was from Australia, one from Wales, two from Scotland, and six from various areas of southern England. Despite these differences in sociocultural backgrounds, all participants described similar experiences of schema therapy and its concepts. Perhaps more important to consider is that schema therapy is not widely available on the NHS and only two participants were receiving NHS based therapy. Moreover, participants were in therapy for varying durations (3 months to 3 years). Therefore, some participants may have had a more articulated understanding of schema therapy than others. Additionally, there was only one man in the group. Men are under-researched and under-represented in eating disorder research. IPA is suited to handling diversity because it is idiographic and, despite differences, participants data suggested commonalities regarding schema therapy and provided an articulate understanding of their EMS, modes, and the eating disorder voice. Future research could select a less diverse participant group.

The aim of this study was to gain an in-depth understanding of experiences with schema therapy with people with an eating disorder, focusing on their understanding of schema modes and the eating disorder voice. To date, this area of research has been explored only minimally, especially qualitatively. Previous research in this area has primarily used quantitative measures (e.g., Simpson et al., 2010), the qualitative research that has been conducted, has not used IPA, and has focused on BPD (e.g., Kellogg & Young, 2006; Tan et al., 2018) and the research utilising an IPA approach has used case studies, focusing on experiences of schema modes in eating disorders (Bowker, 2021; Edwards, 2017a; 2017b). Thus, there is a gap within the literature to explore experiences of schema therapy in those with an eating disorder with particular focus on experiences the eating disorder voice and schema modes. In the subsequent section, the key findings will be considered in light of the questions above and discussed in relation to existing theory and evidence base.

5.5.1 Adverse Experiences

Research has long suggested that traumatic life experiences, including CSA, CEA, and neglect, are risk factors for eating disorders (e.g., Fischer et al., 2010; Kent & Waller, 2000; Kimber et al., 2017; Waller et al., 2007). It could be that the eating disorder has developed a way of protecting oneself from harm (e.g., binge eating to soothe oneself or restricting calorie intake regain a sense of control). From this perspective, it is reasonable to hypothesise that the eating disorder has developed with a protective intent; often leading to an amalgamation of EMSs and schema modes that exacerbate the eating disorder (e.g., Detached Self-Soother bingeing to soothe the Vulnerable Child, leading to compensatory behaviours), and perpetuate the eating disorder voice (e.g., with an increase in negative, critical thoughts about oneself).

Trauma and Maltreatment/ Detachment and Dissociation.

The narratives found that all participants, except Jane, had experienced some form of trauma or maltreatment in their early life (e.g., bullying or sexual assault). This finding is consistent with previous research that those who have experienced trauma in early life are more at risk to developing an eating disorder at some time in their lives (Brewerton, 2007; Brustiengh et al., 2019; Groth et al., 2020). It is likely that the EMSs and schema modes experienced by participants have developed as a result of these experiences (Young et al., 2003).

EMSs and schema modes are often misused in adult life and may develop into default coping modes when a person experiences similar feelings to when they were a child. A default mode is a mode that is relatively stable for clients (Edwards, 2022). Sometimes, this mode can be perceived as an adaptive mode because it is how the person normally presents or responded to situations. Nonetheless, it is often a maladaptive coping mode that has been engrained from a young age that it is how participants respond to situations, it becomes their way of being, which is why it can be mistaken for an adaptive mode. This is reflected in the findings. In those diagnosed with a bulimic disorder (Clare, Emma, Billie, Anne, and Ian), Detached modes were common default modes, particularly Detached Protector. As seen in Ian

where he will bunker down and detach from the world, this could be perceived as ‘usual Ian behaviour’ but it is in fact, a coping mode. Whereas, in those with restrictive disorders (Gertrude, Diane, Fiona, Harriet, Jane), the Eating Disorder Overcontroller was frequently experienced as the default mode. This mode has been found to be elevated in those with a diagnosis AN (Bowker, 2021) and acts as a coping mechanism to control food, shape, and weight, when everything else may seem out of control.

Additionally, detachment and dissociation could be perceived to be a form of default mode. As with previous literature, (Rabito-Alcon et al., 2020), findings of this thesis imply that dissociation has developed in participants as a coping mechanism following childhood trauma. Childhood trauma affects the individual’s relationship with their body. This is reflected in the results. Of the participants who described childhood trauma or maltreatment, the same participants reported experiencing detachment or dissociation at some point in their lives.

Psychological Functions of Food and Eating.

Within qualitative literature, eating disorders and the eating disorder voice are thought to provide a perceived function such as providing comfort (Tierney & Fox, 2010) and a sense of control (Fox et al., 2011) in the early stages of the disorder, yet can become more hostile as the illness progresses (Williams & Reid, 2012). The findings of this study suggest that those with bulimic disorders reported the eating disorder to be one that provides comfort in times of distress, akin to the Detached Self-Soother mode. However, this attempt to soothe can become maladaptive as it can perpetuate high levels of distress; demonstrated by Gertrude who reported feeling ‘disgusted’ after bingeing.

The findings propose that many participants also experienced ‘guilt’ and ‘shame’ following bingeing and were likely to engage in compensatory behaviours – demonstrated by Billie who self-induced vomiting after drinking a milkshake. The link between shame and bulimic disorders has been found previously (Keith et al., 2009). Whereas those diagnosed with AN

(Gertrude, for example), found their eating disorder to provide them with a sense of control (Eating Disorder Overcontroller), thus, providing a psychological function.

The psychological functions of the eating disorder voice was introduced in this subtheme. Participants remarked how they could not live without it despite being aware of how critical it can be and described the various ways in which it is experienced: as an addiction (Anne and Billie), as a devil (Fiona) or as an inner critic (all). Thus, proposing that it has a function in those with an eating disorder.

Thus, answering the question, are schema modes and the eating disorder voice experienced as being separate from self? Participants experienced schema modes and the eating disorder voice as part of their reality, albeit phenomenologically separate. This theme suggests that schema modes and the eating disorder voice are experienced as internal parts of self often having developed from adverse early life experiences.

5.4.2 Interpersonal Relationships

Those with an eating disorder often recall interpersonal difficulties from an early age (Allen et al., 2013); this was reflected in the accounts of participants who recalled bullying, difficulties at school and at home. Within this theme, the counterbalance of a good, therapeutic relationship was also explored.

Difficulties in Family Relationships.

Interpersonal difficulties are proposed to maintain eating disorders (Fairburn et al., 2015). Previous research has reported a link between negative parenting experiences such as emotional abuse and invalidation, and eating disorder pathology (Talbot et al., 2015), this was evidenced in narratives (Fiona, Anne, Ian, and Clare). High maternal over-protection and low paternal care have been linked to Defectiveness/Shame and Dependence EMSs (Turner et al., 2005); for example, it is assumed Fiona’s experience with her father (e.g., his criticalness towards her) could have led to the development of her Defectiveness/Shame EMS.

Eight out of ten participants in this study had a Defectiveness/Shame EMS as scored on the YSQ-2SF (Young, 1998), yet only Jane had a Dependence EMS, and she was not included in this subtheme. Jane also had an Enmeshment EMS, as did Gertrude, who was also not included in this subtheme. Both Jane and Gertrude discussed heavy parental involvement in their lives and awareness of their Enmeshment EMS; for instance, Jane stated she rarely did things without approval from her parents first, such as shopping; Gertrude became a carer for her parents, and they became heavily enmeshed in her life. Enmeshment has been found consistently in those with an eating disorder, particularly, AN (Elmquist, 2015; Unoka et al., 2010); Jane and Gertrude had a diagnosis of AN. It could be that both Jane and Gertrude did not experience difficulties in interpersonal relationships due to this schema. Enmeshment could, therefore, represent a maladaptive way to feel protected.

The results are supported by evidence that EMSs and coping modes may elucidate the relationship between adverse childhood experiences and the onset of eating disorder pathology (Brown et al., 2016; Sheffield et al., 2009; Turner et al., 2005). Theoretically, EMSs are proposed to cause interpersonal problems through maladaptive coping; for example, if someone is bullied by peers, they may develop a Mistrust/Abuse schema, making it difficult for them to trust people later in life, and thus, develop a Detached Protector mode (e.g., Billie). In Detached Protector, people shut down and withdraw from their emotions as a coping technique (Young et al., 2003); often due to unmet needs, in Billie's case, being socially excluded. Due to fear of exclusion, Billie detaches when this threat is present, leading to disruptions in future interpersonal relationships as she believes people will leave her, due to her Mistrust/Abuse schema, and thus, detaches to avoid exclusion. Therefore, supporting the schema therapy model that EMSs and modes reflect early adverse interaction patterns, leading to interpersonal difficulties later in life.

Importance of the Therapeutic Relationship.

The goal is for clients to internalise a Healthy Adult mode, modelled by the therapist, which can fight EMSs and inspire healthy behaviour (Young et al., 2003). The importance of the therapeutic relationship is at the centre of schema therapy and has been demonstrated in previous research (Tan et al., 2018); this was echoed throughout each of the participants' interviews. The aim of schema therapy is to strengthen the Healthy Adult mode and weaken the maladaptive coping modes (Young et al., 2003). This can be accomplished by providing a safe place for clients to access their vulnerable side and tune into their Healthy Adult. As demonstrated by participants, providing a safe place was perceived as a fundamental aspect of the therapeutic relationship. Participants reflected on how this has enabled them to tune in to their Healthy Adult, to both nurture their Vulnerable Child, and challenge their coping modes. This view was regarded as something specific to schema therapy, as throughout narratives, participants elucidate their previous therapeutic experiences as not being particularly helpful.

5.5.3 Self-Awareness

Interoceptive awareness is defined as the ability to identify, understand, access, and respond appropriately to patterns of internal signals (Craig, 2014). Previous research suggests that those with an eating disorder have poor interoceptive awareness (Taylor et al., 1996) in identifying and responding to their body's emotional and physical cues. Contrasting, this study found participants articulated good interoceptive and self-awareness regarding schema modes and the eating disorder voice. Good interoceptive awareness provides a distinct advantage to engaging in life challenges and ongoing changes (Craig, 2014), this was reflected in narratives as some participants articulated their awareness of their maladaptive modes and the needs of their Vulnerable Child.

Attunement to Modes.

The findings in this research support and elaborate upon the mode structure identified in the schema therapy theory and illuminate the idiosyncratic nature of schema modes; demonstrated by Edwards (2017a; 2017b) and Bowker (2021). The results of this study found

that eight participants were able to articulate and understand when a particular mode was activated; of the two that did not, they spoke of an inner critic, which could be perceived as a mode, but was more suited to the eating disorder voice within the context of their narratives, this is explored in the subsequent section. Modes were primarily experienced as internal parts of self with awareness around the different parts of the self (e.g., Billie and Clare with their teams). Coping modes and critic modes were the modes that participants were mostly aware of, very few were aware of their Vulnerable Child mode.

Many participants were unaware of their Vulnerable Child mode, primarily at the start of therapy; some even refused to acknowledge they had a vulnerable side and appeared shocked when their SMI-ED score for this mode was high. It is intriguing to know why this is; perhaps due to fear of being perceived as weak (suggested by Harriet) or defective (inferred by Clare) if this vulnerability were to be exposed. Previous research has found all types of eating disorders to have a significant Vulnerable Child mode (Masley et al., 2012; Talbot et al., 2015). Although common in the literature, only 4/10 participants (Emma, Gertrude, Ian, and Jane) scored highly on this mode. This is interesting as in Harriet and Clare experienced a Vulnerable Child Mode in their narratives yet did not score highly on this mode.

Identifying the Eating Disorder Voice.

Maladaptive modes including the critic modes and coping modes were widely acknowledged by each participant. Some modes, including Punitive Critic, Demanding Critic, and the Eating Disorder Overcontroller, had similarities to the eating disorder voice.

Understanding and awareness of these modes was prevalent in all ten participants. Participants frequently articulated the Punitive Critic mode to the eating disorder voice; it is likely that this is due to the critical and frequently punitive nature of the voice. Pugh and Rae (2019) also suggest that the eating disorder voice is an inner critic. Some participants also expressed how they felt their Demanding Critic mode echoed their eating disorder voice, demanding them to restrict calorie intake or to engage in compensatory behaviours as a way of achieving

success or to rectify previous mistakes, with 7/10 experiencing this mode. Thus, the findings suggest that the voice is a form of critic encompassing both punitive and demanding elements.

Furthermore, the Eating Disorder Overcontroller as the eating disorder voice has not been found in previous research, yet was conveyed across narratives, with participants describing engaging in compensatory behaviours to provide a sense of control. The results of this study infer that the eating disorder voice manifests itself in various schema modes, predominately as a form of critic or Overcontroller. Therefore, suggesting that the eating disorder voice is another way of describing schema modes in action or perhaps, the eating disorder voice is its own mode related to eating disorders.

5.5.4 Recovery

Recovery is subjective. Participants in this study said they felt they would be into recovery, for example, if they could go to a café and have cake and not ruminate (Jane), be at peace with themselves (Billie), or to manage their eating disorder in an adaptive way (Fiona). There was a general sense of ambivalence expressed throughout each narrative. The elements of the recovery process important to participants are illuminated below.

Finding the Inner Child and Managing Emotional Needs.

As explored, the goal of schema therapy is to strengthen the Healthy Adult mode; this appears to be positive and is specific to schema therapy as it places onus on weakening the maladaptive modes to aid in recovery. Throughout narratives, we see participants working towards their Healthy Adult mode and acknowledging its role in recovery. The literature depicts a different picture and suggests that those with an eating disorder have primarily maladaptive modes with little adaptive modes (Pietrabissa et al., 2020; Talbot et al., 2015). However, this could be because previous research utilised quantitative measures, whereas this research captured experiences of schema modes qualitatively and illuminated client’s growing relationship with their adaptive modes.

Moreover, this theme emphasised participants' journey to finding their inner child and the management of their emotional needs in an adaptive way. Prior to schema therapy, many participants stated they would go to their 'default mode' to soothe their inner child, which was often a maladaptive way of coping and at detriment to the Vulnerable Child. Whereas, due to schema therapy, many are working towards soothing their Vulnerable Child in an adaptive way, such as Clare, who previously engaged in bingeing and purging behaviours, now has her elephant to soothe triggered EMSs.

Ambivalence.

Accounts of recovery varied throughout the participants; however, all ten participants expressed a level of ambivalence, and many seemed reluctant to give up their eating disorder. Ambivalence has long been linked to hindering recovery from an eating disorder (Pugh, 2019; Williams & Reid, 2010) and this was evidenced throughout this study. Particularly with Fiona, who remarked she does not think she will ever be fully recovered but is learning to manage and live with her eating disorder. Such experiences may shed some light on the low recovery rates for eating disorders, particularly AN, as it seems that restrictive symptoms can have a powerful personal salience.

5.6 Reflexivity

Professor Reid observed my first interview; this was beneficial as her feedback provided me with areas to focus on such as allowing flexibility with the interview schedule and letting participants guide the interview. Professor Reid's clinical and academic experience provided me with confidence in subsequent interviews and although my Unrelenting Standards EMSs was activated, I believe that this was a positive as I endeavoured to complete the interviews to the highest standards to ensure participants voices were heard.

During the interviews, participants described trauma, abuse, and suicidality in their past which made for difficult listening. However, from working in a crisis team and being an expert by experience, I have developed a robust set of coping mechanisms and was able to manage any

challenges that arose emotionally. There were times when participants experiences mirrored my own and quotes such as: *"I had to get so bad before things got picked up"* and *"you don't realise how much self-hatred it takes to make yourself throw-up"* had a profound impact on me. I was grateful to my supervisory team be able to discuss these matters and found the process of reflexivity helpful in articulating my thoughts and own recovery.

Reflexivity enabled me to bracket off when conducting the analysis; having lived experience enhanced my analysis as I felt I had a deeper connection to participants. I did not share my experiences due to the competitive nature of eating disorders and because it was their experiences I was focused on. Following analysis of the transcripts, I sense checked my interpretations with my supervisory team to ensure I was not guided excessively by my own lived experiences.

Across participants, Unrelenting Standards was the highest EMS, as is well-known in the literature both as unrelenting standards and the more common term perfectionism. Compliant Surrenderer was the highest scoring mode, which is a novel finding. When asked about it, participants seldom recognised or identified with this mode, identifying more with Detached coping modes, regardless of diagnosis, thus supporting the transdiagnostic approach.

5.7 Conclusions

Participants highlighted how they felt able to understand the function behind their eating disorder; often as a coping mode, which is beneficial for future work with clinicians in order to assess its function. Additionally, clients articulated their vulnerability and the role the Vulnerable Child has in their life, although many were reluctant to accept this part of them, they conveyed a growing awareness of this part. The awareness of vulnerability enabled participants to soothe themselves in an adaptive way, thus, also strengthening their Healthy Adult mode. Participants experienced schema modes and the eating disorder voice as part of themselves, something that was within them, but also phenomenologically separate in that they would create dialogue with them and create teams of modes to guide them through life adversities.

Despite participant similarities, their experiences were quite diverse. Internal entities varied in number with key modes being some form of Overcontroller, a critic mode, some form of Detached mode and, generally masked by them, a Vulnerable Child which the maladaptive modes may have evolved to protect. Interestingly, all participants recognised and identified with the eating disorder voice. Findings add to evidence that schema therapy is beneficial in treating eating disorders. Specifically, the mode model could be helpful in treating and understanding them. Furthermore, phenomenological methods of inquiry for investigating modes seem to be useful, particularly as IPA captured the important dynamic aspects of modes. Future research could develop these findings and explore the effectiveness of schema therapy for eating disorders with an emphasis on modes and the eating disorder voice.

Following the results of this study, two further studies were developed. A follow-up study explored client's experiences 12-18 months on from the initial interview (Chapter Six). A further study explores schema therapists' experiences of delivering schema therapy to those with an eating disorder, see Chapter Seven.

Chapter Six: Schema therapy as a toolkit, not a cure. A longitudinal follow-up

6.1 Introduction and Methodological Rationale

Following preliminary examination of the data from people treated with schema therapy (Study One, Chapter Five), it was decided that a qualitative longitudinal follow-up would be of interest after participants had received additional, or possibly completed, schema therapy. The aim was to explore potential changes that may have occurred because of additional schema therapy. This study explores changes in schema modes and the eating disorder voice alongside changes in how participants identify with these phenomena and any personal changes in participants experienced in their eating disorder recovery journey.

This study sought to address:

- Are there any changes in how participants experience schema modes and the eating disorder voice?
- Are there any changes in how participants identify with schema modes and the eating disorder voice?
- What do participants feel personally has changed in the last 12-18 months [e.g., in their recovery journey, relationship with food, impact of treatment]?

Longitudinal qualitative research (LQR) can answer questions about the lived experiences of change over time (Calman et al., 2013). In contrast to longitudinal quantitative methodologies, LQR emphasises individual narratives, capturing important moments and processes in their experiences. IPA was re-employed to explore lived experiences at two time points of schema therapy for those with an eating disorder.

When using Longitudinal IPA (LIPA), it is important to decide if it is being used to obtain depth or to investigate a longitudinal change (Flowers, 2008). In this study, it was to investigate longitudinal change. IPA's idiographic commitment focuses on the meanings of a phenomena as they arise for an individual in a particular context. It is this detailed focus that can reveal the

changing meaning of an experience as it is lived through a person's trajectory, thus, by using longitudinal research, temporal experiences of schema therapy for eating disorders were brought to light during the analysis, with emphasis on schema modes and the eating disorder voice. LIPA is therefore well-positioned to explore a range of temporal experiences (Farr & Nizza, 2019), including therapeutic interventions. However, the current literature is limited.

Longitudinal research on treatments of eating disorders is scarce, predominately quantitative and focussed on treatment for AN. For example, Rossi et al. (2022) found insecure attachment to be a predictor of poor treatment outcomes in CBT-E in those with AN at a year's follow-up (*N*=123); Terache et al. (2023) explored the effects of Multi-Family-Therapy for AN (*N*=150). They found improvement in BMI and eating disorder symptoms at six- and twelve-months, thus, Multi-Family-Therapy could be a promising treatment for AN. Calugi et al. (2017) investigated the impact of CBT-E on those with severe and enduring AN (SE-AN; *n*=32) and on AN (*n*=34). At six- and twelve-months follow-up, they found improvements in BMI (>18.5) and general psychopathology in both groups, suggesting it is beneficial for those with AN and SE-AN. These studies emphasise the importance of longitudinal measurement to observe changes.

There are even fewer LQR studies exploring eating disorders. At the time of writing, only one used IPA. Eli (2014) explored experiences of eating disorders and recovery in (*N*=13) Israeli adults in 2005/06 and again in 2011. Inpatient care was found to have profound impact on patients' lived realities with key themes capturing ambivalence. By developing a protective, ambivalent positioning, participants recognised their eating disorder identity and connected with others on the ward, whilst simultaneously asserting a non-disordered identify and distancing themselves from the ward; participants were both a part of and apart from their community. This study highlights the benefits of LIPA in eating disorder research in capturing experiences over time, thus, suggesting that more research of this type is needed.

Current longitudinal schema therapy research predominately focuses on EMSs and modes, using quantitative measures. For example, longitudinal studies have found EMSs to be

predictors of PTSD and anxiety (Calvete et al., 2015; Edworthy et al., 2008) and to have an impact on attachment type over a 15-year period (Simard et al., 2011). To date, the only research to investigate longitudinal impacts of schema therapy was carried out by Lolkema (2022), who assessed the relationship between functional schema modes (Happy Child, Healthy Adult), and wellbeing at the end of inpatient treatment in those with personality disorders. Treatment outcomes including functional modes, emotional wellbeing, psychological wellbeing, and social wellbeing that were assessed two to eight years following treatment. Inpatient schema therapy was found to increase functional modes, positively impacting mental well-being, change in personality pathology and societal functioning. Although promising, this research did not look qualitatively at client's experiences, indicating a gap in the literature.

None of the aforementioned schema studies utilised qualitative methodology, nor did they focus on those with eating disorders. Therefore, there is a gap in addressing qualitative experiences of schema therapy over time for those with an eating disorder. The following study sought to fill the gap by re-interviewing participants who had taken part in Study One, to explore any changes in their experiences of schema therapy, focusing on schema modes and the eating disorder voice.

6.1.2 Participants

The same eligibility criteria from Study One was applied.

6.1.2.1 Recruitment and Sampling.

All participants from Study One were invited for a follow-up interview twelve to eighteen months later. Of the (N=10) that were contacted, (n=5) took part. Five participants are considered methodologically sufficient for conducting IPA in a robust manner (Smith et al., 2009; Smith et al., 2022), but it should be noted that the outcomes for those who declined to participate may have been very different.

6.1.3 Interview Development Schedule

The questions were developed following Smith et al.'s (2009) approach to interview construction. The decision of whether to use the same or alternative interview schedules across time in longitudinal designs has an impact on the sort of data collected (Farr & Nizza, 2019). In the follow-up, questions asked about their experiences of schema therapy, while also focusing on any changes that may have occurred.

To explore participants' lived experiences and any changes with their eating disorder and schema therapy, open-ended questions were developed to provide a phenomenological map. The funnelling of questions across the interview schedule allowed participants to provide narrative across their whole schema therapy experience and any changes they felt may have occurred, with focus on schema modes and the eating disorder voice. It was important to ensure the interview was participant led.

Additional questions focused on participants EMSs and schema modes based on their answers to the quantitative questionnaires, for example, *'you scored highly on Emotional Deprivation 12 months ago, this seems to have decreased, do you recognise this? If so, can you tell me more,'* still ensuring the participant was leading the interview. A copy of the interview schedule can be found in Appendix F.

6.1.4 Procedure

Participants were asked to complete the same three questionnaires (YSQ-2 SF, SMI-ED, and EDI-3); some participants declined to complete the weight section of the EDI-3 as they found the questions to be triggering (e.g., *what is your current weight?*) Following completion of the questionnaires, participants were invited to an online interview via Zoom to discuss their experiences with schema therapy, and to discuss things that had changed or stayed the same, with focus on schema modes and the eating disorder voice. Confidentiality and anonymity were explained at the start of the interviews and participants were informed they did not need to answer any questions they did not feel comfortable with. Interviews were recorded and

participants provided written and verbal consent for this. Participants consented to their verbatim quotes being used in dissemination of research. Participants were sent a debrief following completion and were given a £15 Amazon Voucher for their participation.

6.1.5 Data Analysis Process

The analytic process set out in Chapter Five (Section 5.3.4) was followed, with data being analysed using IPA (Smith et al., 2009; Smith et al., 2022).

6.2 Results

Interview times ranged between 35 and 75 minutes. The mean age of participants was 32.60 years (*SD=6.87*). Self-reported BMI ranged from 16.3 to 35.4 with the mean being 25.33 (*SD=9.59*); this may be skewed as two did not wish to disclose their weight. All participants were from the UK. To ensure safety of participants, participants were asked to confirm in the consent form that their BMI was >15 at any time in the study. Each participant confirmed this.

Table 12

Demographics for Longitudinal Study

Participant*	Diagnosis	Age	Gender	Height (CM)	Weight (kg)	BMI
Billie	BN	27	F	170.2	Unknown	Unknown
Gertrude	AN	25	F	154.9	Unknown	Unknown
Fiona	AN	32	F	164	64.7	24.3
Ian	BED	41	M	172.7	106	35.4
Jane	AN	38	F	165	44.4	16.3

*Pseudonyms from study one were retained

The following subsection is a snapshot capturing each participant’s journey since their first interview.

Billie is no longer having regular schema therapy but arranges an appointment if she feels something is not quite right. For instance, following a relationship breakup, she sought support. She reported an overall increase in awareness of schema modes and was able to convey her needs in contrast to interview one, where she referred to feeling confused about her emotions. In contrast to her initial interview, Billie had increases in: Vulnerable Child, Undisciplined Child, Demanding Critic, Detached Self-Soother and Helpless Surrenderer modes. She had a decrease in Compliant Surrenderer and Happy Child. Billie understood her changes in EMSs and modes and was able to describe this in her narrative. She had a reduction in Unrelenting Standards and Defectiveness EMSs and increases in Emotional Deprivation, Failure to Achieve, Enmeshment and Entitlement EMSs.

She reflected that her relationship with her eating disorder voice was turbulent at times, but manageable. There was an increase in her relationship with her Healthy Adult. No schema modes were scored as highly significant, this reduction could possibly be due to schema therapy. Billie completed the EDI-3. Many of her responses to the EDI-3 were low scoring; this could be demonstrating her recovery journey.

Fiona is no longer receiving schema therapy but is receiving eye movement desensitisation and reprocessing (EMDR) therapy. Since the initial interview, Fiona described rebuilding a relationship with her father following her parents' divorce. Fiona expressed an improvement with her Vulnerable Child, being able to access and, more importantly, listen to this mode. She reflected upon her relationship with her eating disorder voice and felt increasingly able to challenge this voice by *'turning the volume down.'* Generally, Fiona's understanding of schema therapy was more articulate than the first interview. This is reflected in her interview where she actively uses schema terminology in discussing her EMSs and modes. Interestingly, Fiona's scoring on the YSQ2-SF was consistent since her first interview. She described how schema therapy has given her the tools to work with the different parts of herself; supported by her SMI-ED scoring as no modes were now high. Fiona had a reduction in her

Eating Disorder Overcontroller, Happy Child, Detached Protector and Self-Aggrandizer modes. Many elements of her EDI-3 scoring had decreased or stayed the same, with few scorings highly, this is reflected in her narrative and the way she experiences her eating disorder.

Gertrude is no longer having schema therapy and is receiving support from a life coach who supports her by giving her tasks such as *'eat three snacks a day.'* She finds this a more practical approach as she often referred to schema therapy as, '*airy fairy.'* Akin to other participants, Gertrude too reported an improved relationship with her inner child. There was still some hesitancy around this part, perhaps because she was uncomfortable with this part of her. She demonstrates a subjective increase in her Healthy Adult and states she can take care of her inner child. Her EMSs were generally consistent with some fluctuations including an increased Vulnerability to Harm; however, Gertrude attributed this to the pandemic and the current affairs in the world. Her modes were similar in both interviews, yet there were increases in Detached Self-Soother, Eating Disorder Overcontroller and Demanding Critic. She did not wish to complete the EDI-3. Gertrude reflected on how she been kinder to herself following a recent illness, seeking support from her mother, which would not have done previously.

Ian is engaging in regular schema therapy. Ian has a new job and reflects on his growing relationship with his mother, after previously describing her as cold, he considered her to be instrumental in his recovery journey. Throughout his narrative he conveys his changes in EMSs and schema modes, why he thinks that may be, and uses more schema terminology. Ian's scoring on the YSQ2-SF were fairly consistent with some new EMSs scoring highly including Dependence, Vulnerability to Harm and Subjugation. Mode wise, there was an increase in coping modes, including Eating Disorder Overcontroller, Detached Self-Soother and Helpless Surrenderer. He states he is aware of this as in his own words, he is experiencing a 'blip.'

He states he has noticed the biggest change in his relationship with his Vulnerable Child. His coping modes are relatively stable; he can articulate their development and the purpose they serve him. Similarly, he reports he has worked on his inner critic and although still

a very prominent mode in many areas of his life, he feels better equipped to challenge it when this mode is active. Although high scoring in some areas (e.g., low self-esteem, interpersonal alienation), across many areas, his EDI-3 scores had decreased.

Jane, in contrast to her first interview, reported a subjective increase in her adaptive modes and was more articulate when describing her modes. She reflected that schema therapy is beneficial but difficult to apply to everyday life. When looking at the complimentary quantitative data, there were no changes in Jane's EMS, but increases in her Vulnerable Child and coping modes. In both interviews, Jane viewed her eating disorder voice as one of the challenges that she faced and did not feel that it had changed. In the EDI-3, eating disorder risk composite, low self-esteem, interpersonal alienation, emotional dysregulation, asceticism, and maturity fears were elevated. This was reflected in her narrative. Jane was recently discharged from hospital where she was receiving inpatient treatment, including schema therapy for her eating disorder. She is currently awaiting community support. Her scoring could be attributed to this change as she describes hospital as a safe place and home is where she struggles.

Overall, participants experienced distinct changes in relationships with their schema modes, the eating disorder voice, and their eating disorder. The quantitative measures were used for supplementary information for qualitative questions and participants were asked if they agreed with the changes reflected in the quantitative measures. The changes in EMSs and modes were similar across participants, regardless of diagnosis, with at least one coping mode being clinically significant for participants. There was a notable increase in Vulnerable Child too, however, this could be attributed to client's deeper understanding of the role of this mode. Regarding EMSs, the increases were varied for each participant, and some remained consistent (e.g., Unrelenting Standards, Emotional Deprivation, Self-Sacrifice). See Table 9 (Chapter Five, page 137) and 13 for quantitative changes.

Table 13

Participants highest scoring EMSs and Schema Modes at follow-up

Participant	Highest EMSs***	Clinically Significant Modes (3+)	High Modes (4+)
Billie	Emotional Deprivation, Abandonment, Mistrust/Abuse, Social Isolation, Failure, Enmeshment, Subjugation, Self-Sacrifice, Insufficient Self-Control, Entitlement	Vulnerable Child, Undisciplined Child, Demanding Critic, Detached Self-Soother, Compliant Surrenderer, Helpless Surrenderer	N/A
Fiona	Emotional Deprivation, Mistrust/Abuse, Defectiveness/Shame, Self-Sacrifice, Emotional Inhibition, Unrelenting Standards, Insufficient Self-Control	Undisciplined Child, Eating Disorder Overcontroller, Detached Self-Soother	N/A
Gertrude	Failure, Vulnerability to Harm, Enmeshment, Subjugation, Self-Sacrifice, Emotional Inhibition, Unrelenting Standards	Vulnerable Child, Detached Self-Soother, Eating Disorder Overcontroller	Demanding Critic, Compliant Surrenderer

Participant	Highest EMSs***	Clinically Significant Modes (3+)	High Modes (4+)
Ian	Emotional Deprivation, Social Isolation, Defectiveness/Shame, Dependence, Vulnerability to Harm, Subjugation, Emotional, Inhibition, Unrelenting Standards, Insufficient Self-Control	Undisciplined Child, Compliant Surrenderer, Eating Disorder Overcontroller	Vulnerable Child, Detached Protector, Detached Self-Soother, Helpless Surrenderer
Jane	Abandonment, Social Isolation, Defectiveness/Shame, Failure, Dependence, Enmeshment, Subjugation, Self-Sacrifice, Emotional Inhibition, Unrelenting Standards, Insufficient Self-Control	Demanding Critic, Detached Protector, Helpless Surrenderer	Vulnerable Child, Punitive Critic, Eating Disorder Overcontroller, Compliant Surrenderer

**Highest scoring modes were Vulnerable Child, Detached Self-Soother, Eating Disorder Overcontroller and Compliant Surrenderer (*n*=4) in each. Highest EMSs included: Insufficient Self-Control, Subjugation and Unrelenting Standards, (*n*=4) in each.

Following an interpretative analysis of participants' accounts, four GETs and subthemes developed, following participant's journey of schema therapy (Table 14). 1. 'Making Sense of Schema Therapy' illuminates experiences of adaptive modes and the tools learned, but also highlight challenges experienced. 2. 'Friend or Foe?' is a particularly powerful theme

demonstrating participants increased understanding of their eating disorder and the way in which it is perceived as a friend. 3. 'Connecting with Parts of Self' encapsulates participant's experiences with schema modes, emphasising an increased understanding and connection. Finally, 4. 'Barriers to Recovery' highlights barriers encountered in their journey to recovery. Themes and sub-themes will each be explored in turn. Line numbers are denoted in parentheses after each quote and refer to the individual transcripts.

Table 14

Group experiential themes and subthemes at follow-up

Group Experiential Themes	Subtheme
1) Making Sense of Schema Therapy	1a) Strengthening of Adaptive Modes
	1b) Challenges in Schema Therapy
	1c) Schema Therapy as a Toolkit, not a cure
2) Friend or Foe?	2a) "The eating disorder is your friend, not your enemy"
3) Connecting with Parts of Self	3a) Connecting with One's Vulnerable Child
	3b) Recognising Maladaptive Coping Responses
4) Barriers to Recovery	4a) The Eating Disorder Voice
	4b) Expectations and Behaviours from Others

6.2.1 Group Experiential Theme: Making Sense of Schema Therapy

This theme illuminates the increased experiences of adaptive modes, in particular the Healthy Adult, as seldom was this mode mentioned in the first interview. This theme also captures the positives and negatives experienced over time with schema therapy, highlighting changes that have occurred.

Sub-theme: Strengthening of Adaptive Modes.

Each participant reported a subjective increase in their adaptive modes. This was experienced in many ways including: managing their coping modes and responding to the activated child modes by means such as nurturing Vulnerable Child or implementing boundaries for Angry or Undisciplined Child.

Firstly, Fiona experienced a distinct shift in narrative in the way she views food, exercise, and her appearance:

> I'm learning to self-sooth more, it's not about food, it's about what do I need, what do I want and taking it away from food cos that's what I've used in the past (…) I still exercise over-excessively but I enjoy that now, it's not about how many calories can I burn, it's about moving, making myself feel better so there has been a shift in the way I think about it.
>
> (Fiona, 226 – 235)
>
> You need to accept your body is what it needs to be, not what you want it to be (…) I shouldn't fit my clothes…my clothes should fit me.
>
> (Fiona, 477 – 481)

By employing a first-person pronoun, Fiona emphasises the focus on herself and how she addresses the needs of the Vulnerable Child. She reflects on her background and describes a change in experience that has profoundly affected her relationship with herself, her eating habits, and exercise, suggestive of her Healthy Adult mode. She switches pronouns in the second extract, this could be assumed to represent the negative side of diet culture in the media and how frequently it distorts one's perception of self, leading to beliefs we should look a certain way. On the other hand, this could be her Healthy Adult addressing her inner child, accentuating the need for acceptance of who she is, supported by the change to a first-person pronoun.

Ian too, experienced a shift in his narrative following additional schema therapy, *"I'm in such a better place (…) I do beat myself up a lot less so as I say I've gone into this mode now [detached], I recognise it, ok I'm overeating again (…) I know it will pass so I'm not beating*

myself up as much (…) this might be a dip for me, I'm managing it a lot lot better than I would have done" (441 – 446). The positive language echoes his change in narrative, symbolising the strengthening of his adaptive modes. He is consciously aware he is currently experiencing a 'dip' and reflects how he may not have recognised this previously; thus, solidifying his adaptive modes. Similarly, Gertrude said *"just being like you're ok, you're ok keep going, keep going…no one is going to hurt you" (382 – 383)* suggesting development of her Healthy Adult. The use of the pronoun 'you' appears to be actively addressing her Vulnerable Child, providing reassurance and support, indicative of acceptance of this side.

Moreover, Billie described a change with her relationship with AN, *"I don't think I could have anorexia again even if I tried cos, I like myself now and I think that has stemmed from that kind of being your own best friend type internal dialogue thing" (371 – 373).* This suggests that her Eating Disorder Overcontroller mode has weakened too, supported by her scoring on the SMI-ED (Simpson et al., 2018). Abandonment and Social Isolation were two of Billie's most experienced EMSs, here she states she is working to heal these by becoming her own best friend and the Healthy Adult that she needs. The ability to create an internal dialogue is likely attributed to chairwork, thus, one could assume that schema therapy has enabled this growth of Billie's Healthy Adult.

Jane vocalised an increase in her Healthy Adult mode *"I would say my Healthy Adult is definitely stronger" (87 - 88),* however, she remains ambivalent:

> Makes complete sense to me when I'm in hospital and basically, I can do it, I can do it, I can eat what's put down in front of me, I can gain the weight, I can have therapy and it starts to make sense.
>
> (Jane, 321 – 323)

The repetition of affirmations *"I can"* implies a battle between adaptive and maladaptive modes. Her Healthy Adult is trying to reassure her that she can gain weight and engage in therapy, however, there is some resistance from her coping and critic modes. From this extract,

it is reasonable to assume that in a hospital setting, she experiences less maladaptive coping and can access her Vulnerable Child mode and subsequently, have her needs met. Contrasting, outside of hospital is where her needs appear to be unmet, indicating that hospital is a safe place. Throughout her account, Jane expresses her fears of making an incorrect decision *"I don't trust myself enough to make these decisions and I don't want to make the wrong decisions, I feel I can't do anything on my own" (74 – 76),* whereas, in hospital, decisions are made for her, thus alleviating the fear of making a mistake. It is likely that this lack of autonomy is hindering the growth of her adaptive modes.

This is supported later in her narrative where Jane ruminates on her experiences with adaptive modes:

> I'd be the first to say to someone else in my position (…) what the Healthy Adult saying like look at what, look at what you've lost, look at what you can achieve if you can just keep the weight stable, look at what you can do, look at what you can achieve but for me? It's one rule for me and one rule for everybody else.
>
> (Jane, 589 – 593)

The comparison in how Jane views herself to how she views others is striking. The emphasis on achievements suggests she views herself as a failure, supported by her high scoring on the Failure to Achieve EMS on the YSQ2-SF (Young, 1998). In contrast to her earlier narrative where she refers to her Healthy Adult as *'my Healthy Adult,'*, she refers to it as *'the Healthy Adult'* which could be interpreted two ways. Firstly, that her eating disorder overpowers her adaptive modes, particularly when alone. Alternatively, it could be perceived that this is her Healthy Adult talking to her, supported by the repetition of *'you,'* telling her what she could achieve. She reflects on the barriers to accessing her Healthy Adult, *"there is a bit of a rebellious child in me and the reasons for that and how I can try and target that and try and make the Healthy Adult side to the front a bit more" (211 – 213).* Her Rebellious Child mode does not wish to abide by her Healthy Adult. Indeed, this quote implies that her Healthy Adult

has taken a backseat and is not as prominent as it could be. Nevertheless, there is now engagement with her Healthy Adult mode, a notable contrast to her initial interview, whereby mention of her Healthy Adult was absent.

This subtheme encapsulates participant's experiences in the strengthening of their adaptive modes, emphasising a change in narrative, with prominence on increases in participant's Healthy Adult mode. The narratives do not explicitly mention the Happy Child mode; however, the extracts above suggest an increase in this mode.

Sub-theme: Challenges of Schema Therapy.

Ambivalence around imagery was expressed as a challenge as participants found it difficult at times to connect to their Vulnerable Child, presumably due to the associated memories. Financial implications and practical applications are also discussed with some participants finding difficulties in applying schema techniques to everyday life.

Firstly, underlying tones of ambivalence have continued throughout participants' journeys. This time, ambivalence was centred around connecting to one's Vulnerable Child and the use of imagery in doing so. The intense emotional hold imagery entailed is discussed:

> Changing that memory to something nice…erm…so that has…that has…yeah I quite enjoyed that side of it…I just…I don't like going back there so I normally do it like my therapist takes me back there in a safe environment.
>
> (Fiona, 273 – 275)

Fiona described difficulties in her childhood in the previous chapter, which could explain her apprehension about revisiting this part of her life. She presents as ambivalent; one could assume this is because she has distanced herself from her past. The breaks in speech emphasise her trepidation about connecting to her Vulnerable Child. Although challenging, Fiona recognises the benefits of this technique.

Gertrude described her experiences with imagery and compares this to her current support:

> It can be quite hard if you're not in that mental space to have imagery (…) I think that's why I like this other method [life coach] …oh you've got a thought? **Slaps hands together** here's one tool that fits all just opposite actions, opposite actions, instead of just being like where does that sit in my little world.
>
> (Gertrude, 372 – 376)

Gertrude described the *'other method'* as a practical approach, where she does not ruminate on her schema modes and instead, engages in practical activities to distance herself from the emotions associated with her modes, *"I've been struggling to push myself to have different kind of snacks, so she'd [life coach] be like pick something random and you're having it three times a week or you're going to a café by yourself three times a week, just do it" (357 – 359)*, distinguishing this new approach from schema therapy. She utilises quick, distraction techniques, emphasising that she does not want to access her *'little world'* due to the associated negative memories encompassed in her Vulnerable Child and perhaps to avoid her Demanding Critic. Unlike Fiona, Gertrude does not display ambivalence and instead shuts down the thoughts before they can occur, mirroring a Detached Protector mode. Arguably, she experiences Detached Protector as a default mode, as it appears that it is masquerading as her Healthy Adult, creating a sense of safety, when in fact, it is creating distance between Gertrude and her Vulnerable Child.

The accounts of Gertrude and Fiona emphasise the emotional toll imagery can have. Gertrude's speech is very pressured, suggesting that she is wanting to remove the thought as quickly as it arrived and not engage in imagery. Whereas Fiona is being guided by her therapist into the unknown to rescript the memory into something positive – both participants highlight the challenges faced in imagery.

A further challenge was the lack of practical advice given, including financial affordability, "*I haven't actually really been having therapy since we last spoke…I've had…I kinda did my stints and erm I can't really afford it" (Billie, 8 - 9)*, or supporting of daily living skills *"I think itself,*

it's a really good tool to unpack things erm…but it was kind of…the skills I learned I wanted to put into practice and I wasn't getting that from therapy" (Gertrude, 31 – 33), which they felt would have been helpful to their circumstances. One could speculate that this focus on practicalities may itself been related to an Avoidant Protector process, however, it could represent a genuine practical need that was unmet by their schema therapy.

Schema therapy was also felt to be complex:

> Just the fact that if it is going to be approachable method to use going forward…it needs to be clear, simplified (…) it's in-depth which is good and bad so I don't know how it could be simplified into a little tool kit and I guess it's different for every individual. (Gertrude, 369 – 378)

In her narrative, Gertrude stated she would like a *"set of instructions to follow I guess rather than discussing and speaking and recognising" (336 –337)*, emphasising the challenges she experienced with schema therapy. It could be interpreted that Gertrude is seeking a faster solution, in contrast to ruminating on her EMSs and modes, this is reflected in her account, *"opposite action, opposite action *slaps hands together* nope, not listening to that [negative thought]" (226 – 227).* The act of slapping her hands together infers she is squashing the negative thought or snapping out of a negative thought spiral and is thus, not allowing herself time to think about it; Gertrude is taking control of her thought before it controls her.

Contrasting, Ian seldom expressed any negative experiences, *"very helpful at the moment to understand all the triggers, (…) what's going on as to why I'm feeling very detached mode at the moment erm so yeah still very useful, still very helpful, still within the participation" (24 – 27).* The use of positive language reflects Ian's experiences; he suggests that schema therapy has provided him with the tools to articulate his emotions. However, like other participants, Ian stated that one challenge was imagery, *"to go back (…) and converse with vulnerable young Ian and soothe him in some way and try to have those conversations with him and for me that's the most challenging aspect" (198 – 200).* His Vulnerable Child is consistently

referred to in the third person, inferring that he is distancing from this part of him. There are underlying tones of fear as though he unsure what to say or how to soothe his Vulnerable Child, noted by the pressured speech. However, it is clear in his narrative that he is making the effort to connect with his Vulnerable Child.

This subtheme encapsulated challenges participants experienced with schema therapy including the emotional toll of imagery work and the practical and financial implications. It is likely that the challenging aspects are not necessarily a limitation of schema therapy and may be around participants' avoidance of discomfort, particularly with regards to imagery.

Sub-theme: Schema Therapy as a Toolkit, not a Cure.

This subtheme captures experiences of schema therapy as a helpful toolkit to utilise in challenging times. Billie reflected upon her time with schema therapy, *"I got given a lot of tools in therapy, through therapy and through my own stuff which I lean on I guess…when things get tough" (42 – 44).* Although she is no longer regularly involved in schema therapy, she has the skills to progress in her recovery journey. Correspondingly, when asked about her recovery journey, Fiona said, *"when I think I can't do it [recovery], I can't love my body so I'm just going to go back to my safe little bubble and nobody bothers me, I can just do my own thing, food and exercise…but what if you can live a better life, what if you can love your body?" (525 – 528).* Initially, she portrays elements of a Detached Protector mode; it is likely this is a default mode that is employed to take her back to safety when sensing a perceived threat. However, there is a noticeable shift in her narrative. Her safety bubble pops, creating initial panic but this allows her to explore positive situations in the future, whereby she can love her body, indicative of a Healthy Adult mode. This contrast is striking to the initial interview where she did not think she would reach this stage in her journey, *"more management rather than full recovery, I'm just not sure that's programmed into us as people what have issues with food, I don't like to say problems cos I think they get easier" (637 – 641),* accentuating the tools she has, to knock down this coping mode and build her Healthy Adult.

Billie further conveyed how schema therapy has enabled her to address her concerns:

> I talked to my friend about it and we kinda said we opened that box, there's a big box inside of me that's got all this stuff in it, and it's been opened, and everything has come out and I feel like maybe the reason is that I feel I've addressed everything in that box. (Billie, 74 – 77)

Schema therapy has allowed Billie to open her box and has provided her with the toolkit to manage these things now they are outside of her box. There is relief and contentment in her narrative that these things are no longer locked away. Billie recognises that her *"stuff"* does not need to be boxed up inside and can be addressed with the right tools. The repetition of *"everything"* emphasises the impact that schema therapy has had on addressing her challenges, Billie now appears to be at peace with the *"stuff"* that was once in the box.

Moreover, both Gertrude and Fiona, respectively, described the decreased volume of their eating disorder voice *"I guess it's quieter" (Gertrude, 221)* and *"it's still there but I turn the volume right down" (Fiona, 344).* The significance of turning it down exerts the control they have over their eating disorder voice. Fiona described a situation in which her voice was activated following a weekend away *"I got weighed and was like OH MY GOD the world has ended, and she [therapist] was like but it hasn't, you've just drunk loads, eaten loads, your body is just fluctuating, that's natural so then I was like right ok, get off your high horse, you're ok, so I think it's not perfect but I'm getting there" (518 – 522).* Immediately, Fiona catastrophises the situation, one could assume this is operation of her eating disorder voice berating her for enjoying food. It could be interpreted that the use of the idiom *"get off your high horse"* is Fiona's Healthy Adult directly addressing her eating disorder voice, followed by reassuring her Vulnerable Child that she will be ok. The switch from talking about her therapist's perspective to her own suggests that she views her therapist as the Healthy Adult who can reassure her Vulnerable Child, whereas she soon realises that she has that ability within her to be her own Healthy Adult, challenge her eating disorder voice and soothe her Vulnerable Child.

Ian reflected upon how he was able to understand the development of his EMSs and the impact on his eating disorder, *"catch twenty-two situation where I eat food to soothe and then I get really upset at how big I am which then triggers me to eat more food so that's kind of the defective thing" (Ian, 83 – 85).* He alludes to an internal battle whereby the mechanism of self-soothing assuages the defectiveness, yet the aftermath of this mechanism consequently augments his defectiveness. However, Ian later states *"schemas are consistent generally I'd say but it's more the impact they have on my life that are dictated by the modes" (121 – 123).* Schema therapy has facilitated Ian to develop an insight to his EMSs and the modes that expedite these. For instance, when feeling vulnerable, it is probable this triggers his Defectiveness/Shame EMS, leading to self-soothing behaviours, further perpetuating the severity of those feelings. Ian's experience provides support for schema therapy giving him the tools to understand and recognise his EMSs and their triggers.

Gertrude provided an overall ambiguous experience with schema therapy, *"the good thing about the therapy, it reminded me, you're not 'fixed'… I don't think I am 'fixed' [Gertrude demonstrated quotation marks when she said fixed]" (22 - 25).* She is no longer having schema therapy and said, *"every time, I went through I was like this patient, and I was ill" (14 – 16).* On the one hand, it could be interpreted she found it beneficial to be a patient as she could be cared for and thus, fixed and have the needs of her Vulnerable Child met. On the other, she highlights how she was no longer benefitting from schema therapy and has expressed challenges with the approach, *"I wanted more practical set of instructions to follow I guess rather than discussing and speaking and recognising" (334 – 337)*; unlike other participants, she felt as though she was unequipped with the tools. Following schema therapy, she said *"this kind of work coach kind of came in and gave me the brutal tools to be like right ok now I'm not feeling sorry for myself here we go" (330 – 332).* The word *'brutal'* is harsh compared to how she describes schema therapy, it could be interpreted that she wanting to punish herself for feeling sorry for herself, this is supported further by how she felt following a task from her coach to

attend a café alone, *“feel the pain do it anyway” (362),* analogous to Compliant Surrenderer mode. Whereas the way she describes schema therapy is much softer but was not the practical set of tools she believed she needed.

One could theorise that additional schema therapy has enabled participants to develop a toolkit to assist them in building their Healthy Adult mode, whilst also aiming to knock down their maladaptive modes. This subtheme illuminates the individual preferences experienced with schema therapy and that it is not for everyone, although there are improvements in adaptive modes, there are still challenges.

6.2.2 Group Experiential Theme: Friend or Foe?

During the second interview, participants referred to their eating disorder as a friend, acknowledging its function in their lives. This theme also captures the eating disorder as a ‘foe’ with the following subtheme encapsulating the raw vulnerability experienced by participants.

Sub-theme: “The eating disorder is your friend, not your enemy.”

Although negatives were experienced, schema therapy enabled participants to express their vulnerability, understanding the role their eating disorder has played in their lives. From this perspective, participants experienced their eating disorder as serving a function. One of the functions was a coping mechanism. Those with bulimic disorders conveyed the function as being soothing in nature. When faced with emotional distress, behaviours associated with bulimic disorders provided comfort:

> Sometimes I have binges that haven’t been emotionally triggered just oh sh** I ate too much and now I feel guilty and need to get rid of it…I think if it’s an emotional one, it tends to repeat itself.
>
> (Billie, 267 – 269)

It could be interpreted that the eating disorder is Billie’s friend informing her that something is not right; thus, bingeing is a physical manifestation of these feelings to soothe the distress experienced. The repetition of the binge emphasises the magnitude of the problems

faced, she further states *“those are the times I’ve gone back to see [therapist] and said look I’m bingeing all the time I need your help” (269 – 270).* This proposes that the role of the eating disorder is one of coping with emotional dysregulation, to help alleviate uncomfortable feelings.

Moreover, Billie’s experiences illuminated her new relationship with the way she views her eating disorder as something with protective intent, *“the eating disorder is your friend, not your enemy; it’s there to protect you and keep you safe” (306 – 307).* It is likely that due to the bullying Billie experienced in her childhood, her eating disorder developed as a coping mechanism with a protective intent behind it; it has been there for her when she felt most alone, keeping her from being isolated. She emphasises that social isolation and abandonment are big triggers for her; thus, one could hypothesise that her eating disorder developed to keep her safe from this, supported by the below extract:

> The eating disorder is the by-product as how I was treated as a child so that’s the mind-set that my child relates (…) it’s like you’re fat, no one likes you, therefore you need to never not be fat again, that’s what little Billie created I guess, that’s how she is feeling.
>
> (Billie, 363 – 366)

Her Vulnerable Child feared abandonment and rejection and one could assume that this led to the development of an eating disorder as a source of protection. This continued into adulthood, likely as a way of protecting Billie from being bullied and excluded. The language used *‘my child’* is personal and suggests gratitude to her inner child for protecting her. Referring to her eating disorder as a friend emphasises the profound impact on sustaining her protection.

Jane too, experienced her eating disorder as serving a protective function:

> The purpose it’s served it’s kept me being looked after; it’s kept my mom and dad in my life.
>
> (Jane, 537 – 538)

One could assume that Jane’s eating disorder has provided her with protection from being alone. She alludes to not having a strong emotional connection with her parents, *“hugs*

and that, we never did have that growing up" (41 - 42), suggesting that her eating disorder has developed as an away to elicit care and ensure the needs of her Vulnerable Child are met. Therefore, she repeats she is *"digging her heels in" (93, 161, 204, 217)* four times throughout her narrative to avoid perceived abandonment and keep her parents in her life, *"the eating disorder is a way of keeping…keeping my mom and dad quite close" (196 – 198).* Jane further states, *"I can kinda see what purpose it's served and why I'm so reluctant to kind of give it up" (529 – 533).* There is a contrast in how Jane talks about her experiences with her eating disorder compared to her previous interview in that there is almost a sense of relief in that she has understood why her eating disorder is still so prevalent in her life.

Recognising the eating disorder's purpose has enhanced some participants understanding of its development and the role it has in their lives and was experienced as a 'friend.' Nevertheless, there were reflections of the eating disorder as a 'foe':

> I can easily tell you how it affects me negatively, in terms of I overeat, I feel ugly, I socialise less, I get apprehensive about socialising.
>
> (Ian, 82 – 85)
>
> As much as I'm clinging on to it, I know that it's, it's essentially ruined the last maybe ten years of my life.
>
> (Jane, 552 – 553)

Jane demonstrates insight to the negative side of her eating disorder, simultaneously, there is a reluctance to let go. One could interpret that this is because of the purpose it has served as her 'friend;' yet, she follows with *"I don't have a job, I've lost a couple of friends, I'm not driving (…) it should be enough for me to say I'm not doing this anymore and eat what I want and keep my weight stable but sometimes it's not enough" (556 – 584). "It's not enough"* creates a sense of panic and hopelessness. One could assume that because she believes she has lost many things in her life that her eating disorder is the only positive thing in her life, which could portray it as a friend. This belief is maintaining the eating disorder as she fears that

without it, she may lose her parents too. It is likely to be that because the eating disorder has long been perceived as serving a purpose, there is ambiguity and fear around letting go. Jane knows what happens if the eating disorders stays but does not if it goes away; there is comfort in that, even if it is detrimental to oneself.

Participants' eating disorder had become such an important part of their lives, that to be without it, would be difficult. There is also an increased sense of awareness of the role the eating disorder has played in participant's lives that was not present in Study One, suggestive of things that have personally changed for participants in their recovery journey.

6.2.3 Group Experiential Theme: Connecting with Parts of Self

Following a deeper understanding of their eating disorder and the ways in which was a 'friend,' participants experienced a deepening connection to their schema modes, predominately their Vulnerable Child mode and coping modes. This theme encapsulates a change in how participants experienced and identified with schema modes.

Sub-theme: Connecting with One's Vulnerable Child.

Previously, modes were experienced as an abstract concept, whereas in this study participants are connecting with the different parts of themselves in their lifeworld. In Study One, many participants expressed 'finding their inner child' and articulated awareness that they each encompassed a child mode. Nevertheless, there was a fragmented sense of uncertainty around this, with some participants not accepting this part of them, perhaps due to fear of being perceived as vulnerable and the negative connotations clients associated with this (e.g., if I show vulnerability, I will get hurt). However, participants in this study noted a significant shift in terms of accepting this side; unless otherwise stated, the inner child refers to the Vulnerable Child. All but one participant scored highly on Vulnerable Child, and Fiona scored highly instead on Undisciplined Child, although she does allude to a Vulnerable Child mode.

Billie reported a substantial change in her relationship with her Vulnerable Child. As in the first interview, she describes her modes working in a team, emphasising the role of the carer to protect her Vulnerable Child:

> The carer comes in the most for me the person that says like it's ok I've got you like, sometimes when those triggers hit and you wanna curl up in a ball, my head comes in and says like I almost wrap my arms around myself like I've got you it's ok…it's ok…that sounds really cringey (…) and then together we get up and like because that is who is crying, you know the person is crying is five-year-old Billie.
>
> (Billie, 330 – 337)

'I' asserts Billie's identity with her Healthy Adult mode. The repetition of *"I've got you"* could be operation of her Healthy Adult mode providing reassurance to her Vulnerable Child. She refers to the foetal position when triggers are present, a position often associated with safety and comfort. This extract portrays awareness and a deeper connection to her inner child, contrasting her previous interview where it received little mention. It is important that the carer gets up when her inner child is ready, going at the child's pace so that EMSs are not exacerbated. She states, *"I think the eating disorder is the inner child" (319 – 320)*, suggesting that acceptance of the Vulnerable Child has enabled her to accept and understand her eating disorder. There is increased awareness of her Vulnerable Child's development.

Correspondingly, Ian describes his improved relationship with his Vulnerable Child, *"the main…erm path that I've taken and that has been successful is understanding vulnerable Ian" (179 – 180).* This quote suggests that Ian is being guided down the path to understanding and soothing his vulnerable side, yet the pause suggests some hesitancy around this. To enable Ian to connect with his Vulnerable Child, he has pictures of himself around his house to encourage and build this connection, *"we have a thing now where we have twenty photos from year one up to twenty years old" (204 – 205).* The ages are likely to reflect the different parts of Ian throughout the years, allowing him to engage with his younger self.

Fiona, too, was connecting with her inner child:

I've been working with the inner child to soothe her and let her feel listened to so we've gone back to what she wants to do (…) we played a game which sounds really stupid but a memory was, one Christmas, I got this game and I wasn't allowed to play it and all little Fiona wanted to was play the game so we went back and played the game so she was soothed and happy.

(Fiona, 254 – 261)

At her initial interview, there was very little mention of her inner child. However, Fiona now refers to her inner child in the third person, suggestive of a distance between her Healthy Adult and her inner child. The switch from first to third person infers that this is still a painful memory, one from which she distances herself. Her language is dismissive which could be an internalisation of how she was treated when she wanted to play the game, indicating an inner critic mode. Nevertheless, there is acknowledgement of her inner child. The switch from 'I' to 'we' is significant as it portrays Fiona working with her therapist to strengthen her Healthy Adult to soothe her inner child, indicating that she is learning accept that this child is part of her.

Gertrude described her improved connection with her Vulnerable Child:

That's just a part of me and there's another part of me that can take of that and it's not anyone else's responsibility to take care of that and I have the power within me….to nurture that child.

(Gertrude, 166 – 168)

I feel stronger in myself when I remind myself that there's that child in me that's me, that's scared, the vulnerable child, I have it within myself to also be a Healthy Adult and take care of her.

(Gertrude, 176 – 178)

Gertrude reminding herself that she has an inner child implies that she often forgets about this side of her, however, acknowledging this side brings about inner strength. She refers

to her child in the third person, creating a distance, suggestive of awareness, but not yet acceptance. However, this is still a noticeable change from her previous interview where there was little acknowledgement of this side, as it was often overshadowed by her perfectionist side, *"when I'm in the midst of the eating disorder, the perfectionist overcontroller or one of the other modes definitely is the one standing up, taking charge" (551 – 553).* Therefore, demonstrating an improved relationship with her inner child. The extracts above indicate that there is now room in her life for this side. Furthermore, Jane said:

> What am I needing? A lot of the time I just need to take a few minutes away and then maybe discuss it with my mom and just try and I don't know, get a hug or something. (Jane, 219 – 221)

There are two important parts of Jane's extract, firstly, the reference to her mom. Throughout her narrative, there is limited reference to her father in a singular way, suggesting he was emotionally absent at times. The comments about getting a hug are noteworthy as, Jane said *"we're not good at showing emotions, you know like hugs and that we never did have that growing up" (40 – 42),* likely fuelling the development of an Emotional Deprivation EMS. This has subsequently manifested into what adult Jane needs to soothe her inner child's needs. By recognising this, Jane portrays an improved relationship with her Vulnerable Child; it is worth highlighting there was no mention of her inner child in her first interview, further indicatory of a deeper connection to and identification of this side.

This subtheme illuminated each participants growing connection with their inner child. The contrast to Study One is striking and demonstrates a change in perception of this side. It is, therefore, reasonable to assume that this change has developed during the process of having more schema therapy, allowing participants to develop a constructive relationship with their inner child and identify this part of them.

Sub-theme: Recognising Maladaptive Coping Responses.

At both interviews, there was reflection on maladaptive coping responses and how they are centred around the needs of the Vulnerable Child. However, there is a difference in the way these are experienced by participants. For instance, Billie initially presented as confused, *"why am I bingeing all the time, why am I always performing for my parents, why am I like this, why am I…" (86 – 87).* The pressured speech mimics her urgency for answers, whilst emphasising the unmet need of her Vulnerable Child. However, she soon states that following more schema therapy she has been able to answer these questions, *"you start to realise why, why, why, why and I think that then creates a level of self-awareness in me" (87 – 89)*. Billie accesses support when needed *"it's really nice to know it's there when you need it" (94),* demonstrating increased recognition of coping responses and the understanding of preceding triggers.

This was further articulated by Ian, *"I think for me eating, this has been consistent and has been in my life through my teenage years as a coping mechanism" (143 – 144).* It is likely that this method of coping continued as it soothed the emotional pain he experienced in early life. From a schema theory perspective, it is likely this mechanism is Detached Self-Soother mode that has been consistent throughout his life. It is this recognition that differentiates his experience from the previous interview:

> I'm in quite a detached space and what is highly synonymous with that for me is eating, that is part of the detached process for me (…) when I'm in this mode and erm I would describe myself as erm…loss of control I wish I possessed otherwise.
>
> (Ian, 54 – 57)

It is reasonable to assume that Ian is oscillating between Detached Protector and Detached Self-Soother, creating a perpetual, detached cycle. Although they are both detached modes, they are phenomenologically distinct from another. For instance, when in Detached Protector he refers to blocking out the world, whereas Detached Self-Soother is associated with an increase in food consumption. The mode he is in depends on the needs of the Vulnerable Child. For instance, if his Vulnerable Child is scared, he tends to operate in Detached Protector

"another element is eating and properly binge eating like I'm going, I'm going to set aside the evening, I'm going to block out the world" (68 – 69). The repetition of *"I'm going"* emphasises Ian's determination in creating a plan to protect his Vulnerable Child. Whereas, if his Vulnerable Child is distressed, the mode will often be Detached Self-Soother *"I'm going to have a massive Chinese and tonne of chocolate" (70).* They are considered comfort foods, suggesting that his Vulnerable Child needs soothing. It is this recognition that differs from the previous study; there is a heightened sense of awareness around the different functions of detachment. The volume of food mentioned could be synonymous with the level of need experienced by his Vulnerable Child; the greater the distress, the higher the volume of food needed.

Additionally, Fiona expressed changes in the way she utilises coping methods, *"I'm trying to find more to life than food and exercise but when I'm stressed, I go back to that cos I don't know how not to" (182 – 183).* There is a sense of hope in challenging this mode, indicative of a change in thinking. She is aware of her default coping mechanisms, but simultaneously acknowledges they are not helpful and is actively working to change this. However, later, Fiona described herself as having a *"mini binge" (352)* and told herself, *"You need to go do something" (332).* Her speech is pressured, highlighting the distress she felt. The use of the pronoun 'you' is addressing her is personally and seems to be experienced internally. One could assume this is a manifestation of her father's voice, as in the first interview, Fiona recalled a traumatic event where her father *"put a load of food on the table and started shoving it in my mouth" (55 – 56).* Another interpretation could be that this maladaptive mode has developed in response to her father actions and thus, she needs to 'do something' – presumably a compensatory behaviour such as excessive exercise – to alleviate distress. Nevertheless, it is the awareness of this mode that distinguishes her narrative from the first interview.

Similarly, Billie said:

> I was dating, and he ended things (…) I was bingeing all the time like what's going on here and now he's gone (…) that's why I got back to [therapist] cos that's the sign for me which I imagine what it's like for an alcoholic when they start drinking again or a drug addict when they start using drugs like it's a sign something not is ok.
>
> (Billie, 275 – 281)

Billie portrays a realistic vulnerability, whereby she accepts bingeing is a sign that things are not ok. The act of bingeing is perceived to assuage the stress she is experiencing, so much so, she likens it to an addiction, a compulsion, something she must engage in. In her first interview, she also likened bingeing to an addiction and described having food in the cupboards as her version of *"crack" (880).* The analogy of addiction related behaviours implies that she views bingeing as an addiction, suggesting it is something she cannot control. She followed with, *"I think acceptance is a key thing like not trying to pretend I'm someone who's not had a mental illness" (292 – 294).* One could assume that this behaviour has served Billie a function in her life by alleviating distress and informing her that something is not right, thus prompting her to seek support, demonstrating change.

Coping modes are experienced as different aspects of the self, and thus, phenomenologically distinct from self. This is important as it emphasises a change from the previous interview whereby coping modes were not perhaps fully understood; now, there is a substantial change in the way participants convey their experiences of and respond to these modes, presumably as a result of schema therapy.

6.2.4 Group Experiential Theme: Barriers to Recovery

This theme relates to the challenges experienced throughout participant's recovery journey, encapsulating barriers such as the eating disorder voice and the behaviours and expectations of others.

Sub-theme: The Eating Disorder Voice.

In Study One, participants had reflected upon how they knew when their eating disorder voice was triggered. There were substantial changes in their responses to this voice, but it was still experienced as one of the most challenging parts of recovery. In Study One, the voice was experienced as the Eating Disorder Overcontroller mode or an inner critic, whereas in this study, it was predominately experienced as an inner critic; participants had more control over it. Throughout this subtheme, it will be referred interchangeably between the eating disorder voice and the critic.

Billie described challenges with her critic:

> It feels like you're a different person and you've got this demon inside you that that is that is taking over and it's really frustrating and it must be a case of your inner child versus the adult of your inner child like I just wanna eat I'm really sad or I'm really scared, and I need comfort.
>
> (Billie, 283 – 286)

Referring to this as a *'demon'* implies that before a binge, she experiences a possession like feeling and is unable to prevent this from occurring. One could assume that the *'demon'* is her Demanding Critic mode in that it wants the needs of her inner child soothed immediately, regardless of whether it is what her inner child needs. The switch between *'you'* and *'I'* infers that she is not herself when the *'demon'* takes over, suggesting it is a part of her she cannot control; whereas the use of first-person pronoun reflects what her inner child truly needs. There are no breaks in speech, suggesting the urgency to have the needs of her Vulnerable Child met. The urgency reflects the confusion about the true needs of her inner child. This extract suggests her eating disorder voice has phenomenological reality, it has been personified as a demon, thus, it is part of her world.

Additionally, Ian described an experience when he was confronted with his critic:

> I got loads of great compliments and over the last four, five years I've put the weight back on and that's really difficult for me to deal with, it's almost worse in a way because

> there's feelings of failure mixed in as well and in the autumn there was a couple of times I went out and I bumped into people I hadn't seen them for a few years and last time they'd seen me was when I was sort of a lot thinner than I am now and they'd seen me go fat to thin to then back to fat and two guys, separately two guys were like what went wrong.
>
> (Ian, 271 – 277)
>
> I am really affected by putting the weight back on because that was my fear that I would go out and like when I was fat because my inner critic would go if you go to a pub people would be like oh look how fat he is. There's an extra critic on top going yeah and those that saw you before are going to go look at him he's failed, look at the weight he's put back on.
>
> (Ian, 300 - 305)

Feelings of failure and defectiveness are prevalent in Ian's extracts. Society's perception of weight loss equating success appears to be a driving factor in Ian's critic. He attributes failure to weight gain, suggesting that his critic is predominately focused on his appearance. His critic is triggered more when other people vocalise what he feels about himself; the two guys have reinforced the messages from his critic, cementing it as a barrier. Ian laughs at the end of this. However, it appears to be a nervous laugh, indicative that this is a prominent barrier and a difficult conversation for him to have.

Moreover, Fiona experienced her eating disorder voice as a consolidation of Demanding and Punitive Critic modes. Speaking of an experience at work, Fiona said *"it picks up on stuff and hones in, it's ridiculous, they're not even talking to me, I'm at the other side of the office and I'm like whaaaat…. oh, for f*** sake stop…and then they'll bring biscuits and donuts and baking, and all sorts and I just think WHY" (369 – 373).* The eating disorder voice blocks out everything else and focus on Fiona's vulnerabilities. There is a sense of panic; the use of profanity and pressured speech accentuates her frustration with the voice. It could be interpreted that the

language used is her Undisciplined Child recognising that the voice is in action and fighting against it. It is noteworthy that the foods listed are generally perceived as treats and how upset she becomes by this. In her first interview, Fiona referred to this part as the *'devil,'* and now, *'it,'* the shift in narrative demonstrates that although a barrier, she feels able to challenge it and recognise when it is present. In some ways, Fiona's experience contrasts other participants as the reference to the voice as *'it'* suggests she can detach herself from this entity.

Billie reported an ambivalent relationship with her eating disorder voice, *"she's only mainly there, yeah, it's really hard, it's more a case of bad days, there's days where it's not there at all and she's there nonstop and you can't get away from her" (386 - 388).* There is ambiguity around her relationship with the voice and the impact she has in Billie's life; referring to the critic as a *'she'* suggests that the critic is a female manifestation from her past. Billie refers to her critic as *'she'* and *'it'* interchangeably; on the good days, it could be that the critic is an entity that Billie is aware of and can challenge. However, on her bad days, she personifies her as this critical female whom she cannot escape, or as referenced earlier, a demon, which could be representative of how she felt in childhood trying to escape her bullies.

Contrasting her first interview, Gertrude provided an alternative narrative on her experiences with her eating disorder voice:

> The strength to listen to what voices want and how to respond and that inner critic the fact the eating disorder isn't me and is just kind of rule-based thing that I've always kind of placed on myself.
>
> (Gertrude, 287 – 289)

This extract suggests that Gertrude has introduced her Healthy Adult mode to enable her to recognise and challenge her voices. One interpretation could be that the critical voices she describes are a consolidation of her critic modes, Demanding and Punitive, suggesting they are all parts within her. This recognition is a significant change since the initial interview in that she is listening and responding to the voices by blocking them out and not engaging with their

demands, *“block, block thoughts, opposite actions” (41).* By doing so, she is creating distance between herself and the voices, arguably operation of a Detached Protector mode. However, an alternative interpretation could be that this the acknowledgement and detachment from the critical nature of the voices is indicative of her growing Healthy Adult mode.

Each participant referred to their eating disorder voice as driving elements of disordered eating behaviour; the voice was often experienced as an amalgamation of Punitive and Demanding Critic modes. This yields for interesting discussion as although the voice was experienced internally by each participant, it was phenomenologically separate from the self and experienced as an entity they could talk to and respond to. This was perceived as a barrier to recovery as each participant reported that this was still a strong presence in their lives. However, this recognition is suggestive of participants developing Healthy Adult mode.

Sub-theme: Expectations and Behaviours from Others.

Participants emphasised the expectations and behaviours from those around them and how this sometimes hindered their recovery journey. It is likely this barrier could link to attachment theory, an underpinning of schema therapy, whereby these underlying beliefs about oneself are difficult to change as they are internalised from those whom participants have formed closed relationships with. Some participants scored highly on the Enmeshment EMS (Billie, Gertrude, Jane) which may account for this barrier.

Participants described how their family’s expectations were sometimes problematic, intensifying EMSs and maladaptive modes, *“expectation from family so that’s quite a hard one to kind of detach myself from” (Fiona, 128 – 129).* This was in reference to Fiona’s Unrelenting Standards EMS. Fiona was involved in competitive sports from an early age; thus, it is likely this EMS has been embedded, leading to the internalisation of perfectionism, fuelled by her family. Presumably, she may perceive herself as a failure if she does not continually reach these high internalised expectations - this was also reported in her first interview. It could be that some

EMSs are harder to change than others, particularly when they have been embedded from such an early age.

Billie also found her family had unrealistic expectations about schema therapy *"people have said to me…family members which I've found quite painful, they've said you still struggle sometimes so that's a waste of time…I was like that's not really fair to say" (160 – 162)*. At first, she states 'people' suggesting that she does not want to say it was her family; after hesitation she discloses it was her family who were dismissive. There are undertones of Failure EMS, evidenced by the feelings of pain experienced. She followed with *"you're not going to be better overnight" (164 – 165)*. These comments are likely to be a barrier to recovery as it may prevent Billie from seeking support when things are not right, due to perceiving it is a *"waste of time."*

Jane described enmeshment with her parents, which is a complex set of expectations:

> I'm very close to my mom and dad (…) [therapist] is trying to get them to take a step back but I am definitely digging my heels in with that and I'm terrified of them actually doing that (…) I think we're still very much together you know and I think that's where the stumbling block comes from I think that's what she was trying to say you know we could be…a little bit further removed from each other that might be, that might help me to grow and get past this little hurdle.
>
> (Jane, 158 - 178)

Jane is ambivalent about her enmeshment. She is 'terrified' of her parents stepping back and digs her heels in about this, yet she sees their closeness as a 'stumbling block.' Jane previously expressed how her eating disorder has kept her parents in her life, thus, cementing this as a barrier to recovery as she believes her eating disorder is the only way her parents will be there. She is unable to move forward due to the degree of enmeshment. At both interviews, Jane scored highly on Enmeshment EMS, it could be this EMS that is a barrier to recovery.

Moreover, other people's language, even when well meant, was sometimes misinterpreted by participants, likely due to a critic mode:

When people say to me 'you look like you've lost weight' and that's when that life trap comes back cos it says like it grasps onto it and it says they're telling you, you look good, and you need to carry on doing that or you won't get those compliments.

(Billie, 262 – 267)

(A 'life trap' is the term for a schema used in self-help materials (e.g., Young & Klosko, 1994).)

The nice comments I find it difficult to hear erm, you know you're looking well or erm…that, that does worry me (…) cos my head obviously goes to damn I've put on a lot of weight and that makes me feel really quite bad and makes me think what can I do to change that then and that, that's when things start to go wrong again.

(Jane, 245 – 263)

Such well-intentioned comments can trigger participants' inner critics and further exacerbate their eating disorders by triggering EMSs, including Unrelenting Standards and Failure. For critic modes weight gain is negative, so Billie believes that she will not get compliments if she does not continue to lose weight. Ian also felt that compliments about appearance were problematic, *"when I lose weight, I don't want people complimenting me, like I feel like why are you commenting on my weight (…) I don't want you to comment on my weight I don't want you to consider my weight in any way" (287 – 292).* The repetition of 'I' highlights the personal elements of these comments and reflects how they make Ian feel. Akin to Jane and Billie, there is a preconception that weight loss will be perceived as good and weight gain has negative associations.

Fiona described how comments regarding food and exercise impacted her, *"at work they're like oh I can only have 1200 calories and my anorexic brain goes ting and I'm like no…ignore, ignore and then it's I've oh God I've eaten this, I've eaten that oh I have my half marathon training, I need to do this…then I'm like I haven't exercised for two days" (364 – 368).* There is pressure of speech in her voice, indicative of panic around food eaten, further

exacerbating her EMSs (e.g., Failure that she is failing if she eats more than her work colleagues). The ellipsis highlights the pause where Fiona ponders her own exercise habits, highlighting the impact that the behaviours of others can have on the critical nature of the eating disorder voice thus, cementing it as a barrier.

Juxtaposing, Fiona described the way in which positive language from others has motivated her, she was told *“you look strong, it wasn’t a you look fat, you look thin, it was…just made me feel better I was like mhm I’ll take that cos I don’t want to look weak” (394 – 396).* This emphasises the importance of language used to those in recovery from an eating disorder. The word ‘strong’ has positive connotations such as confident and determined, likely driving, and strengthening Fiona’s adaptive modes.

This subtheme illuminated the impact expectations and behaviours can have on ones’ eating disorder, EMSs, modes, and eating disorder voice.

6.2.5 Summary of Results

Schema therapy is not a one size fits all approach and the results capture participants idiographic experiences. Overall, experiences of schema therapy were generally positive, particularly in recognising and identifying with schema modes. There is a very noticeable change in how participants discuss and articulate their modes, EMSs, and the eating disorder voice; supported by the ways in which participants convey their experiences, particularly with their Vulnerable Child. Prior to schema therapy, there was an awareness of this mode, now there appears to be acceptance, indicative of a deeper connection to this side. The first-person language used cements this mode as part of participants’ identity. Schema modes were experienced as distinct from self, a part of participant’s phenomenological reality and similar experiences were found with the eating disorder voice. Moreover, there was a change in how participants viewed their experiences with their eating disorder, with many highlighting a function or purpose their eating disorder has served. The results are subsequently discussed.

6.3 Discussion

Five participants from the initial study did not engage with this follow-up; two did not respond and three declined to be re-interviewed. The aim of this study was to attain an in-depth understanding of experiences of schema therapy in those with an eating disorder over time, with emphasis on changes experienced in schema modes or the eating disorder voice. Literature surrounding eating disorders and schema therapy is scarce. As highlighted earlier in this chapter, the studies exploring this phenomenon have utilised quantitative measures and have seldom looked at people having schema therapy. Therefore, there was a clear gap within the literature on not only experiences of schema therapy in those with an eating disorder, but experiences over time. In the following sections, the key findings will be considered in light of the questions above and discussed in relation to existing theory and evidence base.

6.3.1 Making Sense of Schema Therapy

Schema therapy moves beyond the core of disordered eating behaviours (Watson & Bulik, 2013) to targeting the cognitive maintaining factors such as maladaptive modes (Simpson & Smith, 2019) and the eating disorder voice (Pugh & Rae, 2019), therefore, enhancing awareness of these. Adaptive schema modes are important because their presence indicates a positive change in wellbeing and the weakening of maladaptive modes (Young et al., 2003). This theme followed participants through their journey with schema therapy, from the strengthening of adaptive modes to the challenges faced.

Strengthening of Adaptive Modes and Schema Therapy as a Toolkit, not a Cure.

Schema therapy has been found to develop client's Healthy Adult mode (Lolkema, 2022; Young et al., 2003); the findings of this study suggest the same with all participants describing a subjective increase in adaptive modes. The findings could be attributed to many factors, including longer time in treatment, ability to recognise and manage coping modes and the strengthening of participants relationship with their inner child. This finding further emphasises

the strength of qualitative research as adaptive modes were not found on the supplementary quantitative data.

Oldershaw and Startup (2020) consider the Healthy Adult not as a distinct mode, but a psychologically healthy sense of self that develops during therapy and works with all modes, this was reflected in participant accounts. The findings of this study suggest that for participants, their Healthy Adult has developed into a conductor like figure, orchestrating the behaviour of other modes, including nurturing the Vulnerable Child, implementing boundaries for the Undisciplined/Rebellious Child, and challenging the critic and coping modes. Indeed, schema therapy was found to elicit a growth of client's Healthy Adult throughout therapy.

We witness participants' use of a described toolkit in enabling the growth of their Healthy Adult, weakening their maladaptive modes, challenging their eating disorder voice and encouraging a deeper connection to their Vulnerable Child. Participants illustrated how schema therapy provided them with *'tools to lean on'* when things in their life became challenging, demonstrating the applicability of experiential techniques. An example is with the eating disorder voice, although still prevalent, participants described it as being quieter. This could be attributed to voice dialogue utilised in chairwork as this has previously been found to be a promising technique in addressing the eating disorder voice (Ling et al., 2022; Pugh & Rae, 2019).

This theme encapsulates the strengthening and growth of participant's adaptive modes. The described toolkit has developed in response to experiential techniques, enabling participants to develop the right tools for challenging moments in their life. It is reasonable to assume that these changes are attributed specifically to schema therapy.

Challenges in Schema Therapy.

Participants found imagery rescripting to be useful but occasionally emotionally confronting, particularly when connecting to their Vulnerable Child. There was ambivalence around this technique as participants displayed apprehension when connecting to this mode due to the meaning it encompassed for them. As found in the previous chapter, ambivalence is

not uncommon in those with an eating disorder (Williams & Reid, 2010). Perhaps it is this ambivalence that emphasises the challenges experienced. Participants suggestions to provide a clear structure with regards to imagery was found in previous qualitative research (de Klerk et al., 2017; Ten Napel-Schutz et al., 2017); with the importance of a proper connection between past and present being described as indispensable. This connection to the past could lessen the ambivalence experienced and subsequently, improve the connection to participants' inner child. This highlights the importance of connecting participants to their past to help them to become comfortable with ambivalence and uncertainty faced in imagery.

There were few negatives experienced by participants with many regarding schema therapy as a helpful approach, despite ambivalence experienced. However, financial considerations and shortages of therapists made schema therapy at times, inaccessible. Nevertheless, schema therapy was overall experienced positively and the challenging aspects could be associated with participants' avoidance of discomfort (e.g., ambivalence about dealing with traumatic memories in imagery and connecting to their Vulnerable Child) and not necessarily a limitation of the therapy itself.

6.3.2 Friend or Foe?

Friend or foe? has been discussed when investigating client's positive and negative experiences of their eating disorders (e.g., Serpell et al., 1999; Serpell & Treasure, 2002; Williams & Reid, 2010). There are many negatives associated with eating disorders including a constant focus on food, low self-esteem, damage to interpersonal relationships and sometimes guilt. In contrast, positives include feeling a sense of control, safety, and protection.

"The eating disorder is your friend, not your enemy."

Previous research has found that some clients with an eating disorder experience their eating disorder as providing meaning and structure in their lives (Serpell et al., 1999; Serpell & Treasure, 2002), the results of this study support this. Participants communicated a benign

perspective of their eating disorder as something that offered control, safety, and protection. It is these three elements that led to the view of it as a friend.

Akin to previous studies (Brede, 2020; Fox et al., 2011) and Study One, clients experienced their eating disorder as providing a source of control when control was otherwise missing in their lives. Within the context of this study, this was often experienced alongside one of the overcompensatory modes, namely the Eating Disorder Overcontroller and was perceived as a positive, a comforting mechanism, a tool in which control could be obtained. This was predominately experienced in those with restrictive disorders or with a history of restrictive behaviour.

Contrasting, those with bulimic disorders tended to primarily perceive their eating disorder as providing a sense of safety and security, probably due to the associated detached modes providing these feelings. For example, binge eating was felt to provide comfort. It is how participants describe their experiences that differs from Study One; particularly Billie, where she describes the differences between an emotional and non-emotional binge. One could assume that schema therapy has enabled her to develop this perspective and, therefore, view her eating disorder as a friend. Participants also experienced their eating disorder as providing a form of protection, keeping loved ones close, which could be conveyed as the Helpless Surrenderer mode. This mode is specific to eating disorders (Simpson et al., 2018) so it is reasonable to assume that this is the case. Billie, Jane, and Ian scored significantly on this mode.

It is important to not dismiss the negative impact. Jane, for example, reflected that her eating disorder had *“ruined the last ten years of my life,”* but equally, feels unable to let go, due her perception that it is the only thing keeping her parents in her life. In this instance, her eating disorder is being perpetuated by this belief. Although participants described their eating disorder as a friend or enemy, as in Study One, Jane and Ian portrayed ambivalence, suggesting that addressing this ambivalence is an important element in recovery. For participants, their eating

disorder provided meaning to their lives, in that they had lived with it for so long, there would be an unbearable void without it.

Referring to the eating disorder as a friend suggests positive affiliations, including a tool for achieving control, for keeping participants safe and providing a sense of protection. It is reasonable to assume that it is as a result of additional schema therapy that has enabled participants to convey their eating disorder in this manner. This theme captures something that participants feel personally has changed; schema therapy has brought clients to a greater awareness to the effects of their eating disorder on their lives, something fundamental to eating disorder recovery.

6.3.3 Connecting with Parts of Self

Schema therapy for eating disorders includes re-parenting to heal the Vulnerable Child mode, recognising and challenging the critic modes, and bypassing the coping modes that are linked to over-evaluation of shape and weight, whilst encouraging participants to connect with these parts (Pietrabissa et al., 2020; Simpson & Smith, 2019). Participants conveyed an improved connection with their schema modes, namely their Vulnerable Child and coping modes. Unless stated, the inner child refers to the Vulnerable Child.

Connecting with One’s Vulnerable Child.

The Vulnerable Child provides the most unequivocal manifestation of unmet needs. Four participants scored highly on this mode on the SMI-ED (Simpson et al., 2018), but all five described experiences with this mode, thus, suggesting that this mode is a part of participants phenomenological reality, and that this mode is important in eating disorders. As the Vulnerable Child holds the most EMSs, it is regarded as the core mode for the purpose of schema therapy (Bach et al., 2018). Compared to the first study, participants described their relationship with their Vulnerable Child in a more positive light, suggesting schema therapy has encouraged this.

Roediger and Archonti (2019) use the metaphor of a theatre to describe schema modes, whereby some modes are ‘frontstage’ and thus, visible. These are generally coping modes.

Whereas others are ‘backstage,’ hidden and less visible, this is often the Vulnerable Child. It is likely that at the time of the first interview, the Vulnerable Child was still ‘backstage,’ whereas now, all participants articulated an improved relationship with this mode, suggesting it is now ‘frontstage.’ This was reflected in the use of personable language *‘my inner child; vulnerable little…,’* therefore suggesting that the Vulnerable Child has phenomenological reality as participants are allowing themselves to be vulnerable, express and acknowledge their needs; a noticeable contrast from the previous study.

This relationship was not apparent in the first study as participants were dismissive of this mode, thus answering, are there any changes in how participants experience/identify with schema modes and the eating disorder voice? Indeed, there are significant changes in how participants respond to and articulate their Vulnerable Child mode. This is experienced as a positive of schema therapy because it is possible that without, the Vulnerable Child would have remained backstage.

Recognising Maladaptive Coping Modes.

This subtheme captured participants developing understanding and recognition of coping modes. Compared to Study One, participants were more aware of and able to discuss their maladaptive coping modes and the roles that they played in their lives. Chairwork was particularly important for differentiating the modes. For example, Billie highlighted its usefulness and viewed her modes collectively as a team.

Participants recognised that although these modes have served a function, they are now more aware of their maladaptive nature. When looking at the SMI-ED (Simpson et al., 2018) results (Table 13), every participant scored highly on at least two or more coping modes with the most common being Detached Self-Soother, Eating Disorder Overcontroller and Compliant Surrenderer. This is concordant with previous findings that people with eating disorders experience more maladaptive coping modes than those without (Masley et al., 2012; Talbot et al., 2015). Coping modes are perceived as blocks to emotional experiences (Oldershaw &

Startup, 2020), functional at the time (Young et al., 2003) but they often deny the person an opportunity to resolve core pain and connect to their Vulnerable Child. Participants had a deeper understanding of their coping modes in this study. Although coping modes were recognised as being maladaptive at times, each participant experienced them as serving a purpose in their lives, particularly, detached modes.

Detached modes, in particular, were recognised by all participants. Restrictive or compensatory behaviours can function as a form of primary or secondary emotional avoidance, leading to feelings of numbness, or sometimes pleasure (Spranger et al., 2001), providing a detaching function. Experiences of detachment differed; Fiona sometimes reverts to excessive exercise to detach; Ian bunkers down to 'block out the world;' Billie engages in binge eating; Gertrude felt compelled to be busy; Jane focused on restricting her calorie intake. Participants were more aware of these behaviours than previously; it is this recognition and increased understanding that distinguishes their phenomenological reality from the previous study.

Participants also scored highly on the Eating Disorder Overcontroller (*n*=4) and Compliant Surrenderer (*n*=4), but discussion of these modes tended to be implicit rather than explicit, so it is less clear that participants felt that they manifest overtly. The Eating Disorder Overcontroller was found to manifest after comments about weight or shape triggered a child mode and was to encourage compensatory behaviours to protect the Vulnerable Child. In Compliant Surrenderer mode, disordered eating behaviours may function as a form of passive compliance in defence to EMSs and the eating disorder voice, thereby surrendering to the eating disorder (Pugh & Waller, 2016); this too is portrayed in clients' narratives.

This theme sought to answer, are there any changes in how participants experience/identify with schema modes? The answer is yes. There is an overall increased awareness and acceptance around child modes and coping modes throughout interviews.

6.3.4 Barriers to Recovery

Recovery from an eating disorder is not a straightforward process and there are generally barriers to progress. Participants were more aware of barriers here, compared to the first interview, which may be due to schema therapy.

The Eating Disorder Voice.

People may relapse because of their eating disorder voice (Duncan, 2015), as the voice is more likely to increase at the same time as relapse, emphasising the need to address this in schema therapy. Interestingly, each participant did not refer to their eating disorder voice as a voice, but as an inner critic; (*n*=3) scored highly on Demanding Critic mode and Jane scored highly on both Demanding and Punitive Critic mode (Table 13). Thus, making it a challenging barrier as like critic modes, it is something that is generated from repeated past experiences.

Similar to Pugh & Waller (2018), the eating disorder voice was experienced internally but phenomenologically distinct from the self. Participants felt increasingly able to challenge it, although there were triggering situations when this was more difficult. Concordant with literature, the voice was experienced as becoming increasingly hostile over the duration of the eating disorder (Williams & Reid, 2012). Generally, the voice was perceived as a negative, challenging entity that continued to affect participants' lives. The eating disorder voice appeared to contribute to maintaining participants eating disorder; previous research reflects this (Pugh, 2018; Tierney & Fox, 2010). Thus answering, are there any changes in how participants experience the eating disorder voice? Although a prominent barrier, participants are more aware of this part of them, indicative of change.

Expectations and Behaviours from Others.

Participants described expectations from family and others in their lives. For instance, Fiona considered that pressure from her family to attain high standards had led to the development of her own internalised high standards (Unrelenting Standards EMS), Billie described pressure from her family to recover (Defectiveness/Shame EMS), and Jane

frequently conveyed how she believed her eating disorder was the only thing keeping her parents in her life (Enmeshment EMS). It is reasonable to assume that these EMSs are barriers to recovery as they are part of participant's internal working model (Bowlby, 1973) and are perpetuated by the expectations and behaviour of others.

Furthermore, participants described the way in which certain language made them feel. For instance, being told *'you look well'* was associated with negative connotations as it was believed that 'well' equalled weight gain which was perceived negatively. It is reasonable to assume that due to the language used by others, EMSs could be triggered, such as Failure, Defectiveness/Shame, and Unrelenting Standards. Participant accounts reflect this, as following *'you look well,'* the immediate thought from Jane was to restrict her calories, presumably activation of her Failure and Defectiveness/Shame EMS, further perpetuating the eating disorder, thus a barrier to recovery.

Participants, here and in their initial interviews, reported that they felt that other people often had unrealistic expectations of them that could perpetuate their EMSs, modes, and their eating disorder. The perceived behaviours and expectations of others create barriers to recovery. Participants spoke about these issues and their modes in a more nuanced way during their second interviews and it is reasonable to attribute this change to schema therapy.

6.4 Reflexivity

At times, certain comments affected me. For example, Ian described how he had gained weight to be greeted with *"what went wrong?"* by someone he had not seen for a while. Other participants also associated weight gain with negative connotations. In contrast, Fiona said, *"I shouldn't fit my clothes, my clothes should fit me."* I have carried this remark with me since and it has had a positive impact on my recovery and how I view clothes/my body.

I conducted the analysis and sense-checked with my supervisory team to ensure I was not clouded by preconceived ideas, findings from the previous study, and my own lived experience. The process of a reflexive diary was fundamental in the analysis of the studies as I

was able to convey if and how the research was impacting me and if and how I was impacting the research (Appendix H). I thoroughly enjoyed exploring how participants had progressed in their schema journey over the last 12-18 months. Billie said *"I don't think I could have anorexia again cos I like myself now"* which I identified with for my own journey.

One surprising finding was the high scoring and recognition of Vulnerable Child mode in this study compared to Study One. Vulnerable Child is widely identified in previous research, but in Study One participants tended no to mention it, possibility due to fear of seeming vulnerable. Seeing participants accept their Vulnerable Child encouraged me to reflect on my own modes and my relationship with my inner child.

6.5 Conclusions

In Study One (Chapter Five), modes were an abstract concept but by this study, participants had formed a deeper connection with those parts of themselves, particularly their Vulnerable Child. Schema therapy enabled participants to increase awareness of their modes and the eating disorder voice so that they had phenomenological reality and could be addressed. Participants were found to recognise and identify with the many types of modes; key modes appeared to be a form of coping mode (Detached Self-Soother, Compliant Surrenderer and Eating Disorder Overcontroller) alongside the Vulnerable Child mode. The key modes remained similar but how participants described, experienced, and accepted these modes was more sophisticated.

Over time participants increased recognition and awareness of schema modes and the eating disorder voice. Which suggests that additional schema therapy amplified these changes, integrating modes and the eating disorder voice into their phenomenological reality. Schema therapy supported participants in their recovery journey by enabling them to develop a deeper connection to their modes and their eating disorder voice. In addition, participants described that sometimes they experienced their eating disorder as a friendly warning sign that something was not right, whereas in Study One, it was seen as predominately negative. This is another

example of how schema therapy was experienced by participants as providing them with a toolkit to manage their eating disorder and support their recovery journey. Indeed, schema therapy was experienced as a toolkit, not a cure.

Chapter Seven: Schema Therapists' Perspectives

7.1 Introduction and Methodological Rationale

Following the results of the initial client study (Chapter Five), emphasis was placed on the therapeutic relationship and the importance of this in schema therapy. Thus, it was decided to speak to schema therapists themselves to understand their experiences of using schema therapy to treat eating disorders. Given the central role IPA offers with its idiographic focus on meaning and accounts of lived experience, IPA was also used in this study to examine how participants made sense of their experiences of delivering schema therapy.

This study sought to explore:

- How do schema therapists experience using schema therapy to treat eating disorders?
- What are the positives and negatives of schema therapy to treat eating disorders?
- When do schema therapists start to see changes in people with eating disorders when using schema therapy?
- How do schema therapists understand and relate to EMSs/schema modes in themselves?

The final copy of the interview schedule can be found in Appendix G2.

7.1.1 Participants

7.1.1.1 Recruitment and Sampling.

A purposive volunteer sample was used. Schema therapists were contacted through contacts that were established through networking via a social media group for practitioners using schema therapy to treat eating disorders. See Appendix G for recruitment information.

7.1.1.2 Inclusion and exclusion criteria.

Participants must:

a) Be a qualified schema therapist;

b) Be currently using schema therapy to treat eating disorders.

7.1.2 Interview Development Schedule

The interview schedule was developed based on formative areas identified from a literature review to explore the aims of the research and from findings of the initial client study (Chapter Five). Open-ended questions provided participants with a phenomenological map, allowing them to begin exploring their own lived experiences of using schema therapy to treating eating disorders.

7.1.3 Procedure

In-depth semi-structured interviews were conducted. Confidentiality and anonymity were explained. Participants consented to their verbatim quotes being used in dissemination of research. Participants were asked questions regarding their experience of using schema therapy to treat eating disorders, including, *'tell me about your experiences before using schema therapy in eating disorders'* and *'are there EMSs or modes that make it particularly difficult for the eating disorder client to recover?'*

7.1.4 Data Analysis Process

IPA was used to analyse the data; see Chapter Five, section 5.3.4 for detailed description of data analysis. This phenomenological approach involved a detailed examination of the schema therapists' personal experiences of treating eating disorders. I transcribed the interviews to become fully immersed in the data.

7.2 Results

Interview times ranged from 40 minutes to 90 minutes. The mean age for participants (N=12) was 46.16 years ($SD = 9.63$), the mean years trained in schema therapy was 8.16 years ($SD = 5.85$) and the mean years of experience in eating disorders was 13.66 years ($SD = 5.84$). Eight participants were from Australia and four were UK based schema therapists. Pseudonyms were given to participants for anonymity and match their identified gender (Table 15).

Table 15

Therapist Demographics

Participant	Age	Years trained in Schema Therapy	Additional Therapies	Experience in Eating Disorders (Years)
Zara	53	25	CBT, REBT	26
Yvonne	60	5	FBT, CBT, CBT-E	15
Xena	57	9	CBT, ACT, Systemic	13
Willow	37	5	CBT, ACT, IPT	12
Vera	64	15	CBT	15
Una	37	4	CBT, CBT-E, DBT, SSCM, FBT, ACT, IPT, Psychodynamic Psychotherapy, Guided self-help	15
Tina	41	6	CBT	17
Sophie	42	6	CBT	21
Rose	43	3	CBT, EMDR, IPT	3
Penelope	34	6	CBT, ACT, DBT	3
Quinn	48	5	CBT, ACT	8
Nathan	38	7	CBT	11

**N.B. REBT = Rational Emotive Behavioural Therapy; ACT = Acceptance and Commitment Therapy; IPT = Interpersonal Psychotherapy; DBT = Dialectic Behavioural Therapy*

Using IPA, four group experiential themes (GETs) were developed (Table 16): 1. ‘Tools and Techniques’ explores participants’ experiences of becoming a schema therapist, emphasising their understanding around the techniques they have learned, leading them to go;

2. 'Beneath the Surface' to encapsulate their understanding of clients' on a deeper level. By doing so, participants spoke of how they were able to; 3. 'Develop the Therapeutic Relationship' and emphasised its importance. Following this, participants explored; 4. The 'Impact on Self', looking at the impact of their own EMSs and modes, as well as their experiences of the client-therapist relationship, including the chemistry between client and therapist schemas and modes.

Themes and sub-themes are explored in turn. Line numbers are represented in parentheses after each quote and refer to the individual transcripts. Themes reflect the participant's words and my interpretation.

Table 16

Therapist Group Experiential Themes and Subthemes

Group Experiential Themes	Subtheme
1) Tools and Techniques	1a) The need for additional therapeutic techniques
	1b) Diverse range of schema techniques
2) Beneath the Surface	2a) Understanding the function of the eating disorder
	2b) Understanding the function of schema modes
3) Development of the Therapeutic Relationship	3a) Overcoming Challenges in Schema Therapy
	3b) Benefits of Limited Reparenting
4) Impact on Self	4a) Awareness of own EMSs /schema modes
	4b) Client-Therapist Relationship

7.2.1 Group Experiential Theme: Tools and Techniques

Throughout narratives, references were made to needing the tools to enable clients to build their Healthy Adult mode. The sub-themes capture the challenges that participants experienced when using first-line treatments in contrast to schema therapy and experiences of the additional techniques that schema therapy has provided.

Subtheme: The Need for Additional Therapeutic Techniques.

Each participant conveyed their experiences of using first-line treatment at length. Rose discussed her experiences, *"I think when someone has a good going eating disorder it's [CBT-E] maybe not, not quite as helpful in terms of it's quite surface level isn't it?" (48 – 50).* She ends with a question, this could be interpreted in two ways, firstly, it could be rhetorical, and she is taking time to think about this as a treatment; alternatively, it could be that she is seeking reassurance to validate her views that additional techniques, not offered by CBT-E, are needed for someone who has a *"good going eating disorder."*

This was further captured by Una:

> It wasn't getting to the core issues, even once you get to the end of CBT-E, there's still so much, once you get to the end of the manual and chronic low self-esteem.
>
> (Una, 47 – 49)

Una mentions the end of the manual, symbolic of the end of treatment for her client, *"there's still so much"* conjures feelings of incompleteness, suggesting she believes there are many things that have been left unaddressed and that therapy is incomplete. This extract infers something more is needed to address these underlying core issues and further highlights the concerns around the techniques to treat low self-esteem.

Conversely, despite disadvantages, some participants remarked how first-line treatment can be beneficial; however, it can depend on the severity of the eating disorder, suggesting that something more is needed:

> If somebody has um, a mild eating disorder, and you catch it early then it's great, I think it's [CBT] really good, I think it's revolutionary (…) if you haven't got those, emotional deprivation from childhood then I think it works really well (…) it really helped and being able to look down on their [client] thoughts and see what they were getting caught up in and step back so yeah, I think it, I think it's a good model as well but if you've got someone with chronicity, with repeating patterns, it doesn't work.

(Xena, 85 – 94)

The word revolutionary is used to describe first-line treatment, but the subsequent words are disjointed and incomplete until the mention of EMSs. It is implied that CBT may not be appropriate for someone with chronic, repeated patterns and an Emotional Deprivation EMS, for example, because of the nature of that EMS (*the expectation that one's desires for emotional support will not be met*)*;* inferring additional techniques are required to meet clients' needs. Willow echoed this, *"I did have some good results with CBT for as I said, less complex cases" (41 - 42)*, highlighting the difficulties complexities can bring. It would be reasonable to assume that complex cases entail comorbidities, chronicity, and entrenched patterns, as highlighted by Xena and thus, surface level treatment may not be sufficient in addressing these.

All participants expressed the desire to learn more and to help clients where first-line treatment was not suitable:

> A major disadvantage is that it [CBT] doesn't…tackle the emotional side of things anywhere near enough and you know, eating disorders are like kinda driven…erm by that heavy cognitive emphasis, overanalysing things, erm…over thinking things and CBT just kinda erm, it is, it uses the same method to treat the eating disorder and I think that can only get you so far.
>
> (Zara, 50 – 55)

Zara is frustrated, *"it can only get you far"* infers that like her clients, she too has become stuck. The broken speech suggests she is seeking answers to help her clients. Her frustrations are repeated in her narrative, *"I'd realised that half my case load really was in that category of not really, not really fully recovering, people weren't fully recovering from CBT, they were still stuck" (86 – 89)*. Zara is likely to be in her Overcontroller coping mode, wanting to help her clients, but is concurrently 'stuck' with current interventions, suggesting additional tools are needed. Xena expressed similar frustrations, *"CBT just didn't cut it, fifty percent of the people just don't get better, and it was really obvious to me that there was, those clients who had*

chronic issues and repeated patterns" (43 – 45). Thus, suggesting that in-line with the literature, first-line treatments may not be suitable to treat all eating disorders (Simpson et al., 2010; Waller & Kennerley, 2003) and that something more is needed, such as schema-focused therapies and interventions to address chronic issues and repeated patterns (Hughes et al., 2006; Unoka et al., 2007).

Frustrations with previous treatments were raised by several participants. Previously, Vera was working as a therapist for people who had experienced childhood trauma, it was during this time that she worked with many individuals with an eating disorder, *"I felt quite I suppose frustrated and sad or at a loss to having the right model to be able to help them" (20 – 21).* Vera trained as a CBT therapist and received training on childhood sexual trauma from her employer; she did not elaborate on what the training consisted of, but went on to say:

> I think sometimes we were re-traumatising the people um, so I, I very, very, very happy to have found schema therapy.
>
> (Vera, 33 – 35)

Vera begins using the pronoun 'we' when discussing past experiences, contrasting her use of 'I' when talking about schema therapy. This could indicate that she is distancing and detaching herself from past experiences due to how she felt. Whereas, shifting to the first-person pronoun when finding schema therapy, suggests she undertook this training to take back control, regain autonomy of her practice, and help clients. The difference in the language used emphasises the contrast in treatments as previous treatment was spoken about in a negative way, whereas Vera associates positive words with schema therapy.

All participants had previously trained in a range of therapies and frequently emphasised that there had been something missing within their current therapeutic practices and techniques. Willow described schema therapy as the missing piece of the puzzle, *"vaguely recall supervisor shoving a book at me like Jeff Young yellow cover and I think it was given to me the year he wrote it and um and it just really, it really took me, and it made sense and all of a sudden I could*

just feel everything going clunk, clunk, clunk into place" (54 – 58). Willow's statement of *"it just took me"* suggests that she was not expecting to find this. She clicked her fingers when repeating *"clunk, clunk, clunk"* emphasising things clicking into place, demonstrating how she perceived something was previously missing.

Participants described that their clients felt misunderstood in previous therapies. Whereas throughout schema therapy, clients said, *"someone really gets me and that's very gratifying and to be working with someone who has had treatment for ten years already, twenty years sometimes and then suddenly to say, I feel this is the first time someone has understood me, really got me" (Zara, 125 – 129),* emphasising the need for additional therapeutic techniques and schema focused approaches to eating disorders.

This subtheme explored participants feeling 'stuck' and expressing a need for additional therapeutic techniques and interventions to help their clients, which could explain why participants sought training in schema therapy. Treatment for eating disorders is not a one size fits all approach and thus, an array of tools and experiential techniques are needed to address clients' needs at an individual level.

Subtheme: Diverse Range of Schema Techniques.

This subtheme captures experiences of the impact of the diverse range of experiential techniques in schema therapy. Quinn said, *"I think you can see change happen in the room, I think in imagery rescripting, chair dialogue, those are the really powerful for people" (62 – 63).* The positive language used accentuates the changes she sees. She follows up her discourse with, *"it gives you a really nice roadmap" (66 - 67)*; one interpretation could be that schema therapy mimics a map; there are many different directions it may take in exploring clients EMSs and modes. The focus is on the client and their needs at that time, as such, schema therapy follows that direction and much like a map, Quinn guides her client to where they need to be.

This was echoed by Una, when talking about how she uses the techniques schema therapy has given her, *"if the client is understanding the parts and if they're good to go through*

with experiential work I kind of jump into experiential work and it can depend what comes up (…) often you know in those early stages of treatment it's a coping mode (…) then I jump into imagery, it's really variable for me" (152 – 160). Techniques in schema therapy are suited to work with the unmet needs of her client. The word 'jump' suggests she is able to jump from technique to technique to work with her client's activated mode and is particularly useful if a client is flipping between modes; 'jump' also implies that there is not one set technique to use for a particular mode. The diverse range of techniques is flexible, much like the motion of a jump. For instance, she utilises imagery to connect with her client's Vulnerable Child, once they understand this part of themselves, she will jump into experiential techniques such as chairwork to challenge their coping/critic modes, but then can also jump back to imagery to address these modes and the impact they have had on the Vulnerable Child in the past.

The Covid-19 Global Pandemic required all therapy to be moved online. Nathan said, *"it's not felt all that different and the feedback I've had from people… when it comes to techniques like chairwork, you have to do it differently, but it can still be powerful and effective" (574 – 577)*; although they are no longer in a therapeutic setting, this can be replicated online. He follows with, *"when you work with people at a distance, they're more willing to be more open with you and be more transparent about their feelings" (578 – 580)*. Perhaps because people are at a distance, they feel they can better express the unmet needs of their Vulnerable Child as they are in their safe place and it is also easier to leave if needed to protect their Vulnerable Child, further accentuating the impact chairwork can have online.

Vera had a particularly soothing method of ensuring clients felt supported in response to online working, *"we're both sort of talking to the chair…if you can see my hand up there [puts hand to screen, so client can put it alongside hers] if you were my client, I'll ask you to put your hand there" (519 – 522).* Contextually, this was in chairwork. When talking to the critic modes of her client, Vera used her hand as a symbol to demonstrate to her client that she is there to comfort their Vulnerable Child, holding their hand, despite not being physically present.

Moreover, Sophie's shared her experiences of the range of techniques she utilises:

I've got a big basket of shells in my room, I make it quite important to make my room nice at work and, and I do a lot of that so I had to adapt that and I have beads so I'd get people to pick beads and I'd send it out with a wee card but it's not quite the same as someone having it at the time, I think it's been ok…it's been much better than I thought it be, and it opens up accessibility.

(Sophie, 451 – 455)

Although this may be common therapeutic practice in therapy, Sophie places substantial emphasis on creating a safe place and a nice environment for her clients; in turn, this strengthens the therapeutic relationship. It could be interpreted that there is a protective intent behind the tokens she has sent, indicative of limited reparenting. Sophie is letting her clients know that she is still there for them, despite being unable to be physically present, her clients are aware she is emotionally present.

Although the diverse range of schema techniques was generally seen as positive, one participant spoke of the drawbacks they had experienced, *"I'm used to working in a way that's very structured, very manualised, very step by step, very procedural whereas in schema therapy there are sometimes what feel like vague phases of therapy but not much guidance of what you do and when and why you do it" (Nathan, 146 – 150).* 'Very' is repeated to emphasise his usual way of working and illuminates how different his experience with schema therapy has been, particularly when using the techniques as he accentuates there is little guidance on when is best to use them and why. He occasionally reverts to CBT, *"maybe go back to CBT for clear answers of what to do and when, when maybe we're drifting from schema" (245 – 247);* thus, although schema therapy has the element of flexibility and an array of techniques, a guided approach may need to be implemented on occasion for the benefit of both therapist and client.

The diverse range of techniques, along with the flexibility of the schema model offers scope for participants to work with their client's active schema modes and EMSs in session.

With this flexibility and adaptability of experiential techniques, there is no rigidity, and participants felt that they could adapt the model to what works best for them and their clients.

7.2.2 Group Experiential Theme: Beneath the Surface

This theme captured participants' experience of going beyond what was previously referred to as 'surface level' treatment. It is illuminated in the language they used as participants describe their experiences understanding the function of the eating disorder and the function of schema modes.

Subtheme: Understanding the function of the eating disorder.

Throughout participants' experiences, it was expressed that their client's eating disorder encompassed many functions. One of which was a form of protection and control:

> Vulnerability behind it and actually the reason why it's berating all the time is because it's, it's concerned if it's not doing these things, the client will suffer so it kind of has a protective intent behind it.
>
> (Nathan, 362 – 364)
>
> Wanna create distance there and you really wanna part it out and see this part that's something that's been a survival mechanism in many ways and we're not trying to alienate it.
>
> (Willow, 174 – 176)

There is vulnerability behind the eating disorder as it has developed as a way of keeping the client safe from harm; 'berating' suggests that they are hurting themselves so nobody else can, akin to Flagellating Overcontroller mode (Edwards, 2022). This mode is common in people with an eating disorder, so this is a reasonable assumption. Although the effects of an eating disorder can be detrimental, Nathan and Willow demonstrate that it is there to try and help their client. Willow describing the eating disorder as a *"survival mechanism"* is particularly interesting as often, eating disorders develop at a young age, perhaps to stay safe and meet the needs of their Vulnerable Child. Willow is simultaneously validating the purpose of her client's eating

disorder and creating a distance from it to strengthen their Healthy Adult mode, in order to help the Vulnerable Child. Rose described a similar experience:

> People just get stuck in this pattern and then they get so hopeless and it's almost like what would life be like if they didn't have an eating disorder, they'd never developed any other way to elicit care and it's almost like that, it, it, it feels too hopeless to get out of that I think and too dangerous.
>
> (Rose, 222 – 226)

In this instance, the eating disorder is a way of ensuring the needs of the Vulnerable Child are met – to elicit care from close others. The use of negative language implies the detrimental impact the eating disorder has had, as although it has protected her client, allowing them to receive care, it has had damaging effects, leading to feelings of hopelessness. It is likely that this client has developed their eating disorder to elicit care due to suffering attachment disruption as a child; this was further encapsulated by Nathan and Vera:

> Maybe that goes back to the way early caregivers responded to needs, some denied them and avoided them and were disinterested and some were unreliable and chaotic in the way they responded to emotional needs which might lead to a more binge eating type presentation.
>
> (Nathan, 477 – 481)
>
> You look at these eating difficulties how they can prevent attachments.
>
> (Vera, 322 – 323)

Nathan's use of negative language is indicative of an insecure attachment in his client. Due to this insecurity, it could be that his client has therefore, developed a binge type presentation to meet the needs of their Vulnerable Child. One could assume that the emotional neglect described has led to the development of an Emotional Deprivation EMS, triggering a Detached Self-Soother mode to provide security through food and self-soothing. The function of the eating disorder in this instance is thus, to heal the disrupted attachments and to soothe

oneself. Vera further remarks how she has experienced clients engaging in unhealthy coping mechanisms, such as binge eating, to fulfil attachment disruptions:

> It usually comes out quite quickly in the initial sessions, you know especially if they're bingeing as they'll say oh, I'll go and buy erm, I go to the shop and buy a load of chocolate, or sweets or crisps or whatever it might be and I take that home and I, I will sit and watch tele and eat it all.
>
> (Vera, 85 – 89)

The function of food is one of self-soothing, providing comfort to their client; something they are unable to achieve elsewhere. The list of foods mentioned are commonly perceived as comfort foods, and often thought of as being childhood treats. Presumably, Vera has experienced clients using food to mimic the attachments they have been unable to form, and, in this instance, it is likely to be the eating disorder is working to soothe the Vulnerable Child.

Attachment difficulties was also explicated by Xena, *"early life things, just mom, I think I read somewhere, you were born as a beautiful swan and your mom treated you like a duck you know? Most of the time it's like the parent hasn't had their own needs met" (478 – 481).* There is an implicit reference to the Ugly Duckling; in the fairy-tale, the duckling is rejected for not being like others, conjecturing that in this extract, this particular client was also rejected by others for being different. Therefore, proposing that the role of the eating disorder here is to compensate for the love her client has not received, with a protective intent to elicit love from those around them. From a psychoanalytical perspective, the emphasis on the mother's behaviour could be because the mother is often referred to as the primary caregiver which could be an unconscious reference to Xena's own childhood and her feeling as though she was the duckling.

Furthermore, participants reflected upon how some clients did not perceive their eating disorder to have a function and discussed subsequent experiences of awareness:

> Like the lightbulb goes off *click, click, click with fingers*
>
> (Una, 108)

Feeling, the underlying experience shifts and the behaviour shifts, so you might observe the behaviour shifting and something has clicked underneath, sometimes it will be that, that wow moment of oh my goodness me I actually didn't realise I was starving myself as punishment for something my uncle did to me for instance.

(Willow, 344 – 348)

The metaphor of a lightbulb moment is present in both extracts; both describe this moment of understanding as though something has 'clicked' into place. Una clicking her fingers is as though the lightbulb has turned on and she can see clearly. Perhaps the lightbulb switch is also a metaphor for her clients and has been 'clicked' on for the first-time, suggestive of clients understanding their eating disorder. Willow provides a fictious example of someone who was presumably abused, and the eating disorder had developed as a form of punishment; simultaneously, it could be there to protect the person and provide them with control. These extracts highlight the importance of understanding both for participants and their clients.

Participants articulated the various functions the eating disorder has for their clients, including but not limited to, to elicit care, as a coping mechanism, a form of punishment, or to protect. Each participant emphasised the need to establish the function of the eating disorder in order to help their clients understand it themselves.

Subtheme: Understanding the function of schema modes.

Understanding the function of schema modes was also revealed throughout participant accounts as being significant in going beneath the surface; Nathan said:

For some people it's lets tarmac over these emotions with Detached Protector, whereas for others it's lets whack the mole down when it comes up, with binge eating and self-soothing.

(Nathan, 471 – 473)

Tarmacking over emotions suggests the emotions are being repressed and his client is detaching from their Vulnerable Child by masking it with their Detached Protector. The mode

becomes a way of functioning for Nathan's client and detaching from painful emotions. Whereas the reference to *"whack the mole"* creates an image of panic, a feeling of not being in control with too many things to deal with at once. Therefore, to assuage this feeling and alleviate panic, binge eating is used to create an element of self-soothing. Although both are detaching modes, they are phenomenologically distinct in the way they operate for Nathan's clients, thus, emphasising the need to understand the function of the mode.

In addition, participants echoed how often coping modes can maintain the eating disorder, *"the behaviours are very entwined in the coping modes and it's rarely about food, it's about all those things underneath" (Sophie, 355 – 357).* The intertwining of behaviours suggests that schema modes are driving the behaviours associated with eating disorders, inferring that eating disorders have developed as a way of coping, much like schema coping modes. Parallel to eating disorders, schema modes provide a survival function. This was illustrated by Quinn, *"if they're really stuck in that Detached Protector or that Avoidant Protector" (208 – 209),* to look at *"where it's coming from and why it might be helping you know, that kind of validate the survival need behind that and trying to bypass that and challenge that to see if it's helping or not so I think acknowledging the mode, identifying the mode" (211 – 215).* The inference of a survival function suggests that schema modes have developed due to adverse life experiences. Thus, it is important to articulate its function for Quinn to enable her client to identify, acknowledge and validate their own schema modes. This is so they can work to build their Healthy Adult to manage their maladaptive modes and nurture their Vulnerable Child.

Xena describes her experience of the Overcontroller mode and the impact this has on her client's Vulnerable Child mode:

> .Overcontroller who loves to give you the rule book on what you can and can't eat, and what I found really interesting was looking at the function of that and spending a lot of time finding out why that part is there (…) seeing exactly why that part doesn't wanna go anywhere, (…) you know I've got a purging part so my purging part is the perfect

> solution to when I feel anxious and I know it's not the best solution but it feels so good. If I wasn't going to interview it, I think it would get worse and worse and then the little side would think about taking their life, (…) you really get much deeper and you're doing it in such a way, it's de-shaming, it's part of you.
>
> (Xena, 186 – 197)

There is an initial pressure of speech, inferring that if the function of the mode is not acknowledged, it can become maladaptive, leading to disastrous consequences on the persons *'little side.'* Overcontroller having a rulebook cements the dominating nature of this mode. One interpretation, given the context, is that the mode in question is the Self-Flagellating Overcontroller mode, encouraging maladaptive, harmful behaviours to oneself, such as purging. Xena is not alienating this mode completely but is explaining that this mode has developed for a reason. By understanding the function, Xena can work with her client to weaken this mode, whilst simultaneously, strengthening the adaptive modes, *"we're working towards building this compassionate side, this grown up you" (198 – 199).* The reference to *"grown up you"* provides support for the schema mode model in that schema modes have developed in response to unmet needs in early life. Therefore, emphasising the importance of schema therapists understanding the function they have had for their clients.

Schema modes, like eating disorders, have been found to operate as a coping mechanism:

> Eating was very much about comfort, about rewarding at the end of the day, about a cocoon of safety.
>
> (Quinn, 217 – 220)
>
> If we're looking at binge eating, the mode would probably start off with feeling vulnerable, some…and then they need something to cope and they look to self-soothe.
>
> (Vera, 146 - 148)

> There's a pattern of eating from a young age or parents using food as a self-soothe mechanism.
>
> (Willow, 217 – 218)

Although all depict Detached Self-Soother mode, it is the way in which their clients use this mode that makes them phenomenologically distinct. For Quinn, it could be interpreted that on good days, eating is about rewarding oneself, alternatively, one is comforting oneself with food at the end of a bad day. A 'cocoon of safety' illustrates an image of this mode wrapping itself around their client to soothe them. For Vera, it is a way of coping and for Willow, it is a behaviour that has been engrained and learned from childhood. Thus, illuminating the importance of knowing the history of the mode as then, the therapist can articulate its function. In each extract, the function of the coping mode depends on the need of the Vulnerable Child (e.g., comfort, reward, soothing).

Another phenomenon experienced explicitly by one participant and referred to implicitly as a form of critic by others, was the eating disorder voice. This appears to be understood in the same way as schema modes, and has similarities with the Overcontroller and critic modes:

> We're asking it why are you here, what do you do and what shows up and I think what we found it moves between these modes between these different functions, it does all of them so sometimes it's punitive and sometimes it's demanding and sometimes it's overcontrolling and um sometimes it's soothing.
>
> (Nathan, 338 – 342)

Nathan perceives the eating disorder voice as an entity which can express the thoughts of various modes, for instance, a function of self-soothing may involve binge eating to alleviate stress, and the punitive voice may involve restriction as a form of punishment and control. The voice encompasses many functions and could be thought of as an amalgamation of modes. Addressing the voice directly suggests it is, indeed, a separate entity, although part of his client's reality, it is phenomenologically separate from the self.

Nathan followed with, *"it [eating disorder voice] kind of occupies all of them [schema modes] (…) it occupies and it demands and it soothes you know people talk about their eating disorder voice in those terms in that if I do what it says, it's soothing and congratulatory, and it creates a sense of pride in me but if I don't co-operate it becomes more and more critical but as time goes on it becomes more demanding so I think it's erm…maybe the anorexic voice has different modes" (343 – 349).* His description of the voice is similar to previous literature (Ling et al., 2022; Williams & Reid, 2012). Similar to modes, the voice is fluid and occupies different functions, these are likely to be in response to how the client is feeling (e.g., critical if they have eaten more, or congratulatory if they have exercised more). The voice is prominent in clients' reality and encompasses many modes, such as critic modes and coping modes, thus, demonstrating the need to know why it is there. The eating disorder voice can be the speech of any maladaptive mode, although, some are more likely to speak than others.

This subtheme described participant experiences with schema modes and the aim to discover the function that they have for their clients. Modes are experienced as positive initially (e.g., self-soothing via binge eating) but can then be experienced negatively (e.g., demanding, compensatory behaviours following a binge). By understanding the function of the schema mode, the therapist can work with their client to weaken the maladaptive modes and increase their adaptive modes.

7.2.3 Group Experiential Theme: The Development of the Therapeutic Relationship

Participants placed significant emphasis on the importance of the development of the therapeutic relationship, the challenges they sometimes faced, how they manage these and importantly, how they remained in their Healthy Adult mode when challenges do arise.

Subtheme: Overcoming Challenges in Schema Therapy.

It was remarked that sometimes, coping modes can present challenges. Una describes her experiences to overcome this:

> You've gotta bypass the coping mode, that's the first step, so I've always got ok the coping mode comes up, bypass the coping mode, if you can get to the Vulnerable Child meet the need, if the critic comes up, deals with the critic.
>
> (Una, 168 – 170)

Una appears to convey a set of instructions on how to manage each mode. Una's pressured speech implies that she must be quick when trying to bypass a coping mode or it may take over the session. Bypassing the modes creates an image of Una ducking and diving, pushing the coping modes out of the way to rescue the Vulnerable Child. Una moves quickly past the coping mode. It is reasonable to assume that Una is doing this to protect her client's Vulnerable Child, enabling them to feel safe. However, this could pose challenges if the coping mode has not been fully addressed, enhancing further feelings of vulnerability.

Penelope discussed her experiences of overcoming barriers in therapy when someone is in a Detached mode, *"the group who don't remember even through imagery so 'I don't have those memories, I don't remember those kind of things' (…) but that can be a barrier (…) I'll talk about more using a sense than an image (…) I'll be like well can you hold this sense or whatever it is, even if it's an image or memory and try and work with that until they start to relax" (146 – 159).* Although discussing sensitive content, Penelope works with the client in a way that is comfortable with them, giving them time to process the emotions they are experiencing. By using the first-person pronoun, she is putting herself in her client's shoes to demonstrate empathy and understanding, thus working together to overcome the challenges of this mode.

Xena discussed her experiences when challenges arose in therapy; her client presented as frightened and detached when engaging in an imagery exercise. To overcome this, Xena said, *"STAND UP to the person" (160).* The exclaiming of the phrase highlights Xena taking control of the situation for her and her client. Contextually, Xena was confronting her clients past. Her client had suffered emotional abuse as a child and appeared to be experiencing a Punitive Critic mode in this exercise. In her interview, Xena stood-up, exerting dominance and

control over the caregiver who had hurt her client, following this action, she said, *"the client said I feel safe, I feel better, I feel someone was there for me, you stood up for me, I feel protected, no one was there for me at the time, you know so I think when there's a sort of need for safety and protection" (174 – 177)*; demonstrating one way of overcoming challenging schema modes.

Later, Xena said, *"just sitting together, being together, I'm just gonna sit here with you, do you want anything to eat? We're just being and when you've got that lonely child you want that presence more than anything and the more emotional deprivation it's you matter, constant messages that you matter" (492 – 496).* Xena and her client are being present in the moment together; it is important that she explains everything she is doing before she does it, particularly, as there is presence of a Lonely Child mode and Emotional Deprivation EMS. She asks her client if they want something to eat, suggesting that Xena is aiming to provide emotional comfort through food. The presence of Emotional Deprivation EMS and Lonely Child mode suggests that this client has emotional unmet needs. Therefore, Xena is seeking to rectify this by being emotionally and physically present.

Empathic confrontation can put pressure on the therapeutic relationship, this may result in triggering EMSs in participants such as Failure or Self-Sacrifice. However, when sufficient limits are set early on, this can have the opposite effect, promoting a positive relationship, *"talking about um how that Detached Protector was stopping me from being able to feel close to her and give her the warmth I was feeling towards her and stopping her from being able to receive…this warmth and you know it just, just kind of melted away" (Willow, 101 – 104).* Willow depicts the Detached Protector mode as a particularly cold and an icy character. She alludes that her client is frozen in this mode, detached from their emotions and likely to be emotionally stuck. By empathically confronting this mode early on, we see Willow figuratively melt away her client's Detached Protector with the warmth she exhibits towards them.

Confronting schema modes can further develop the therapeutic relationship through empathic confrontation. In this extract, we see Penelope bringing awareness to her client of

their actions when in Detached Protector mode, *"empathic confrontation with the client around when this is happening, this is the part of you that when this is happening that wants this or says this interacts, in this way um, essentially trying to give back or feedback the difficulty" (239 – 242).* Penelope is working to help clients understand how sometimes, their Detached Protector may cause tensions in interpersonal relationships. She emphasises to her clients that their modes do not define them but are a part of them; by reiterating this, she is validating them and helping them understand their function, highlighting the importance of empathic confrontation.

Participants further explored how the Covid-19 pandemic made it easier, in some ways, to challenge their client's maladaptive modes. This could be due to clients being in their own space:

> I can put a chair in front of me, if it's a very Punitive Critic chair in my room so it's not left with the client at the end of the session.
>
> (Vera, 515 – 517)
>
> They're already feeling in their kind of safe place, they're not in a strange room with someone, they're not as anxious, I think other people find it less challenging and I think that has a knock-on effect and then it doesn't feel as difficult for me.
>
> (Rose, 388 – 391)

The use of assertive, first-person language signifies Vera is exhibiting control, once the removal of the critic is completed, there is the establishment of a therapeutic connection. She puts herself in front of the chair, establishing dominance over the Punitive Critic, creating safety for her client. Vera taking the chair away is significant as she is demonstrating to her client that she is there for them, and therefore allows the client to feel safe at home by removing the threat of the Punitive Critic. Rose expresses similar experiences and reflects upon the effect it has for her too. Thus, suggesting that when both client and therapist are feeling comfortable, maladaptive modes can be challenged effectively, supporting the development of the therapeutic relationship.

When analysing the data, it transpired that it is not only important to recognise challenges participants faced, but how important it was for them to acknowledge and overcome these in building the therapeutic relationship. This is important as when there is a good, therapeutic relationship, participants felt they could channel their Healthy Adult mode and provide therapeutic techniques including limited reparenting effectively.

Subtheme: Benefits of Limited Reparenting.

At the core of limited reparenting is the belief that clients did not have their core emotional needs met by their primary caregivers in early life. In response, therapists attempt to compensate for this, acting as a secure base (Young et al., 2003).

Initially, Nathan found this an uncomfortable and challenging experience, *"an uncomfortable one at first, coming from a CBT background you know, telling people I like them, I value them, I'm really proud of them, I think about them in between appointments? That initially felt really weird" (122 – 125).* It could be interpreted that he believes his own vulnerabilities and insecurities will be exposed and that he will be in his Vulnerable Child mode in sessions, instead of his Healthy Adult. Nevertheless, the repetition of 'I' demonstrates how personable the therapeutic relationship is in schema therapy. Juxtaposing, *"in CBT it's so, so pragmatic, it's so collaborative, it's almost transaction like, it's business like whereas limited reparenting is a completely different way of understanding people and relating to people a way that's so much warmer and nurturing and erm I guess human" (115 – 119).* Depicting schema therapy as *'warmer'* suggests it is metaphorically melting away client's maladaptive modes whilst describing it as *'nurturing'* and *'human'* emphasises the importance of limited reparenting.

Furthermore, Vera highlighted how engaging in limited reparenting from the beginning of therapy is integral for the development of the therapeutic relationship:

> It is paramount building that relationship and doing the limited reparenting right at the beginning of the therapy so hopefully the relationship will start to help the person feel safe enough to let go or let you past those real, rigid modes.

(Vera, 223 – 226)

The beginning of therapy mirrors the beginning of her client's lives, in this way, she can develop the therapeutic relationship early and provide limited reparenting experiences that her client may not have experienced. Correspondingly, Una said, *"I find most useful… helping people to understand the parts of themselves (…) it's like this lightbulb goes off for people and they go oh wow this is just a part of me that's protecting the vulnerability" (97 - 111)*. This could be interpreted that previously, her clients were in the dark and unaware of their schema modes, whereas the light has come on and they are able to clearly see their modes. Through limiting reparenting, Una has turned the light on for her client.

Furthermore, limited reparenting was discussed as an important part in helping the growth of clients' Healthy Adult mode:

> Strengthen the Healthy Adult and to support the process of really kind of challenging and…the vulnerable kind of working with Vulnerable Child, being able to really take care of that part.
>
> (Penelope, 377 – 380)
>
> I like working on the interpersonal relational level and helping people have their needs met so I just feel it fits really well.
>
> (Tina, 383 – 384)

Penelope and Tina utilise positive language when discussing their experiences with limited reparenting, highlighting its benefits. Both emphasise the necessity for meeting unmet needs; with Tina, the relationship is reciprocal, by helping other meet their needs, she is simultaneously meeting the needs of her own Healthy Adult. The focus on their client's Vulnerable Child truly captures the essence of limited reparenting and the importance that participants have placed on meeting this part's needs.

Yvonne too, highlighted the benefits of limited reparenting:

I think the reparenting and the re-scripting process, I think kind of tends to resonate with them, because, from the number of young ones I've got, there's an awful lot of emotional deprivation, awful lot, emotional, and it's probably causing unrelenting standards, defectiveness, shame.

(Yvonne, 195 – 198)

The emphasis on Emotional Deprivation illustrates the importance of this technique to bring about change in EMSs from a young age. As a result, this can weaken the EMSs Yvonne discusses such as Unrelenting Standards and Defectiveness/Shame in later life, having a beneficial impact on her client.

This sub-theme discussed the importance of limited reparenting as providing a stable base for their clients. Throughout narratives, participants discussed their experiences of being the Healthy Adult for their client to help them meet the needs of their Vulnerable Child. However, this was not without its drawbacks and participants spoke of the impact it can have on them as therapists, this is explored in the subsequent subtheme.

7.2.4 Group Experiential Theme: Impact on Self

This theme was developed as participants explored their understanding of their own EMSs and schema modes, their experiences of delivering schema therapy and the client-therapist relationship.

Subtheme: Awareness of own EMSs / Schema Modes.

Participants illustrated how their training had led to them to develop their own understanding of their own EMSs and schema modes. Zara spoke of her experiences:

My patients have been my biggest teachers for sure.

(Zara, 266)

We often have very similar schemas to those of our patients.

(Zara, 275)

One could assume that the similarities in EMSs between client and therapist enhance the therapeutic relationship, due to a deeper understanding of empathy between both. It is likely that this self-awareness of her own EMSs and modes has enabled Zara to do this. Zara followed with, *“I think we’re not so dissimilar from our patients and you know, we, as we do this kind of this work, we learn more about ourselves, reflect on ourselves and learn more about our own coping mechanisms, um…*pause* and I would say for me, that’s been a lifelong process” (280 – 284).* Thus, highlighting the importance of understanding oneself; life-long suggests that Zara is always learning and reflecting on her own development. One could assume that Zara is unconsciously drawn to working with people who have EMSs that mirror her own as she knows how to best support and guide her clients, emphasising the importance of self-awareness.

Moreover, Sophie discussed the journey of her development:

> I’ve learned loads about myself, loads, I spot it all the time, even to the point where my boyfriend goes, that’s your self-sacrifice schema and I’ll go oh God how embarrassing is that that my boyfriend even knows about schemas.
>
> (Sophie, 177 – 180)

Sophie was particularly jovial, inferring the positive impact that self-awareness has had on her, and her interpersonal relationships. She is consciously aware when her EMSs/modes are activated as she can ‘spot’ them; she jokes of it being embarrassing, yet it is this awareness that enables her to develop good interpersonal and therapeutic relationships. It could be interpreted that *“I spot it all the time”* means she is putting a metaphoric spotlight when a particular EMSs or mode is activated; thus, demonstrating insight. Similarly, Yvonne said, *“there’s certainly Unrelenting Standards but I think I’ve managed to um you know work on that myself, it certainly was in my early years, early on in my life” (398 – 400).* The word *‘certainly’* implies that this is a particularly strong EMS for Yvonne and demonstrates her awareness when it is triggered. She repeats how it was activated more in her early life, further supporting the notion that EMSs develop in response to early life experiences and while they can remain

stable, they can also fluctuate throughout life, depending on the present situation, thus are difficult to change.

Furthermore, Penelope spoke of an experience that highlighted her Self-Sacrifice schema and Overcompensatory modes to her:

> Strong Helpless Surrenderer mode (…) very difficult trauma history and struggling, so it was constant things for me to be really aware of my response, one, do I need to be more flexible for this client? So, I can see you more often? or I can schedule extra session or um yeah I'll follow this up for you (…) I can do that, I can write those things up, I can communicate with this person and having to really be aware of that and going hang on ooh that's not um (…) that's not really one, appropriate but part of my own reaction to the client and not what the client really needs.
>
> (Penelope, 204 – 213)

Penelope refers to have *"bit of a Detached Protector" (197)* earlier in her narrative, whereas now, she appears to be in an Overcompensatory mode; the constant reflection and questioning of her behaviour towards her client reflects this. Penelope has pressure of speech, indicative of her need to please her client and appease her Overcontroller mode by telling herself *"I can"* repeatedly. However, simultaneously appeasing her Detached Protector mode by saying *"I can"* instead of 'I will,' suggesting she is making these claims to herself, but her Detached Protector is likely to be stopping her from acting on them. By repeating *"I can,"* she is taking ownership of the client's actions, the client is not taking responsibility, possibly exacerbating their Helpless Surrenderer mode, leading to further overcompensatory behaviours.

In addition, Sophie had a unique way of ensuring she was in Healthy Adult mode in online sessions, *"there was a client I had to put a post-it note on my screen that said Healthy Adult, Healthy Adult to stay in Healthy Adult…" (198 - 199).* It is reasonable to assume that this client triggered Sophie's coping modes, perhaps at detriment to the therapeutic relationship. The repetition of 'Healthy Adult' is mantra like, typically, mantras are used to guide meditation,

and assumes that Sophie is doing this to remain calm in sessions when her own coping modes may be activated. The post-it notes are there to remind her to engage in this mantra, demonstrating her awareness.

Participants reflected on the YSQ they had completed in the past. Almost every participant expressed having high Unrelenting Standards EMS and were generally not surprised by their EMSs, however, Rose experienced a different outcome, *"I remember doing the form myself …when I got the results being absolutely horrified at how high my erm my kind of admiration seeking schema" (147 – 149).* Rose's use of *'kind of'* suggests she is not wanting to accept this as a schema and is equally unaware this was present, *"doesn't make sense, this isn't me at all, this is not, not me at all, I am not that schema" (152 – 153)*; she appears distressed by this and has ruminated on her results. However, we then see her accept this is part of her *"when I sat and thought about it, I kind of I can see that I do have schema" (153 – 154).* Yet, the use of *'kind of'* infers her reluctance to fully accept this as a core schema.

Yvonne experienced similar *"I was a bit confronted by it if I'm honest cos I found that they all said oh you've gotta have something about we've all got problems, they really painted it in a negative way and said we've all come from terrible backgrounds and I'm thinking well I didn't come from a terrible background, I came from a loving family" (136 – 140).* Yvonne is almost panicked by this, supported by her pressure of speech. Yvonne is justifying her experiences by emphasising she belongs to a loving family; she is upset and affronted by the team with whom she was doing this training. These comments are interesting, as schema therapists encourage clients to view their EMSs and modes as part of them, so it is intriguing as to why there is some reluctance to accept their own.

The impact of understanding oneself has been found to have a profound impact on the delivery of therapy and the subsequent therapeutic relationship:

> Notice the parts of you that show up in your work and they tend to guide the ways in which you deliver the therapy.

(Nathan 197 – 199)

Acknowledge parts of yourself and seeing how that plays out for you and erm which may be coping modes come out for you or schemas.

(Penelope, 165 – 167)

Both Nathan and Penelope emphasise the importance of acknowledging that schema modes and EMSs are part of them. There is a contrast in how they experience this. Nathan refers to the impact they have when he is delivering therapy, suggesting that he is consciously aware of his modes and uses them to guide the session. He is mindful of this in sessions. Whereas Penelope states *"how that plays out for you,"* implying that she may have little control over which mode could be triggered in a session. One could suppose that it is dependent on how well the session goes to which modes are activated. For instance, she has previously referred to a client's Helpless Surrenderer, which triggered a Detached Protector response. She did not have control over her response to Helpless Surrenderer, thus, further accentuating that schema modes are semi-autonomous parts of the self. Additionally, it is interesting how Nathan states they *"guide the ways in which you deliver therapy"* following on from his comment around schema therapy not having much guidance; perhaps his self-awareness has led to him subconsciously create a guide to assist him in delivering schema therapy.

Participants frequently referred to their own EMSs and modes and the impact these can have. Upon reflection, it may have been beneficial to ask participants to complete the YSQ2-SF (Young, 1998) for reference and to explore this further.

Subtheme: Client-Therapist Relationship.

It is inevitable that at times throughout schema therapy, therapists EMSs and schema modes will interact with their clients, creating what schema therapy calls chemistry, or countertransference. Through revealing their own emotional reactions, the therapist serves as a healthy role model for their client. However, from time to time, unresolved inner conflicts of the therapist can be activated within the therapeutic environment, triggering their own EMSs and

schema modes. Sometimes, without even realising this has happened. For instance, a Helpless Surrenderer mode may trigger a Detached Self-Soother response, or a rushed, Perfectionistic Overcontroller response without taking time to understand what their client is truly needing:

> Very helpless, save me, save me kind of wanting to be rescued, then we have that mode then we're kind of very prone to jumping in too early and not seeing what's really needed.
>
> (Zara, 349 – 351)
>
> A very strong dependency schema and um, sense of helplessness, if clients have this sense of helplessness, sometimes if you keep doing things for them, giving them things or you know, providing the reassurance they're looking for, it just reinforces the problem, it doesn't always heal.
>
> (Zara, 299 – 303)

Zara repeats the phrase *'save me,'* which could be interpreted that her clients are drowning and wanting to be saved, she states how this can elicit a response of her own Overcontroller mode, leading to her *'jumping in*,*'* whereas in hindsight, it can be counterproductive as it will prolong the time a client is in this mode. *'Jumping in'* too quickly has a negative impact on the participants too as they are not looking at what the client is truly needing, making it challenging for both. Furthermore, she discusses how engaging with this mode can cause challenges for both therapist and client and suggests that if this reassurance is constantly provided without appropriate boundaries, the client may become dependent on the therapist, thus causing challenges when trying to elicit growth of the client's Healthy Adult mode.

Nathan described his experiences and the impact that a client's Angry Child mode has had on him, *"might tend to bring their anger to therapy and to, the therapeutic relationship and I think in those situations I feel myself being very anxious going into my child modes" (233 – 235).* In this instance, it is reasonable to assume that Nathan's Vulnerable Child mode was activated. He later discloses that this is due to his past experiences, *"back to my childhood where I was*

surrounded by people who were very angry and very aggressive but I learned the best thing to do in those moments was to make yourself small and just get out of the way and that can be hard when people can be quite big or mad in therapy sessions" (237 – 241). The situation he encountered in therapy was one which was familiar to Nathan and brought back similar feelings. He refers to making himself 'small' in the past, suggesting he was able to hide. Whereas, in a therapy setting, he infers there is nowhere to hide and thus, he must confront his own Vulnerable Child and his client's Angry Child mode.

When feeling overwhelmed, Penelope said, *"you kind of get to a point where you put your own needs first too and that process of modelling and being aware of what you need, how that helps and what whole kind of idea putting your mask on first before you tend to anyone else" (186 – 189).* The implicit aeroplane reference is describing the importance of being in Healthy Adult mode for the client and modelling this. However, continually being in Healthy Adult is likely to take its toll on Penelope too, putting others first and not acknowledging that her own feelings could lead to her own maladaptive coping modes coming to the surface. Sometimes, coping modes can manifest as the Healthy Adult mode, this is referred to as a default mode. One interpretation could be that Penelope is in her default mode, it would be reasonable to assume that this is a type of Overcontroller mode, evidenced by the way she is putting all her focus onto her client, at expense of her own needs. This could lead to a detrimental impact on the therapeutic relationship as the client may become dependent on Penelope due to the way she has responded to their needs, developing the client-therapist relationship, highlighting the importance of acknowledging one's own EMSs and modes.

Xena explores her experiences with a client who said therapy was unhelpful:

> He's like this isn't going anywhere, it's just not going anywhere and you're like OH GOD IT'S NOT GOING ANYWHERE, and I just kinda felt these really tight knots I'm like breathe, breathe, breathe and I'm like please don't tell me why, please don't tell me more about it cos I'll be on the stocks, I'll be in court, no good as a therapist.

(Xena, 379 – 384)

Xena has incredibly pressured speech, indicative of anxiety. The capital letters represent when she shouted, potentially capturing the panic she experienced when being told that therapy was not progressing. She appears vulnerable with a sense of insecurity. The reference to being in the stocks is a strong metaphor, revealing that she feels guilty for not having helped her client how she believed she should have. She suggests that she deserves to be punished for this, begging for forgiveness; it is possible that this is operation of Xena's Punitive Critic, telling her she is not good enough and deserves to be punished.

Zara and Nathan, respectively, described their experiences of client-therapist chemistry:

> If the therapist has a Self-Sacrifice Schema, if the therapist has an Unrelenting Standards Schema that you just keep going and going and going and going and not realising what the client needs at that point.
>
> (Zara, 303 – 306)
>
> Therapy goes nowhere, and the therapist gets so burnt out with someone that is struggling but not making the changes the need and eventually therapists just give up and burn out and withdraw from the work.
>
> (Nathan, 516 – 519)

It is likely that the EMSs Zara listed are her own and ones which are triggered when she believes that the therapy is not progressing. Self-Sacrifice suggests that she puts her client's needs first, without considering the emotional impact on herself. Unrelenting Standards is likely to encourage Zara to keep going without understanding the true needs of her client, this could lead to the client withdrawing from therapy as their needs are unmet, affecting the client-therapist relationship, causing Zara's Unrelenting Standards to work harder. Nathan's reference to the therapist withdrawing could also lead to their client withdrawing emotionally from the therapy too due to unmet needs, resulting in the activation of his Unrelenting Standards EMS. He exhibits the same EMSs as Zara; Zara's third person reference to 'therapists' as a collective

group infers that many therapists have the EMSs that she has listed. It is reasonable to assume that the activation of Unrelenting Standards or Self-Sacrifice in a therapist is going to cause a clash and may cause the client to disengage from the therapy or do the opposite and become dependent on their therapist, further exacerbating these EMSs. Neither Zara or Nathan uses the first person, but instead refer to EMSs in the second or third person, indicative that they want to distance themselves from these EMSs, perhaps to prevent a schema-clash.

Finally, schema therapists can be seen as catalysts for helping clients build their Healthy Adult mode and provide the metaphoric tools for them to do so; however, it is when they do not recognise their own needs that burnout occurs:

> I'm like s*** I need to give them tools, I need to give them, they're telling me I'm not doing this, and I need to do this, and I can't let them down and I need to give them tools. (Rose, 324 – 327)

Approval Seeking and Subjugation EMSs have been found to be common in health professionals (Simpson et al., 2019) and they may influence a schema therapists' willingness to engage in empathic confrontation due to the potential of client conflict; evident in Rose's narrative. The use of profanity infers distress and panic. The repetition of 'I' is indicative of Rose taking ownership for her clients and feeling personally responsible. There is an element of panic and urgency in her voice, supported by the language used and the repetition of commands. She repeats needing to give her clients tools, suggesting that they need tools to build up their Healthy Adult and break down their maladaptive coping; at the same time, Rose appears to be neglecting her own Healthy Adult at detriment to herself.

Participants discussed their experiences of their own EMSs and modes and how this can sometimes benefit therapy, but equally, it can hinder it if they themselves are in a detached or overcompensatory state. Overall, it appears that schema therapy can have a substantial effect on the therapists delivering it and can in some cases cause problems in the client-therapist relationship, resulting in EMSs/modes clashing.

7.3 Discussion

Most participants in this study were from Australia and a third were from the UK. All participants except two, who worked for the NHS, worked in private practice. Participants from Australia described 'Telehealth' where treatment is online and is partially funded by the government, this could account for wider use of schema therapy in Australia due to accessibility and affordability. In contrast, schema therapy is not widely accessible in the UK for eating disorders and is currently not recommended by the NICE (2020) guidelines. This does not mean it is ineffective but is under-researched, with only one RCT (McIntosh et al., 2016) demonstrating its effectiveness. This study is the first to explore schema therapists' experiences of treating disorders, building on preliminary evidence in the literature.

To date, the four qualitative studies investigating the perceptions and experiences of schema therapists have not utilised an IPA approach, nor have they focused specifically on experiences of treating eating disorders (de Klerk et al., 2017; Pilkington et al., 2022; Pugh et al., 2021; Tan et al., 2018). The present study is the first to do so. In the following section, the key findings will be considered in light of the research questions and discussed in relation to existing theory and evidence base.

7.3.1 Tools and Techniques

First-line treatments are not suitable for all clients with eating disorders, especially where cases are more complicated (Fairburn et al., 2009; Jenkins et al., 2019; Poulsen et al., 2014), suggesting an alternative approach is needed. Results of this theme reflect participants' experiences with delivering first-line treatment and how often, they felt stuck with current approaches, compared to how they felt finding schema therapy.

The Need for Additional Therapeutic Techniques and Diverse Range of Schema Techniques.

The results of this study mirror that of Simpson et al. (2010). Participants found that sometimes first-line treatment was completed with some behavioural improvement (e.g., less

purging/bingeing), but some clients remained emotionally stuck and would continue to experience strong preoccupations with eating disorder thoughts and urges. Therefore, suggesting that some clients may benefit from a schema focused approach. The results portray a narrative shift in how participants described schema therapy in contrast to previous therapeutic practices. Participants conveyed joy when finding schema therapy, describing it as, to quote Willow, *"everything going clunk, clunk, clunk, into place" (58),* accentuating the impact it has had on the way in which participants practice.

Experiential techniques used were perceived as instrumental by participants, with previous studies yielding similar results (de Klerk et al., 2017; Ten Napel-Schutz et al., 2017). Chairwork was found to be beneficial by all twelve participants, with each discussing the positive impact it had had on their clients (e.g., enabling clients to understand parts of the self, challenge their maladaptive coping modes and strengthen their Healthy Adult). This is supported by and builds upon findings that suggest that chairwork may be an effective technique in working with eating disorders (e.g., Pugh, 2015; Pugh & Rae, 2019; Pugh & Slater, 2018).

This theme suggests that experiential techniques in schema therapy are instrumental in the treatment of eating disorders. Thus, answering the question how do schema therapists experience using schema therapy to treat eating disorders? Participants experienced chairwork as being the most beneficial technique and described how they had found the missing piece of the puzzle when they discovered schema therapy, further emphasising the importance of these tools and techniques.

7.3.2 Beneath the Surface

The findings illuminate the importance of truly understanding the function of schema modes, whilst simultaneously, understanding the function of the eating disorder. Evidence proposes that eating disorders may have a function, for instance providing a sense of control (Crisp, 1997; Espíndola & Blay, 2009); like schema modes (Simpson et al., 2018), but until now, this had not been seen from a schema therapists' perspective. Therefore, by understanding and

articulating the function of both modes and the eating disorder, schema therapists can help their client in understanding their behaviours and needs, aiming to make their modes more adaptive and their eating disorder manageable. This theme addresses two questions, what are the positives and negatives of schema therapy? And, when do therapists start to see changes in people with eating disorders with schema therapy? It is important to note that all participants were included in this theme and encapsulated subthemes.

Understanding the function of the eating disorder.

Patmore (2020) alludes to the fact that those with an eating disorder perceive it to have a positive function, enabling them to have a sense of control over their emotions and attachments. The results of this study, however, proposes that eating disorders may disrupt attachments. This finding is supported by Armstrong and Roth (1989) who defined eating disorder behaviours as maladaptive coping mechanisms in the setting of attachment-related distress. From this perspective, the eating disorder has developed to cope with attachment-related distress at an early age, and subsequently, eating disorder behaviours have developed as a coping mechanism, activating when similar feelings arise as an adult. In terms of schema therapy, this is likely to be a detached mode to shield the person from the attachment-related distress and could manifest in terms of binge eating and purging, for example.

When exploring attachment in Chapter One, the psychoanalytic literature suggests that children enjoy being looked after by someone who is attuned to their emotional needs and responsive to their hunger cues (Nicklaus, 2016). However, if these needs remain unmet, food can become toxic nourishment, leading to eating disturbances later in life, such as using food to self-soothe or as a form of control. Winnicot (1956) proposed that eating disorders are presentations of emotional distress, due to unmet needs in childhood. The findings of this study support this as participants found that their clients had often developed eating disorders due to repeated unmet needs. Many participants found that their clients use food as a mechanism of

self-soothing, to soothe their own emotional needs or as a function of control and thus, food becomes toxic nourishment.

By understanding the function of eating disorders, schema therapists can aim to provide an emotional, corrective experience that is synonymous with schema therapy. Understanding the function may also have an impact on recovery and may help in lowering the high relapse rates, as research suggests rates of up to 31% in AN (Berends et al., 2018) and up to 44% in BN (Olmsted et al., 2015).

Understanding the function of schema modes.

Young et al. (2003) suggests that there are functional modes such as the Healthy Adult and Happy Child, and maladaptive modes such as Detached Self-Soother and Punitive Critic mode. In participants' experiences, the maladaptive modes described, such as Detached Self-Soother, appear to have a positive impact for their client in alleviating distress. The findings suggest that the function of schema modes is very similar to the function of the eating disorder; it can have a perceived positive function initially but can also be maladaptive in that it can significantly impact someone's life, leading to long-term emotional dysregulation.

Many participants considered schema modes to have survival intent behind them. Research suggests that maladaptive schema modes can develop due to childhood trauma (Goddard et al., 2022; Johnston et al., 2009), subsequently developing into coping mechanisms later in life. Although schema modes have a protective intent, they can become maladaptive. Detached Protector may develop following childhood trauma, which may lead to detachment and dissociation, as seen in Chapter Five; this mode was described as challenging at times to work with by participants. Simultaneously, however, participants felt they were able to understand why this mode was present for their clients.

In client studies (Chapters Five and Six), emphasis was placed upon experiences with the eating disorder voice. In this study, the similarities between the eating disorder voice and schema modes were highlighted. For example, schema modes can be punitive and demanding,

much like the critical nature of the eating disorder voice (Noordenbos et al., 2014). Schema modes can also have an overcontroller element, analogous to the eating disorder voice where perhaps restriction is employed as a means of control (Fairburn et al., 1986). For example, the voice may encourage binge eating to soothe stress, and following a binge, it may provide critical, guilt-inducing messages encouraging the person to engage in compensatory behaviours (e.g., purging). The eating disorder voice is expressing the thoughts of the modes. Thus, it is reasonable to assume that the eating disorder voice may be driving these behaviours. Or, it could be that the eating disorder voice is an extension of modes specific to eating disorders; further research is needed to determine this.

This theme answered what are the positives and negatives of schema therapy? The positives appear to be when clients acknowledge that their eating disorder and schema modes have provided them with some sort of functionality; however, the negative is that these functions are not necessarily always positive and can cause challenges. Nevertheless, it is these moments in which participants state they notice change in their clients. Thus, also answering, when do therapists start to see changes in people with eating disorders when using schema therapy? It seems to be when both therapist and client can articulate the role that the eating disorder and schema modes have played for the client.

7.3.3 Developing the Therapeutic Relationship

Previous literature investigating experiences of schema therapy has found the therapeutic relationship to be central to the process (de Klerk et al., 2017). This theme encapsulates the development of the therapeutic alliance, encompassing the challenges faced and the positives too. This theme answered, what are the positives and negatives of schema therapy? And how do schema therapists experience using schema therapy to treat eating disorders? Participants experienced challenging schema modes from time to time, which was perceived as a negative at times, nevertheless, the positives are experienced when they overcome these challenges and the subsequent strengthening of the therapeutic relationship.

Overcoming Challenges in Schema Therapy.

Conceptualisations of the eating disorder population suggests that schema coping modes play a significant role in maintaining and perpetuating eating disorder behaviours (Waller & Kennerley, 2003) and can thus, pose challenges. Stuck points and challenges in treatment of eating disorders are common struggles that many therapists face (Skewes et al., 2019). In this study, participants described challenges with coping modes. An important element of schema therapy is bypassing whichever coping mode is currently active; coping modes can cause challenges as they emerge in early life to protect the Vulnerable Child (Young et al., 2003) and are thus often well cemented within a client. More than half of participants in this study experienced Helpless Surrenderer and Detached Protector as the most challenging modes to work with in eating disorders and described instances where this occurred. To engage with these modes, participants illustrated the importance of experiential techniques, such as chairwork and empathic confrontation.

Empathic confrontation is used to challenge client's maladaptive coping responses from an empathic stance (Behary, 2020), the findings in this study portray the effectiveness of this approach in working with challenging modes. Each participant emphasised its importance and its effectiveness when they were challenged with coping modes. Narratives described how empathic confrontation would result in client's coping modes gradually *'melting away,'* revealing their Vulnerable Child, thus, answering when do therapists see changes in those with an eating disorder? The answer lies within the use of empathic confrontation in overcoming maladaptive schema modes.

Benefits of Limited Reparenting.

Limited reparenting is designed to serve as an antidote to the clients' EMSs (Fassbinda, 2016) and its effectiveness has been found in studies in clients with BPD (e.g., de Klerk et al., 2017; Kellogg & Young, 2006; Tan et al., 2018) and studies with eating disorders (e.g., Brockman & Stavropoulos, 2019; Simpson et al., 2010). An important goal of limited reparenting

is teaching clients how to regulate their emotions and manage them adaptively (Young et al., 2003). This is achieved by using modelling techniques in which clients learn their therapists' method of emotional regulation. This method is often internalised by the client and helps them to develop their Healthy Adult mode.

Limited reparenting could be thought of as mirroring the attachment process. Attachment is thought to be formed by infants from as young as six months old (Bowlby, 1969). Thus, by starting limited parenting in the early stages of therapy, schema therapists can seek to build a secure attachment, developing a strong therapeutic alliance with their client. The findings suggest that by engaging in this process early on, schema therapists are encouraging the development of their client's Healthy Adult mode and acting as their client's secure attachment base. Each participant in this study perceived limited reparenting to be a relational procedure, providing the client with protection, safety, care, empathy, and behavioural limits; akin to Young et al., (2003) definition.

7.3.4 Impact on Self

Throughout interviews, participants articulated the impact that schema therapy had on them, their EMSs, modes, and the therapeutic relationship. This subsection addresses: how do schema therapists experience using schema therapy to treat eating disorders?

Awareness of own EMSs and schema modes.

Therapist self-awareness is an important component of clinical practice (Nutt-Williams & Fauth, 2005). Activation of a therapist's EMSs can influence clinical decision making and the therapeutic relationship (Saddichha & Pradhan, 2012). For example, a therapist with an Abandonment EMS may have difficulty ending therapy to avoid the loss of a relationship, and a therapist with a Subjugation EMS may impact their willingness to engage in empathic confrontation (Pilkington et al., 2022) particularly if a client has an Entitlement EMS. The ability of the therapist to reflect on these EMSs and emotional responses is an important contributor to the effectiveness of schema therapy (Young et al., 2003). This study captured schema

therapists' understanding of when their EMSs were activated in sessions, demonstrating self-awareness.

Upon reflection, it may have been beneficial to ask participants to complete the YSQ-2-SF (Young, 1998) and the SMI (Young et al., 2007) to add to the depth of the interviews and to ask about specific EMSs and schema modes; nevertheless, each participant demonstrated awareness of their own EMSs and modes. Consistent with previous literature (Simpson et al., 2019), this study found Self-Sacrifice and Unrelenting Standards to be most widely experienced by participants. This appears to be the first study to my knowledge, to capture these experiences qualitatively. Participants described sacrificing their own needs for their clients (e.g., frequently expressing, 'I will do x, y, z for my client; I need to see them more often'), as well as setting high internalised expectations of oneself (e.g., I need to do this for my client, otherwise I am no good), with reference to being 'in the stocks' when these were not met.

Moreover, many participants highlighted their awareness of when they were in particular modes, such as Overcontroller, Detached, or Vulnerable Child and recognised when they felt they would need to 'take a step back.' Similar results were found in Pilkington et al. (2022) who found that participants used detachment as a primary coping mechanism. Simpson et al. (2019) also suggested that Detached Self-Soother and Detached Protector are most prevalent amid this group. The current study demonstrated participants consistent reflection and monitoring of their schema modes. In some cases, awareness moved beyond the therapeutic setting and into everyday life (e.g., Sophie who frequently spotted her EMSs and modes).

This subtheme illustrated experiences of EMSs and schema modes within participants and found that every participant recognised when certain EMSs and schema modes (e.g., detached modes, overcompensatory modes) were activated, particularly in therapy sessions. This is important as practically, if schema therapists are aware when EMSs and modes are activated, they can work with them to ensure they do not hinder the session or detriment the therapeutic relationship.

Client-Therapist Relationship.

Unresolved inner conflicts are universal, and therapists bring their own history into the therapeutic relationship (Hayes et al., 2018). Countertransference is rooted deep in psychodynamic concepts (Freud, 1910; 1959, pp. 144 - 145). Within schema therapy, this is specifically referred to as client-therapist chemistry (Roediger & Archonti, 2019, p. 222), which occurs when a client's EMSs or modes influence their therapist's EMSs or modes and vice versa. Such interactions can be therapeutically beneficial or problematic.

It is likely that from time-to-time, schema therapists' EMSs and schema modes will be activated by the interpersonal processes within the therapist-client dyad (Simpson et al., 2019). Throughout narratives, participants acknowledged how their clients' EMSs or modes impacted their own EMSs and modes. This would often result in a schema clash (Young et al., 2003) or schema chemistry (Leahy, 2008). For instance, this study found that if a client has an Entitlement EMS, and the therapist has a Self-Sacrifice EMS, the focus of sessions will be on the clients' needs, despite the fact it may conflict with the therapist's own personal needs; therefore, accentuating these EMSs in the client and therapist. As also depicted in previous literature (Leahy, 2008; Pilkington et al., 2022; Young et al., 2003) the results of this study found that all participants experienced instances of client-therapist chemistry.

Given the universality of EMSs and schema modes, the process of schema activation is relevant to both client and therapist. This theme therefore sought to answer how do schema therapists understand and experience EMSs /schema modes in themselves? The answer is through continually engaging in activities to enhance self-awareness around their own EMSs and schema modes. A client-therapist relationship is essential and generally beneficial, for instance when the therapist's Healthy Adult mode is active and limited reparenting can take place, encouraging client development of this mode. However, as explored, to ensure the relationship is beneficial, therapists need to have awareness of their own EMSs and coping modes, such as Detached Protector, so they are aware when they begin to disengage from

therapy, for instance, if triggered by a strong Angry Child mode, or Bully/Attack mode. By continually engaging in self-reflection and supervision, it is likely that schema therapists will be able to monitor their common EMSs and modes that arise in sessions.

7.4 Reflexivity

Participants recognised and identified for themselves with a form of Overcontroller and Healthy Adult, alongside a Detached Protector mode. This was an interesting finding as participants described how their coping modes would become activated in sessions that were perceived as challenging as a way of protecting themselves and would sometimes find themselves subconsciously withdrawing from therapy. Having experienced therapy, myself (albeit not schema therapy) the findings surprised me, particularly the strong connection to Detached modes, which I had not noticed in my own experiences. However, I recognised an Overcontroller response from therapists, especially when I was younger, suggesting an area of focus in future research.

As with the previous studies, I did not disclose my lived experience with AN and CBT as I did not wish to influence participant responses. I conducted the analysis and sense-checked with my supervisory team to ensure I was not being guarded by my experiences with previous treatment. Throughout all three studies, I consider that doing this enhanced the analysis and reliability of the results as final GETs were agreed upon.

7.5 Conclusions

Participants emphasised the benefits of schema therapy in contrast to the treatments they had previously trained in, suggesting it is a promising treatment for eating disorders due to the value it holds. Schema therapy allowed participants to go beneath the surface to truly understand the function that their client's eating disorder and modes had served them. Therefore, suggesting that the mode model may be beneficial in working with eating disorder clients. Participants experienced experiential techniques as beneficial in mode work, with a particular emphasis on the importance of limited reparenting and chairwork in working with

challenging modes. Further, the importance of having insight to one's own EMSs and modes was considered important to not only oneself, but for clients, for the development of a strong therapeutic alliance and to avoid negative schema clashes. Future research could elaborate on the findings of this study and use quantitative measures such as the YSQ2-SF (Young, 1998) and SMI (Young et al., 2007) to further support qualitative findings. The subsequent chapter explores all three studies and provides an overall discussion for this thesis.

Chapter Eight: Overall Discussion and Conclusions

8.1 Introduction

The main aim of this thesis was to explore experiences of schema therapy in those with an eating disorder and in schema therapists treating eating disorders, with the goal of improving knowledge and understanding of schema therapy as a treatment for eating disorders. Another aim was to explore how those with eating disorders experience schema modes and the eating disorder voice and to what extent do they identify with and understand these concepts.

These aims led to the following research questions:

1. How do people with eating disorders experience schema therapy?
2. How do clinicians experience using schema therapy to treat eating disorders?
3. Do schema modes and the eating disorder voice have phenomenological reality?
4. How do clients identify with and understand schema modes and eating disorder voice?

This chapter seeks to answer these questions and addresses: experiences of schema therapy, theoretical implications, methodological and practical considerations, limitations, and future directions.

8.2 Experiences of Schema Therapy

8.2.1 Introduction

The studies in this thesis portray a series of experiences of what was unfolding for participants and how, whilst reflecting the processes of schema therapy. This research is the first to explore experiences of schema therapy from the perspectives of therapists and clients (longitudinally) using an IPA approach. Key findings from Study One (Chapter Five), highlighted participants' understanding of the function of their eating disorder, namely as a coping method. This is important as, once the function of coping is identified, clinicians can work with this and the associated modes driving their clients' eating disorder. Further, participants conveyed an understanding and awareness of their modes and eating disorder voice. All clients identified

with and recognised coping and critic modes the most. This supports the transdiagnostic theory that there are common maintenance mechanisms across eating disorders, regardless of diagnosis, with the findings suggesting that coping and critic schema modes are likely to be involved in the maintenance of eating disorders. There was some overlap in phenomenology between modes and the eating disorder voice. Clients frequently identified with their voice as a form of critic, which is beneficial for clinicians as it suggests that the voice can be incorporated into the mode map and addressed in schema therapy.

Study Two (Chapter Six) found participants moving from initial awareness of their modes to acceptance of them as parts of themselves. Participants formed a deeper connection with their modes, particularly their Vulnerable Child and described being able to nurture this side of their self, something that they felt unable to do before, highlighting the benefits of the mode approach. All participants continued to recognise and identify with their eating disorder voice as a form of inner critic, continuing to suggest that it tends to be a manifestation of a critic mode. The use of phenomenological tools for investigating modes is supported as the results of the client studies captured the dynamic aspects of modes that are important to them. Indeed, modes were something that participants identified with and could use to understand themselves.

There does not appear to be previous research investigating schema therapists' experiences of treating eating disorders. Therapists emphasised the benefits of schema therapy in contrast to other therapeutic practices, with a particular emphasis on the mode model for working with eating disorders. Schema therapy enabled therapists to go beneath the surface to truly address their client's underlying unmet needs and found the mode model (including associated experiential techniques such as chairwork and imagery) helpful in doing so. The results of this thesis build on preliminary evidence that schema therapy is beneficial in treating eating disorders, demonstrating the value of the mode model for clients and therapists alike.

The following sections explore what schema therapy means for clients and therapists, beginning with clients.

8.2.2 Experiences of Schema Therapy from Client Perspective

According to Husserl (1991/1893–1917), all experience is lived through and has a temporal flow. Ashworth (2016) proposes that the flow of events in a person's lifeworld requires investigation. For instance, when is the starting point of the experience and what is its conclusion, if it has one? For this thesis, the question lies in when did participants start their experience with schema therapy for their eating disorder and when did it end, if it has? And how did participants identify and recognise their modes and eating disorder voice in this temporal flow?

All participants were involved in schema therapy in the initial study, and this brought to light their understandings of schema therapy, their schema modes, and the eating disorder voice. In the longitudinal study, only one client was continually having schema therapy, with two on an as-and-when basis, and two clients opted for alternative treatment. One could argue that although the physical experience of schema therapy has ended for some, they are continually implementing learning acquired from schema therapy, supported by narratives and client's ever evolving understanding of schema modes. Thus, it could be that there is no end point, and the temporal flow continues throughout a person's lifeworld.

An important element of client's journey was their deepening connection to their Vulnerable Child over the course of schema therapy, with clients seemingly going from being aware of this part in Study One, to accepting this part of them in Study Two. Clients initially were not strongly aware of their Vulnerable Child. Trauma and maltreatment were remembered in 9/10 clients in the first study which is likely to have contributed to clients being reluctant to connect with their Vulnerable Child, possibly due to the hurt that they had experienced, accentuating the initial disconnect with this mode. This disconnect could also be attributed to the Vulnerable Child often being dominated by coping modes that may have developed to cope with the trauma and maltreatment. Although the Vulnerable Child was mentioned in the initial interviews, it was often ignored. Nevertheless, this awareness indicates phenomenological

reality as the Vulnerable Child was continually present in the experiences of clients, with the follow-up interviews encapsulating participants acceptance of this side. This finding concurs that schema therapy is beneficial in addressing and uncovering the needs of one's Vulnerable Child (Young et al., 2003), particularly in instances when clients had detached from this part of themselves. Thus, suggesting the applicability of the schema mode model in eating disorders.

The improved connection to client's Vulnerable Child could be the result of a strong therapeutic relationship. Limited reparenting was experienced by clients as providing a partial antidote to their EMSs over time, particularly those who experienced Emotional Deprivation and Abandonment EMSs. Indeed, there were notable decreases with the aforementioned EMSs in both the quantitative data (Table 9, Chapter Five; Table 13, Chapter Six) and in client's subjective experiences. Schema therapists were perceived as becoming the secure emotional base that clients did not have previously, in accord with Attachment Theory (Ainsworth, 1968; Young, 2003). The importance of this secure, therapeutic base was interwoven throughout accounts and has likely helped participants in the acceptance of their Vulnerable Child and management of their EMSs.

Moreover, a key element of participants journey was their continued understanding of their eating disorder and eating disorder behaviours, with many feeling that schema therapy enabled them to articulate why they were engaging in these behaviours. There is a distinct shift in narrative in the way participants view and understand their eating disorder in their journey.

In the initial client study, there was little mention of client's eating disorder with underlying tones of shame and guilt when it was spoken about. In the follow-up study, there was a significant improvement in the way in which participants described their relationship with their eating disorder; it was referred to as a friend, something that provided comfort, safety, and protection. The ways in which clients experienced their eating disorder as a friend were unique to them. It could be argued that participants' eating disorder was experienced as having evolved to protect their Vulnerable Child, thus providing a nurturing function associated with a friend. It is

through the longitudinal analysis that this came to light, suggesting that clients had, in some ways, learned to accept their eating disorder. Espíndola and Blay (2009) reported similar findings in those with AN viewing their eating disorder as a friend; Patmore (2020) suggested that some individuals with an eating disorder experience it as serving a positive function.

Additionally, clients experienced an eating disorder voice across both studies, with all participants referring to this as an inner critic. Schema therapy encouraged participants to recognise and understand when this entity was activated, similar to experiences with modes, with all clients describing how they had learned to engage with their inner critic, this was experienced across both time points. The critic appears to be consistent in clients' lifeworld.

When referring to the initial question, when is the starting point of the experience and what is its conclusion, if it has one? One could argue that this process has no end point, as even if therapy has physically ended, clients are continually learning and their understanding of the parts of themselves are evolving. Over two time points, clients experienced a growing connection to their Vulnerable Child, described an emerging Healthy Adult mode, alongside diminishing Coping and Critic modes. Clients also experienced a deeper understanding of their eating disorder and suggested it was a friend to them; these changes could be attributed to schema therapy. The following subsection explores schema therapist's experiences.

8.2.3 Experiences of Schema Therapy from Schema Therapist Perspective

Each schema therapist interviewed had experience in a wide range of therapeutic practices including CBT, CBT-E, FBT, and DBT. However, as reflected in the Group Experiential Themes (GETs) in Chapter Seven, schema therapy was described as their preferential treatment for eating disorders as it provided them with additional *tools and techniques* to help them to go *beneath the surface,* to *develop the therapeutic relationship*, whilst continually reflecting on the *impact on self*. Indeed, the GETs illuminate participants' positive experiences with schema therapy as a treatment.

Tools and Techniques such as experiential techniques, limited reparenting and empathic confrontation, promoted the development of a good therapeutic relationship. The findings in this study mirror previous literature (de Klerk et al., 2017; Pilkington et al., 2022; Pugh et al., 2021; Ten Napel-Schutz et al., 2017), whereby therapists, similar to clients, valued experiential techniques but at times, felt emotionally overwhelmed, particularly when using imagery. Participants illustrated the importance of being aware of their own EMSs/modes and the impact this had, particularly in promoting both their clients and their own Healthy Adult. Throughout, a good therapeutic relationship was described as the driving catalyst for recovery to begin.

Bowlby (1969) describes the therapeutic relationship as two people with different internal working models interacting with each other in some way. When the therapeutic relationship goes well, it is referred to as resonance (Siegel, 1999), this was seen in narratives and generally experienced by participants. However, at times, participants experienced dissonance in the client-therapist relationship (Young et al., 2003) or a schema clash (Leahy, 2008). This thesis highlighted scenarios when this occurred, such as experiencing a Vulnerable Child or Detached response to a client in Angry Child mode, or an Unrelenting Standards EMS, coupled with an Overcontroller mode in response to a client's Helpless Surrenderer mode. The theme *'impact on self'* captures these experiences and demonstrates self-awareness, emphasising the impact that this had on participants.

In contrast to previous therapeutic practices, aligned with client's experiences, schema therapy was described as going beneath the surface to reach client's core issues. First-line treatments were described as surface-level and unsuitable for clients with a *'good going eating disorder;'* aligning with previous research that first-line treatment may not be suitable to treat all eating disorders (Waller & Kennerley, 2003, p.239) with poor outcomes often described (Simpson et al., 2010). Additionally, schema therapy was experienced by all as beneficial in working with challenging schema modes, such as the Helpless Surrenderer, Detached Protector and Overcompensatory modes.

Going beneath the surface allowed participants to understand the function that schema modes and eating disorders had for their clients. For example, coping modes had often evolved to protect and/or soothe client's Vulnerable Child and were found to work in such a way that responded to the unmet needs of the Vulnerable Child, creating an instantaneous relief, albeit often maladaptive long-term. Schema therapy enabled participants to go beneath the surface and 'detect' these functions with one participant referring to schema therapists as 'detectives,' *"you have to do a lot of detective work and I love that; I love that kind of challenge really of what, what's the formulation for this person" (Zara, 135 – 137),* accentuating the depth of schema therapy in discovering these functions.

Similarly, schema therapy was experienced as allowing therapists to uncover the meaning and function of their client's eating disorder. Previous literature deduces that eating disorders have a positive function for some clients, often as control and security (Crisp, 1997; Erikson et al., 2012; Patmore, 2020). In this thesis, participants experienced their clients eating disorders as acting as a source of protection, safety (soothing), and control. Therapists emphasised the importance of understanding the function that client's eating disorders had served them, particularly the positive attributes that clients assigned to it. Participants spoke highly of schema therapy and emphasised the benefits of this approach, particularly in contrast to previous therapeutic approaches.

8.2.4 Summary of Experiences of Schema Therapy

Schema therapy encompassed many positive experiences for clients and therapists in their lifeworld, including, but not limited to, the therapeutic relationship, understanding the parts of oneself, understanding the function behind the eating disorder and schema modes, and the importance of experiential techniques allowing clients to build a connection to meet the needs of their Vulnerable Child. Clients in particular, reflected on the benefits of schema therapy in their eating disorder journey, cementing it as an important part of their lifeworld.

The following sections explore the theoretical implications of this thesis, including clients and therapists understanding and identification with schema modes and the eating disorder voice, alongside the meanings that these encompassed.

8.3 Theoretical Implications

8.3.1 Introduction

A goal of phenomenological research is to understand the underlying structure of human experience by going beyond the bare verbal descriptions and reading between the lines to provide an in-depth explication. The GETs in this thesis emphasise experiences of schema therapy, with focus on the experiences of modes and the eating disorder voice, particularly in clients. Previous literature is sparse (but see Bowker, 2021; Edwards, 2017a; Edwards, 2017b).

The idea that there are discrete parts of the self has been widespread for decades. Berne (1961), in Transactional Analysis, coined the term 'ego-states', when he described three ego states: Parent, Adult, and Child. He described these as *"not just concepts but phenomenological realities"* that reflect differences and experiences within the individual, much like the schema mode model (e.g., Punitive Critic, Healthy Adult, Vulnerable Child), while Ellenberger (1970) suggested that beneath the ego are a multitude of sub-egos that are not in our conscious awareness and are *"constituted to our unconscious life"* (p. 168). Schema therapy theorises these sub-egos as the different modes. Each schema mode is based on an internal organisational unit, allowing an individual to repeatedly exhibit the same cognitive, emotional, and behavioural patterns when confronted with similar situations, hence they become semi-autonomous states (Lazarus et al., 2020). Within schema therapy, the parts of the self are categorised as: child, coping, critic, and adaptive schema modes (Young et al., 2003). The aim of the following section is to address whether participants recognised and identified with the concept of schema modes and eating disorder voice across all three studies. Particularly using IPA, it is important to bear in mind that schema therapy theory does not insist that everyone experiences manifest schemas and modes in exactly the same way. There were individual

differences in how different modes manifested for the person. However, the focus here will be on commonalities of experience.

8.3.2 Do participants recognise Child Modes, Coping Modes, Critic Modes, and Adaptive Modes?

8.3.2.1 Child Modes. Although experienced by all, child modes were described and recognised less explicitly than other modes. For example, seldom was the Vulnerable Child mode spoken about in the initial client interview, with many expressing reluctance to accept it, often making their Vulnerable Child sit backstage, disengaging from this part. In chairwork, clients described how their Vulnerable Child would often be in a corner chair, a position often symbolic of wrongdoing – i.e., the naughty corner - thus creating distance from this mode.

Roediger and Archonti (2019) suggest that the Vulnerable Child is frequently placed backstage behind other modes, with coping modes often taking frontstage. As therapy progressed, clients began to speak more openly about their relationship with this part of them and the growth is reflected for participants who participated in the follow-up study (Chapter Six). Although suppressed initially, the results propose that this part of them was always there, suggesting phenomenological reality. The Vulnerable Child mode is elevated in those with an eating disorder (Bowker, 2021; Edwards 2017a; Talbot et al., 2015), and this research has captured the importance of a developing recognition and understanding the role of the Vulnerable Child during schema therapy.

The Vulnerable Child was frequently described as an 'inner child,' it was through the context of the narratives that I was able to interpret this as the Vulnerable Child, rather than another child mode. It could be that clients identified more with their Vulnerable Child mode than other child modes, or they do not recognise the nuances between child modes and as such, collectively refer to this part as their inner child. There was little explicit mention to other child modes such as the Happy Child, Angry Child, or Undisciplined Child, despite participants scoring highly on these following completion of the SMI-ED (Simpson et al., 2018). Fiona

alluded to an Undisciplined Child and Jane recognised a Rebellious Child, one could assume that this is also the Undisciplined Child. Although seen in the quantitative data in the first client study, the Happy Child mode was not explicitly recognised by participants, despite subtle references in interviews.

Child modes were also recognised and experienced by schema therapists. Participants (Chapter Seven) reflected on the recognition of child modes in their clients but were less explicit about their own experiences. This is not to say that they did not experience these modes, with some participants alluding to having their Vulnerable Child triggered in challenging sessions. For example, when confronted with a client with an Angry Child or Demanding mode or an Entitlement EMS, participants described feelings of fear and inadequacy, feelings representative of the Vulnerable Child, also reported by Pilkington et al. (2022).

To summarise, narratives demonstrate that clients had seemingly detached from their Vulnerable Child for so long that this part was initially quite challenging to reach and recognise. Many clients described a history of trauma and maltreatment which may account for the detachment from their inner child. For therapists, they too were less explicit about their child modes, however, did recognise them in themselves and their clients. Therapists were perhaps more attuned to their inner child and their needs and thus, were more aware of this part.

8.3.2.2 Coping Modes. Previous research has found coping modes to be elevated in those with an eating disorder (e.g., Luck et al., 2005; Talbot et al., 2015; Voderholzer et al., 2014; Waller et al., 2007) and in healthcare professionals (Pilkington et al., 2022). Coping modes were most widely recognised by all participants in this thesis. In the first client study there was awareness of these modes, whereas in the follow-up, the function these modes served was understood. The GET *'connecting to parts of self'* in Chapter Six, truly captures clients increased recognition of these modes.

Eating behaviours in coping modes are theorised shut down stress experienced by the Vulnerable Child (Simpson, 2019). This was found in both client studies, whereby binge-eating

was frequently used as a self-soothing detaching method in bulimic disorders and overcompensatory behaviours including restriction and over-exercising were commonly utilised in restrictive disorders. Participant accounts reflect their recognition and understanding of these modes. There were some negatives associated with coping modes in clients as these modes were experienced as perpetuating disordered eating behaviours, including purging, bingeing, and restricting long-term. Initially, coping modes, such as Detached Self-Soother, were perceived as functional and a method of soothing distressing emotions, however, they were found to frequently maintain a dysregulated emotional state (Dadomo et al., 2016), leading to long-term emotional dysregulation, despite short-term relief.

Nevertheless, not all coping modes were perceived this way. For instance, overcompensatory modes were perceived as functional in helping participants reach their goals in life (e.g., reference was made to obtaining a degree) and detached modes were recognised as enabling clients to detach from painful situations, creating a temporary soothing environment. Overcompensatory modes were predominately experienced by those with restrictive disorders, whereas detached modes were experienced more by those with bulimic disorders but were also present in restrictive disorders. Detached modes were particularly evident, for all participants recognised these and awareness of the coping modes increased in the second interview.

Simpson et al. (2018) developed the eating disorder specific Eating Disorder Overcontroller and Helpless Surrenderer modes. The Eating Disorder Overcontroller was recognised and often experienced as the eating disorder voice; for instance, participants described how this mode provided them with control over food and gave them a physical and emotional ‘high.’ Clients in the initial study described experiences that mirrored the Helpless Surrenderer mode with 8/10 participants scoring highly on this mode and 3/5 in the follow-up study. Simpson et al. (2018) suggest that this mode is elevated in those with an eating disorder which could account for the higher scoring. However, clients did not recognise this mode in themselves, although their narratives suggest that they had experienced it.

Moreover, schema therapists recognised their coping modes and described situations in therapy in which they were activated. Simpson et al. (2019) found coping modes to be elevated in mental health professionals. Pilkington et al. (2022) found that schema therapists employed coping modes in sessions in response to client's schema activation; this was often a detached response. Here, therapist-participants reflected on how particular modes in clients, often a Helpless Surrenderer or Angry Child mode, would trigger a Detached Protector response to manage their own needs in sessions.

Coping modes were widely experienced by client and therapist alike, indicative of phenomenological reality. Although a variety of schema modes were experienced by all, clients and therapists primarily recognised detached and overcompensatory modes. It is hypothesised that people may be unconsciously drawn to those with similar EMSs and modes to their own, Zara (Chapter Seven), states *"we often have very similar schemas to those of our patients"* (275), suggesting that therapists and their clients are not too dissimilar from one another.

8.3.2.3 Critic Modes. Parent modes were initially divided into Demanding Parent and Punitive Parent (Young et al., 2003); as the literature has evolved, more have been identified, such as Guilt-Inducing Parent mode (Jacob et al., 2014, p.51). However, for this section, I will focus solely on Punitive and Demanding modes. Instead of having separate parent modes, participants recognised and experienced a parent mode that combined both Punitive and Demanding aspects, this was referred to as a general inner critic.

Parent modes are described as critic modes as the literature suggests that the term 'parent mode' does not resonate well with clients (Roediger & Archonti, 2019, p.229). The inner critic has parallels to the eating disorder voice (Pugh & Rae, 2019). For clients, the critic was a prominent part of their phenomenological reality and was frequently personified as a negative entity, such as, *'the dragon,' 'the devil'* or a *'demon.'* The negative attributes of the eating disorder voice have been widely conveyed and are expressed in several studies (e.g., Noordenbos et al., 2014; Pugh & Waller, 2017; Pugh, 2018; Reid et al., 2008). Whereas the

positive presence of the voice has been found in limited research (e.g., Tierney & Fox, 2010). Clients acknowledged that their inner critic has a functional element and was experienced by some as working with their Unrelenting Standards EMS or Overcontroller mode, resulting in feelings of achievement, for instance, if one had eaten less than the previous day or exercised more. The recognition of the voice as a barrier (Chapter Six) stipulates that schema therapy has enabled participants to recognise this part of them, particularly when activated, thus indicative of recognition.

Schema therapists too recognised and described their own inner critics (e.g., *"I'll be in the stocks")* and the impact it has on them. Their inner critic frequently created anxiety and panic, often driving unhelpful coping such as the activation of an Overcompensatory mode to try and meet the needs of their clients *"I need to give them tools!"* Unlike clients, the inner critic did not appear to have a functional element, perhaps due to therapists increased understanding of the nature of this mode. Further, therapists also discussed recognising their client's inner critic too. Alike clients, this was generally perceived as the eating disorder voice, suggesting some overlap in terms of phenomenology, or indicative that the eating disorder voice is a form of critic mode specific to eating disorders due to the nature of the criticism, as seldom was criticism in other areas of life (e.g., work) expressed, with criticism predominately experienced around weight, shape, and food. Indeed, all participants in each study recognised a form of critic.

8.3.2.4 Adaptive Modes. Previous research suggests that the Healthy Adult is limited in people with eating disorders due to the dominant presence of maladaptive modes (Talbot et al., 2015; Voderholzer et al., 2014). Clients were less articulate about their adaptive modes. There is an acknowledgement of the Healthy Adult as the catalyst in recovery in the initial interviews, then in the follow-up the Healthy Adult mode was discussed more, probably as a result of schema therapy. In the follow-up client study, the Healthy Adult was experienced by clients as a conductor, orchestrating their other modes, nurturing their Vulnerable Child, and managing their coping and critic modes. This is supported by the GET '*making sense of schema therapy,'*

Chapter Six. The Happy Child mode was also experienced by clients, but mainly implicitly in both interviews, indeed, little recognition was given to this mode.

Every participant recognised the Healthy Adult to some extent, but it was predominately discussed by schema therapists, with many reflecting on how they maintained their Healthy Adult mode in sessions (e.g., limited reparenting, empathic confrontation, and Sophie's novel use of post-it notes, see Chapter Seven). This could be because therapists are more versed in the concept of schema therapy and have had more practice at being in this mode in contrast to clients. Their active engagement with this mode suggests phenomenological reality for the therapists, while schema therapy proposes that clients may have only a limited Healthy Adult, which seemed to be the case here, particularly in Study One.

Whereas we see clients embrace their Healthy Adult and recognise and identify with this part of them as a valuable mode in their recovery in their follow-up interviews. The Healthy Adult mode improved clients' understanding of their eating disorder and empowered them to manage their coping modes in a more adaptive way, particularly in terms of reducing disordered eating behaviours (e.g., Detached Self-Soother and the Eating Disorder Overcontroller). Indeed, schema therapy was considered by all to be a beneficial treatment for eating disorders.

8.3.3 Summary of mode recognition

Schema modes were experienced as fluid states, adapting to the situation as required. As expected, therapists had a more nuanced understanding of modes and recognised the phenomenological reality of schema modes. Clients also recognised the broad phenomenological reality of schema modes: child modes, coping modes, critic modes, and adaptive modes. Interestingly, some clients were not in touch with their inner child prior to therapy and initially experienced a limited Healthy Adult. All participants from each study recognised and understood the concept of schema modes and some felt able to apply this learning into everyday life. This demonstrates the applicability of the mode model and the proposed benefits of schema therapy in treating eating disorders. The following section

addresses participants' identification with specific schema modes. Although many were recognised, participants identified with a select few.

8.3.4 Do participants identify with specific modes, if so, which ones?

Schema modes are part of an individual's experience and are *"derived phenomenologically by therapists in each therapy session"* (Edwards, 2017a, p.4), they continue to be developed as schema therapy evolves. This section captures the modes which participants identified with in each of the three studies. Client studies will be discussed separately as 'time point one' and 'time point two.' In time point two, comparisons will be made between the five participants who took part in both client studies to explore any changes in identification with modes. Schema therapists' identification of schema modes is also explored.

8.3.4.1 Clients Time Point One.

Although there was variability in the quantitative results, with high scoring modes on the SMI-ED (Simpson et al., 2018) being: Compliant Surrenderer (*n*=8), Demanding Critic (*n*=6), Vulnerable Child (*n*=5) and Happy Child (*n*=5), clients only tended to identify with a few specific modes. The qualitative data portrays participants identification of certain modes and the meaning that these encompassed, emphasising the importance of qualitative research as without it, it is likely that these experiences would not have been captured.

Firstly, all ten participants identified with a form of inner critic. This finding is consistent with the literature (Noordenbos & van Geest, 2017), in that those with an eating disorder are more likely to experience a recurrent and distressing critical internal voice. The criticism described was predominately around food, weight, shape, and appearance, a presentation consistent with the eating disorder voice. Participants personified it as a negative entity, emphasising the critical nature of this mode. Therefore, one could argue that the inner critic experienced by those with an eating disorder could be the eating disorder voice.

Secondly, clients identified with the Eating Disorder Overcontroller which also has similarities to the eating disorder voice. Clients with restrictive disorders were found to identify

with this mode more than those with bulimic disorders and described how it gave them a sense of control when other areas of life were perceived as out of control, particularly in areas relating to food restriction. This is further elaborated upon in section 8.3.5.

Third, clients identified with the detached modes, with many accentuating the role that detachment has played in their lives, *"I have a Detached Protector who is queen of everything!" "I'm in an orb state," "I'm in quite a detached space."* Seldom did clients differentiate between Detached Protector and Detached Self-Soother, but generally identified with a detached mode combining both aspects. Identification with detached modes was encapsulated by the subtheme *detachment and dissociation*, Chapter Five, whereby participants utilised this method of coping to avoid emotionally painful situations. Dissociation has been found to be an adaptive response to trauma (Nijenhuis & Van der Hart, 2011). 9/10 participants in this study described a form of trauma or maltreatment in their childhood, thus, it could be that the detached modes have evolved to continually protect participants, even if they no longer need it. Detached modes are likely to have developed to protect the Vulnerable Child from harm that could not be escaped any other way (Young et al., 2003). One could argue that detachment has developed as a method of protecting client's Vulnerable Child from intense emotions. Therefore, the reason for not identifying with the Vulnerable Child in this study could be because participants were too detached to experience this side.

There was little awareness of the Vulnerable Child in this study, this could be due to the negative connotations that participants associated with vulnerability. Simpson (2019) suggests that many clients with an eating disorder have learned to avoid feelings or vulnerability as they are associated with being weak. Often, this is an internalised message from client's inner critic. This was reflected in narratives as participants described how close others would perceive vulnerability as a weakness, for example *"my dad was very much stiff upper lip," "it was weak to show emotions,"* likely leading to the development of an Emotional Inhibition EMS and detached coping modes, blocking the connection to the Vulnerable Child. The narratives suggest that

although participants did not explicitly identify with their Vulnerable Child, accounts infer that it was present, indicative of phenomenological reality.

8.3.4.2 Clients Time Point Two.

Since the initial interview, some participants declined a follow-up interview. This section covers the (*N*=5) clients who also took part in this study and the modes which they identified with in their second interview, in comparison to their first interview. Common high scoring modes on the SMI-ED (Simpson et al., 2018) included: Compliant Surrenderer (*n*=4), Eating Disorder Overcontroller (*n*=4), Detached Self-Soother (*n*=4), Vulnerable Child (*n*=4), Demanding Critic (*n*=3).

Clients were found to identify with critic modes, coping modes (detached modes and the Eating Disorder Overcontroller), child modes (Vulnerable Child and Rebellious Child – likely Undisciplined Child) and most importantly, clients identified with their Healthy Adult. Clients continually identified strongly with an inner critic mode, yet the nature of the criticism experienced was synonymous with the eating disorder voice and as such, is discussed in section 8.3.5.

For participants included in both this study and the first study, their coping modes remained fairly consistent. Coping modes commonly develop in early life (Young et al., 2003) and are often perceived as helpful, which could account for the continued recognition and identification with these modes. Coping modes generally operate outside conscious awareness; thus, it could be argued that schema therapy has brought them into client's conscious awareness, enhancing their identification with these modes.

In the second interview, clients still identified with detached coping modes. However, clients with bulimic disorders identified more with detached modes than those with restrictive disorders. Bingeing and purging are impulsive acts that block out affect following the activation of an EMS; detached modes are thus activated to cope with the activation of EMSs and to protect/soothe the Vulnerable Child. This, therefore, could explain the continued identification

with these modes. There were subtle nuances between Detached Protector and Detached Self-Soother experienced in narratives, however, seldom were detached modes distinguished with participants referring to a generic detached state. It is likely that this mode has developed to protect clients, hence the continued identification with this mode due to the importance held by clients. Simpson (2019) suggests that those with an eating disorder are bonded to a particular coping mode; clients in this study were seemingly bonded to their detached modes.

Additionally, clients continued to identify with the Eating Disorder Overcontroller. This was seen in all participants, regardless of diagnosis, suggesting that there are commonalities across diagnoses, thereby aligning with the transdiagnostic approach that coping modes are likely to be maintaining and perpetuating eating disorders (Simpson, 2012). As with the initial interviews, this mode mirrored aspects of the eating disorder voice, whereby participants described the sense of control it gave them.

An important change across interviews was that participants moved from having some awareness of their Vulnerable Child, to accepting their Vulnerable Child. This finding is particularly important as the Vulnerable Child is often the side that has suffered from unmet needs in childhood. Schema therapy helps clients to accept the existence of their Vulnerable Child (Simpson, 2019). This was reflected in this study as clients expressed feeling more attuned to their inner child and felt able to identify and nurture this part of themselves with support from their Healthy Adult. In their interviews, all participants identified with a form of inner child, often the Vulnerable Child and of the five, two also identified with a form of Rebellious/Undisciplined Child.

The biggest change was participants' identification with their Healthy Adult mode. Although this mode was acknowledged during the first study as important for recovery, there was little explicit mention of the Healthy Adult. It was more present in the follow-up study and was experienced in ways including, references to this part in the first person, the hope portrayed towards recovery and the way in which clients responded to barriers. A psychologically healthy

sense of self was experienced by participants (Oldershaw & Startup, 2020). Thus, it is plausible that schema therapy has strengthened clients' Healthy Adult mode.

The GETs reflect the growth, understanding and identification with modes following additional schema therapy. As a result of schema therapy, one could assume that the barriers to accessing one's Vulnerable Child have been broken down, allowing clients to connect to their vulnerability and this part of them, enabling healing to begin.

8.3.4.3 Schema Therapist's Study.

"We should take care of ourselves in a healthy way before taking care of others."

(van Vreeswijk & Zedlitz, 2019, p.249)

Although schema therapists recognised each category of mode, they particularly identified with Detached Protector, a form of Overcontroller, and the Healthy Adult mode. Participants were consciously aware of when Detached Protector was activated in sessions with many identifying with this mode as a way of coping when experiencing a schema clash with a client. For example, if a client expressed an Angry Child mode or Entitlement EMS, schema therapists described how they would find themselves in a detached mode to protect themselves and their own Vulnerable Child. The literature depicts this mode as common in mental health professionals (Pilkington, 2022; Simpson et al., 2019), which may explain why many participants were found to identify with this mode.

Furthermore, participants described experiencing an Overcontroller during therapy. Participants frequently referred to needing to give their clients 'tools' and described instances where they would exceed expectations for the clients *'what can I do, I will…, do you need me to...'* at expense of their own needs. All participants experienced and identified with an Overcontroller response. Simpson et al. (2019) suggest that many healthcare professionals may utilise an Overcontroller mode and cope through striving for achievement or perfectionism. Perfectionism was illuminated within participant narratives, thus, solidifying participants' strong identification with this mode.

Moreover, the narratives portray participants identifying with their Healthy Adult in sessions, with many having their own unique way of doing so, for instance, Sophie would stick post-it notes in her office as a reminder to be present in this mode, particularly in challenging sessions. Each therapist described having consistent and frequent supervision to strengthen their Healthy Adult both in and out of sessions. Therapists were found to model their Healthy Adult to their client. All therapists in this study identified with their Healthy Adult.

Schema therapists were found to have a more nuanced understanding of modes than clients. Although they identified with coping modes such as Detached Protector and Overcompensatory modes, they were aware of instances when they were becoming maladaptive, such as doing too much the expense of one's own needs. Schema therapists recognised an inner critic; however, they did not identify with this mode and in contrast to client studies, they were more reflective around the impact that this mode had. Schema therapists predominately identified with their Healthy Adult Mode. This is particularly helpful as by revealing their own emotional reactions, they served as a healthy role model for their clients (Roediger & Archonti, 2019, pp.222).

8.3.5 Do clients recognise and identify with the eating disorder voice?

Heard voices are recognised to be an important source of meaning-filled information regarding vulnerability and unresolved trauma (Steel et al., 2020). Schema modes are composites of EMSs, that is internal organisational units, whereby individuals repeat the same emotional, cognitive, and behavioural patterns when similar situations arise (Lazarus et al., 2020). The same could be argued for the eating disorder voice and it may be a manifestation of the Eating Disorder Overcontroller. It is experienced as an internal unit that is activated when EMSs around food, shape, and weight are triggered, such as Unrelenting Standards or Defectiveness. There was recognition by clients of their eating disorder voice in the first study in the sub-theme *'identifying the eating disorder voice'* and throughout into the follow-up study as the voice was recognised as a barrier for recovery.

Clients identified with a general inner critic encompassing both demanding and punitive elements. As the literature suggests (Pugh & Rae, 2019), the eating disorder voice could be a form of critic specific to eating disorders. The critic was a prominent part of client's phenomenological reality, regardless of where they were in their recovery journey. Indeed, there was a strong identification to this part from all clients in both studies. Much like the ego-syntonic nature of the eating disorder voice (Reid et al., 2008), critic modes have been described as highly ego-syntonic (Simpson, 2019). Thus, like modes, both client studies suggest that the eating disorder voice is part of an individual's internal organisational unit and could be an extension of critic modes specifically in relation to eating disorders, encompassing elements of the Eating Disorder Overcontroller.

Like modes, the eating disorder voice is fluid and functions in response to how the individual is feeling. For example, it may be soothing following a purge, congratulatory if one has restricted more or critical if one has eaten 'too much.' This suggests that the voice is separate to modes, however, appears to function in a similar way; there is overlap in terms of phenomenology, nevertheless, there are distinguishing characteristics. Firstly, the eating disorder voice is specific to eating disorders, whereas one could argue that anyone can experience schema modes. Not everyone with an eating disorder will have experienced schema therapy and may be unfamiliar with the concept of modes, however, the literature suggests that the concept of the eating disorder voice resonates with those with an eating disorder (e.g., Ling et al., 2022; Pugh et al., 2016; Pugh & Waller, 2017). The results of this thesis also support this.

It is worth noting that clients did not spontaneously discuss an eating disorder voice; in fact, it was seldom referred to as a voice by clients. In the steering group, prior to the initial client interviews, participants considered that the word 'voice' held a lot of stigma, which may explain why clients referred to it as a critic. Despite not calling it a voice, when asked explicitly about the eating disorder voice, clients recognised this as a part of themselves, as a form of inner critic, focused on weight, food, and appearance.

The content of the voice differed between clients but there tended to be a melange of the critic modes (e.g., demanding, and punitive messages about looking a certain way, eating certain foods, exercise) and coping modes (e.g., soothing, congratulatory, and controlling) and is perhaps closest to the Eating Disorder Overcontroller due to the competitive nature of the voice and the sense of competence, omnipotence and control that it provides. All clients, across both studies, were found to recognise and identify with their eating disorder voice.

8.3.6 Summary of identification of modes and the eating disorder voice

All participants experienced at least one mode from each category. Clients identified most with a form of coping mode, often a detached or overcompensatory mode, as did therapists with the addition of a strong Healthy Adult. Indeed, clients and therapists identified with and experienced similar modes. Although recognised by all, clients tended to identify with a critic mode, whereas therapists did not, suggesting the identification to the critic for clients could be their eating disorder voice.

Child modes were recognised by all participants but were also least identified with. For clients, this could be explained by the domineering presence of coping modes. Simpson et al. (2018) suggest that the Eating Disorder Overcontroller and Detached Protector are highly correlated with the Vulnerable Child. Coping modes are often used to keep the Vulnerable Child outside of conscious awareness whilst they attend to distress. This may explain why clients were apprehensive about this mode as their coping modes had kept their Vulnerable Child outside of their conscious awareness for so long, and thus, to be faced with their Vulnerable Child initially created fear and ambivalence. It is through schema therapy that clients’ Vulnerable Child has been brought to light, particularly at time point two. For therapists, it is likely that they are aware and accept their Vulnerable Child.

8.4 Methodological and Practical Considerations

8.4.1 Methodological Considerations

A strength of IPA was that it allowed an in-depth exploration of participants' experiences. Each interview was analysed carefully and in detail to improve the rigour of the studies, to ensure participants' experiences were captured, and to facilitate a good level of interpretative engagement with the script. The sample sizes were sufficient to allow for in-depth analysis and ensuring that the voices of all participants were heard, thereby meeting the idiographic commitment of IPA (Smith et al., 2022).

A criticism of IPA is that a small sampling pool was used. Only those who were receiving schema therapy for their eating disorder or schema therapists treating eating disorders were eligible; this was adapted in the client follow-up study as some participants were no longer having schema therapy. Nevertheless, it was important to capture their experiences over time with a focus on schema therapy, schema modes and the eating disorder voice.

Schema therapy has only been applied to eating disorders in the last two-to-three decades and it is likely that this was a factor in the recruitment difficulties. When recruiting, I was invited by a schema therapist whom I had contacted, to join a specialist group on social media for schema therapists working with eating disorders. I advertised my client study and schema therapists shared it with their clients, who then contacted me if they were interested. This same method was used when recruiting schema therapists. The homogeneity of the client sample comes from included participants having an eating disorder. The heterogeneity of diagnosis within client's diagnosis is defensible in terms of transdiagnostic conceptualisations of eating disorders, which is supported by the identification of consistent themes between clients. Similar themes also developed from schema therapists. The heterogeneity of schema therapists it is that they are all treating people with eating disorders.

Furthermore, regarding validity of findings, all participants in the first client study were engaged in schema therapy, but only one was consistently having schema therapy at follow-up,

with two having it on an ‘as and when basis is, due to practical constraints, and two opting for different treatment (EMDR and a life coach). It is acknowledged that this may have influenced participants’ interpretation of schema modes and the eating disorder voice. Schema therapists had varying years of experience of using schema therapy to treat eating disorders. It is recognised that the variation of years of experience (3 – 25 years) may have had an influence on the results, however despite the variation in years of experience, therapists had a comparable understanding of schema therapy and its application to eating disorders.

As discussed in Chapter Four (Methodology), I consider I have achieved Yardley’s principles for quality for qualitative research, including: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance (2000). More recently, Nizza et al. (2021) proposed four markers for achieving quality specific to IPA research; I will discuss each of these in turn and reflect upon how my thesis met these criteria.

8.4.1.1 Markers of IPA: Constructing a Compelling and Unfolding Narrative

This is where the analysis describes a persuasive and coherent study (Nizza et al., 2021). The narrative is constructed through an unfolding analytic dialogue between carefully selected and interpreted participant extracts. The interpreted extracts from clients convey their story, highlighting their experiences with schema modes and the eating disorder voice.

It is particularly important that clients identified with their schema modes as it captures their understanding of schema therapy and the parts of the self in relation to their eating disorder. Clients also identified with their eating disorder voice, despite not bringing this up themselves; the continued reference to an inner critic, focused on weight, shape and food, encapsulates client’s understanding of this part. Similarly, the interpretations from therapists’ narratives portray their story from finding schema therapy, to the impact it has on them, demonstrating their journey and understanding of their own EMSs and modes.

8.4.1.2 Markers of IPA: Developing a Vigorous Experiential and/or Existential Account

This marker focuses on the important experiential and existential meaning of participant's accounts (Nizza et al., 2021). Throughout the analyses, insight, and depth into experiences of schema modes, the eating disorder voice and schema therapy are portrayed; whilst also illuminating client's experiences of what led them to have schema therapy and their understanding of the development of their schema modes. And for therapists, their experiences leading up to them training in schema therapy is conveyed, with particular emphasis on their own EMSs, schema modes, and experiences of previous treatments. In unison, the analysis provides experiential accounts of both participant groups.

8.4.1.3 Markers of IPA: Close Analytic Reading of Participant's Words

This marker focuses on thorough analysis and interpretation of quoted material within narratives to give meaning to the data (Nizza et al., 2021). This was accomplished through careful analysis and interpretation of interview data, thus, giving meaning to experiences of schema therapy. Quotes were not only analysed as an immediate quote, but in the wider context of participant's narratives, bringing about author transparency. For instance, capturing experiences of schema modes and the eating disorder voice and how these were experienced by participants. As well as how therapists worked with maladaptive modes in sessions, therefore drawing out meaning from the quotes.

8.4.1.4 Markers of IPA: Attending to Convergence and Divergence

This marker illustrates the similarities and differences between participants, demonstrating the connections across participants but also highlighting what makes a particular experience unique to a participant (Nizza et al., 2021). This can be seen throughout each analysis as clients are connected, for instance in their experiences of schema modes and the eating disorder voice. Although participants experienced similar modes, it was the way in which these were experienced that suggest individual differences and emphasises the idiographic nature of modes. An example is that each client experienced a form of detachment, but it is how they experienced this that makes this unique to them and phenomenologically distinct from each

other. A further example of convergence is that all participants experienced the eating disorder voice, however, the divergence was the content from the voice and the impact that differentiated participants. For schema therapists, the similarities were in the EMSs and modes they experienced, but the divergences developed in the way they experienced these and the ways in which this impacted them. Thus, for the reasons described, when assessing my research against these criteria, I believe this thesis has achieved the four markers of quality in IPA.

8.4.2 Practical Considerations and Implications

This thesis sought to build on existing evidence for schema therapy as a treatment for eating disorders. Client and therapists alike valued schema therapy with many preferring this approach to other treatments. Schema therapy is thought to be beneficial in clients where first-line treatment has not been effective (Simpson et al., 2010; Simpson & Smith, 2019). Simpson and Smith (2019) suggest that it is the level of engagement that distinguishes schema therapy from other treatments, as clients feel understood on a deeper level. It could be argued that schema therapy is advantageous when compared to current recommended first-line treatments in that it is suitable for different diagnoses of eating disorders (e.g., AN, BED, BN), whereas many first line treats such as MANTRA, SSCM, and FPT, focus on AN.

Distinguishing schema therapy from other treatments is the concept of limited reparenting (Young et al., 2003). As described in section 7.3.3, limited reparenting is thought to mirror the attachment process and can help clients to meet their core needs such as stability, autonomy, and security. Therapists can thus serve to compensate for their client's EMSs, particularly those in the Disconnection and Rejection Domain (e.g., Abandonment), therefore strengthening their Healthy Adult. The results of this thesis reflect this, supported by the ways in which clients described their therapists '*she saved me,' 'so compassionate,' 'the actual nurturing side of things as I never learned how to do that,'* thus, differentiating schema therapy from other therapies due to limited reparenting and healing attachment disruptions.

Another concept specific to schema therapy is the mode model. The results of this thesis and previous research (e.g., Bowker, 2021; Edwards 2017a; Edwards 2017b) support the use of the mode model in treating eating disorders. In this thesis, the mode model provided clients with a deeper insight into the development of their modes and the impact they have had on the development and maintenance of eating disorder pathology. For example, almost every client had one of the Detached Coping modes, suggesting that they are an important area for intervention. Therapists too resonated with the mode model both in themselves and in their clients.

Furthermore, clients in this research were in treatment for varying times, ranging from three months to three years with many opting to pay privately for treatment. Young et al. (2003) recommend three years of schema therapy for those with BPD, which may also be appropriate for people living with an eating disorder and BPD or another characterological problem. More recently, briefer (Kiers & Haan, 2024) and group (Simpson & Smith, 2019) versions have been developed, which may also be useful (and more affordable) for less complex clients.

Ideally, schema therapy will end when a client feels their Healthy Adult has developed so that they can manage their eating disorder, meet their unmet needs, and challenge their coping and critic modes. The findings of this thesis suggest that this is not the only acceptable end point of therapy. Schema therapy does not necessarily eliminate clients' maladaptive schemas and modes. Even when some are still present, it appears that schema therapy can provide clients living with an eating disorder a life-long toolkit that they can use to understand and manage themselves and their eating disorder. Recovery is subjective and relative to the severity of the person's prior issues. Here, many participants described learning, via schema therapy, skills to manage their eating disorder, rather than eliminating it.

Moreover, many benefits were found in this thesis; however, schema therapy was sometimes inaccessible due to practical reasons and affordability. Healthcare services are under pressure to find ways to provide treatments for people with eating disorders. One possible

way to address this is combining group and individual protocols (Simpson & Smith, 2019). Simpson et al. (2010) suggest that group schema therapy may catalyse the effects of schema therapy, providing a corrective emotional experience, and strengthening the client's Healthy Adult. A group format is thought to amplify treatment outcomes found in individual schema therapy (Wetzelaer et al., 2014) as well as facilitating connections between clients, empowering them to heal their EMSs and maladaptive modes. To add to this, schema therapy could work as an adjunct to existing treatment. For example, Waller et al. (2007) suggest that schema focused CBT has benefits in treating eating disorders, but further research is needed to assess the feasibility and applicability of schema therapy within the current UK healthcare system.

Schema therapy is not widely available on the NHS in England, particularly for eating disorders. A third of schema therapists interviewed were based in the UK and eight in Australia. At the time of writing, schema therapy was not included in the NICE (2020) guidelines, but is in the Scottish guidelines (SIGN, 2022) as a secondary treatment for bulimic disorders, suggesting that is emerging as a treatment for eating disorders. Schema therapy is recommended by NICE (2020) as a first-line treatment for personality disorders. One could theorise that the high co-morbidity with eating disorders of up to 69% (Talbot et al., 2015), alongside growing research, suggests that the implementation of schema therapy as a first-line treatment may not be in the too distance future.

The evidence base is growing, emerging qualitative studies (Bowker, 2021; Edwards 2017a; Edwards 2017b) found that participants valued schema therapy as an approach and preferred the nature of the approach to other treatments. Findings in quantitative studies (e.g., McIntosh et al., 2016; Simpson et al., 2010; Simpson & Slowey, 2011; Talbot et al., 2015), suggest that schema therapy is beneficial in working with eating disorders. As detailed, one RCT (McIntosh et al., 2016) found schema therapy to be comparable to CBT-ED in terms of treatment outcomes. However, to reach the evidence-based criteria for national guidelines (e.g., NICE, 2020), two RCTs comparing the new treatment (schema therapy) to another evidence-

based treatment (e.g., CBT) need to be conducted by two separate researchers. Thus, further research is required.

8.4.3 Practical Considerations for the Eating Disorder Voice

The Experience of the Anorexic Voice Questionnaire (Hampshire et al., 2020) is used to measure the severity and intensity of the voice in AN. However, there does not appear to be a universal eating disorder voice questionnaire measure that is used across diagnoses. Therefore, could the severity of the eating disorder voice be measured using subscales on the SMI-ED? The experiences of participants suggest that it could.

Any mode can have a voice – as in chairwork – but only certain modes appeared to be linked to the eating disorder voice in the studies of this thesis. When looking at the SMI-ED (Simpson et al., 2018), the experience of the eating disorder voice is analogous to that of a Punitive Critic (*e.g., I do not deserve anything that gives me pleasure, such as eating*), particularly in restrictive disorders where some participants described feeling how they did not deserve food. Although, the same could be argued for those with bulimic disorders when taking binge eating as an example, it could be that eating a lot of food quickly derives the person of the pleasure of enjoying the food. The eating disorder voice is highly critical of one's shape, weight, and food, demanding certain things from the individual regarding these areas (e.g., excessive exercise), similar to Demanding Critic mode. One of the statements associated with this mode is *'I demand high standards of my body to avoid being judged.'* Indeed, previous literature suggests that the eating disorder voice is a form of inner critic (Brennan et al., 2014; Pugh & Rae, 2019), so it is not unreasonable to assume that, in schema terms, the eating disorder voice could be an extension of this category of modes.

Additionally, references were made to the eating disorder voice and its similarities to the Eating Disorder Overcontroller mode. The voice was experienced by clients and therapists as having properties that mirror the Eating Disorder Overcontroller mode, supported by questions on the SMI-ED (Simpson et al., 2018), e.g., *'feeling in control of my eating 'trumps' any*

problems or disappointments going on my life' and *'controlling my eating giving me a physical and mental high'*. Therefore, suggesting that these subsections of the SMI-ED (Demanding Critic, Punitive Critic, and Eating Disorder Overcontroller mode) could be adapted and used to measure the eating disorder voice. Once the severity of the voice has been measured, treatment can explicitly tailor this.

Current methods in addressing the eating disorder voice are limited with few studies examining methods for working with and treating this phenomenon. A fundamental part of chairwork is understanding that the self is composed of multiple parts, including self-related representations (e.g., eating disorder voice) and others (e.g., child modes; Hermans & Gieser, 2012). Previous research suggests that two-chair dialogues produce positive effects in emotion focused therapy (Brennan et al., 2014; Dolhanty & Greenberg, 2009). The chairs in voice dialogue create psychological and physical boundaries between the self and the eating disorder voice, helping clients relate to their voice as a discrete entity and as part of the self (Ling et al., 2022). Similar to modes, the eating disorder voice is part of the self that needs to be understood, thus, it is reasonable to assume that this approach could be adopted within schema therapy specifically for the eating disorder voice.

8.5 Reflexivity

The process of the PhD has truly taught me the meaning of *'it's a marathon, not a sprint'* and has enabled me to acknowledge and understand my own Overcontroller mode. Coming to the end of my PhD, I am now ten years into recovery from AN. Hearing participants journeys from both client and therapist perspective was inspiring and enabled me to reflect on my own journey, notably how similar my experience was to some clients. My reflexive diary (Appendix H) has been imperative in noting my reflections and reflexivity throughout this research and acknowledging my own recovery journey.

One important thing that I have learned from my engagement in this research was how to nurture my own Vulnerable Child. I described in Chapter Four how I regularly completed the

YSQ2-SF (Young, 1998) and the SMI-ED (Simpson et al., 2018) to monitor my EMSs and modes. My highest EMS was continually Unrelenting Standards and modes were: Detached Self-Soother, Overcontroller and Healthy Adult. I noticed an absence of my Vulnerable Child. One personal change is that I consider I am now able to nurture and listen to my inner child.

Throughout this process, I became more aware of when my detached modes were activated, it occurred to me this is something I have always done but not necessarily realised. I would go for a long run alone or take a book and detach from the world, I consider this to be a form of Detached Self-Soother and for me, personally I do not perceive this as maladaptive due to the comfort and escapism it provides my Vulnerable Child.

This thesis drove my continued recovery from AN enabling me to understand myself, EMSs, and modes. I have also been able to acknowledge when I was in what I thought to be a Healthy Adult mode, but was Overcontroller, it is thus likely that Overcontroller has at times, been my default mode. Through this increased recognition and identification, I have been able to empower my Healthy Adult and recognise when my Overcontroller was masquerading as this mode.

I consider that I have developed as both a researcher and an expert by lived experience. As a researcher, I am now confident in using IPA and, although I acknowledge the strengths of Thematic Analysis, Narrative Analysis and Grounded Theory for example, I strongly believe that IPA was the most suitable methodology for uncovering the phenomenological experiences of schema therapy. I consider that my analytical skills, alongside my interview skills have developed – particularly given the sensitive topic of this thesis. Regular feedback from my supervisory team has been invaluable and has enabled me to develop as a researcher whilst also being mindful of my own recovery journey.

8.6 Strengths, Limitations, and Future Directions

8.6.1 Strengths

This thesis provided new insights into schema therapy as a treatment for eating disorders, demonstrating the applicability of the mode model from both client and therapist perspectives using qualitative methodology. Further, this thesis captured the dynamic aspects of modes important to all participants with clients seemingly being bonded to a particular coping mode, often a detached mode. The findings also portrayed the effectiveness of schema therapy in facilitating clients developing functional relationships with their modes. Over time, clients bonded with and nurtured their Vulnerable Child mode, moving from awareness of this part of them, to acceptance - this has not been found previously and is important as it portrays the growth of the Healthy Adult mode over the course of therapy. The mode model is unique to schema therapy, thus emphasising the importance of this finding.

Additionally, this thesis is the first to adopt a phenomenological approach when looking at experiences of schema therapy from the perspective of eating disorders with an emphasis on modes and the eating disorder voice. This thesis is unique in that it captures the longitudinal changes participants experience with their modes and eating disorder voice. Participants demonstrated an increased understanding of these parts of themselves, suggesting that modes and the eating disorder voice have phenomenological reality for eating disorders. Clients continually recognised and identified with coping modes and portrayed insight into when they were becoming maladaptive or when they were functional. Additionally, the eating disorder voice was recognised by all; this is important for future work as the finding suggests that the voice is not unique to AN as previously thought but is likely to be experienced across eating disorders. The results from each study suggest that a phenomenological approach should be considered in future research. This, therefore, highlights the strengths of IPA in exploring such phenomena.

Due to the Covid-19 Pandemic in 2020, data collection for this thesis was conducted entirely online. On the one hand, this could be considered a limitation as I was unable to interview participants face-to-face and may have missed bodily cues or some expressions. On the other hand, this was advantageous as I was able contact participants from around the globe, from different areas of the UK to Australia, which was a strength.

8.6.2 Limitations

As a more experienced researcher, I would aim to have an even sample of both men and women, with particular focus on recruiting more men as generally, research into men with eating disorders is limited. However, I do not think this greatly impacted the findings. Moreover, at times throughout client interviews, there was some confusion around schema terminology, specifically the names of the modes and their attributes. For instance, the Vulnerable Child was often called the inner child, which could be confusing as there are many child modes. If I were to do it again, I would circulate a one-page information sheet explaining each mode on the SMI-ED (Simpson et al., 2018) and each EMS on the YSQ2-SF (Young, 1998) so there would not be any barriers in language or terminology used. However, it is acknowledged that it is the naming of the modes that make them relatable and important to clients.

Furthermore, in hindsight, it may have been beneficial to discuss the findings of Study One (Chapter Five) with the steering group to gather feedback on how to design the longitudinal element of the thesis – particularly regarding the design of the interview schedule. Similarly, with Study Three, input from the steering group may have been beneficial in designing the interview schedule. Future research in this area should consider in having active public, patient involvement throughout the duration of the research.

Additionally, regarding the quantitative measures utilised in this thesis, I would change how I used the EDI-3 (Garner, 2004). This questionnaire provided useful information on clients' eating disorders, however, I do not consider that I utilised its full potential. In this thesis, the main purpose of this measure was to understand clients' eating disorder and to collate

additional demographic information (e.g., BMI, education level) of participants. In hindsight, asking more specific questions to the areas on the EDI-3, such as perfectionism, may have been beneficial in understanding participants' eating disorder and their EMSs and modes further. However, I do not think this impacted the results greatly as in their interviews, clients spoke openly about areas of their eating disorder that did correlate to the areas on the EDI-3 such as perfectionism and low self-esteem.

8.6.3 Future Directions

Future research could look to follow participants over the duration of their treatment with schema therapy for their eating disorder utilising a mixed methods approach by employing the measurement of the YSQ-R (Yalcin et al., 2022) and the SMI-ED (Simpson et al., 2018) to explore changes over the course of schema therapy at various intervals e.g., every three months from initial assessment alongside regular interviews. Regarding schema therapists, additional research is needed from both qualitative and quantitative measures to capture their experiences and understanding of schema therapy as a treatment not just for eating disorders, but their overall experiences of this approach and their experience of EMSs and modes. Overall, the findings provide a strong base for the use of schema therapy in eating disorders, however, as highlighted, additional research is needed to implement this treatment into practice.

8.7 Overall Conclusions

Clients and therapists alike understood the broad phenomenological reality of schema modes and the eating disorder voice. Identification with the eating disorder voice as a mode suggests that it could be a mode specific to eating disorders. Across client studies, key modes appeared to be a form of inner critic – presumably the eating disorder voice – a form of coping mode, namely a detached mode or the Eating Disorder Overcontroller, often masking the Vulnerable Child. Regarding schema therapists, they too tended to identify with a form of coping mode, often a detached or overcompensatory mode, and the Healthy Adult, suggesting that therapists may be unconsciously drawn to working with those with similar modes to their own.

This, therefore, emphasises the importance of the therapeutic relationship and a deeper level of understanding that schema therapy can bring to both clients and therapists.

Clients and therapists emphasised the benefits of schema therapy in recognising and identifying their modes and for clients, recognising and identifying their eating disorder voice too. Schema therapy empowered clients to bring their modes into their being, allowing participants to assign meaningful attributes to their modes, such as a team, creating a deeper understanding and connection to the parts of self. Over time, schema therapy also encouraged clients to accept their modes, particularly their Vulnerable Child and their Healthy Adult, with the follow-up client study capturing this development.

The findings of this thesis suggest that schema therapy provides clients with an effective toolkit for their eating disorder in terms of identifying, recognising, and understanding the parts of themselves and for therapists in treating eating disorders. Additionally, this recognition and identification of schema modes suggests applicability of the schema mode model in treating eating disorders and emphasises the benefits of a schema-focused approach in this particular group. The studies in this thesis are being written for publication and the results have been shared at conferences (Table 17).

Table 17

Dissemination of Research

1). Conference Poster (London Conference for Eating Disorders, 2022)
‘*Understanding the Phenomenological Experience of Schema Therapy in Those with an eating disorder’*
2). Conference Presentation (PsyPAG BPS Conference, 2022)
‘Understanding the Phenomenological Experience of Schema Therapy in Those with an eating disorder’

Feedback from Attendee: *"Your talk was brilliant. As someone with an ED, I've recently started schema therapy. Even though I've been feeling a bit pessimistic, listening to your research today has given me hope."*

3). Invited Speaker (FREED Community of Practice Meeting, West Yorkshire, 2022)

Overview of PhD research focusing on client's experiences of Schema Therapy

4). Conference Presentation (BPS Counselling Psychology Conference, 2023)

'Schema Therapy: A Toolkit, not a cure, a longitudinal follow-up study'

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Appendices

Appendix A: Steering Group Qualitative Questions

Version 3, 27.06.2020

Please look at these questions that will be given to participants in a follow-up interview. I will need your feedback on them, and you will be asked questions regarding the suitability of these. Please write down any thoughts so you can discuss them in the subsequent zoom discussion.

Experiences of your eating disorder:

- What is the story of your eating disorder from the start to the present day?

Prompt: When were you diagnosed? How did you feel?

Experiences of treatment:

- What had your experience of treatment been like before schema therapy?

Prompt: what treatment have you experienced/how did you find it?

- How would you describe your experience with schema therapy?

Prompt: how did it make you feel?

- How did it compare to...?

Understanding of schemas and schema modes:

- Therapy will have discussed different schemas:

How do you understand schemas?

Which schemas do you recognise in yourself?

- Therapy will have discussed different modes:

How do you understand schema modes?

Which schema modes do you recognise in yourself?

Experience of schema modes:

- How do you recognise and identify schema modes within yourself?

Prompt: Which ones and do you recognise when you switch modes?

- How does that mode link to your eating disorder?

- If you do not recognise modes in yourself, then how have you used schema therapy to get better?

- How have your modes changed during therapy?

Experience of eating disorder/anorexic voice:

- Does your eating disorder ever feel like another person talking to you or making your do things?

- If so, how do you feel schema therapy has addressed this?

Schema Therapy and Recovery:

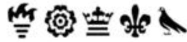
- What are the most significant changes you have experienced during schema therapy?

Prompt: how has this helped in recovery?

- How do you see your recovery now?

- How does your eating disorder affect your life now?

Appendix B: Ethical Approval



REF FHS176 – "Understanding the phenomenological experience of schema therapy for people with an eating disorder"

PRIVATE AND CONFIDENTIAL
Alice Cunningham
Faculty of Health Sciences University of Hull
Via email

3rd June 2020

Dear Alice

Thank you for your responses to the points raised by the Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of any amendments to your study.

I wish you every

success with your

study. Yours

sincerely

Professor Liz Walker
Chair, FHS Research Ethics Committee

Liz Walker | Professor of Health and Social Work Research |

Faculty of Health Sciences

Appendix C: Poster for Clients in Study One

Understanding the experience of schema therapy for people with an eating disorder

Are you 18+ and interested in contributing to research designed to improve our understanding of treating eating disorders?

If so, you are invited to take part in this study! You will be asked to complete three short questionnaires about your beliefs, and your eating behaviours.

You will then be invited to attend a short interview over zoom, where you will be asked some questions about your experiences of eating disorder treatment. The focus of this chat will be on your experience of schema therapy. You are welcome to provide as much or little information or feedback as you feel comfortable with. The information you provide will be used to help us to understand which aspects of treatment are most/least helpful for people with eating problems, in order to improve the treatments we offer in future.

If you are interested or would like further information, please email alicecunningham13@gmail.com or a.cunningham-2018@hull.ac.uk where you will be provided with additional information.

I thank you for considering taking part in this study; your valuable time is very much appreciated.

This project has received ethical approval from the University of Hull.

Appendix D: Schema Mode Inventory for eating disorders –Short Form

Name: ______________________________ Date of Birth: __________________

Highest Educational Level: ______________________ Today's Date: ___________________

INSTRUCTIONS: Please answer all questions by selecting ONLY ONE numeric value that best represents what you feel right now.

FREQUENCY:	0 = Never or almost never	3 = Frequently
	1 = Rarely	4 = Most of the time
	2 = Occasionally	5 = Always

Frequency	
	1. I feel lonely
	2. If I lose control of my eating I feel unsafe
	3. I feel lost
	4. I feel weak and helpless
	5. I have a lot of anger inside of me that I can only soothe through my eating behaviours (e.g. restriction, bingeing, purging, exercising)
	6. I feel like telling people off for the way they have treated me
	7. I have a lot of anger built up inside of me that I need to let out
	8. I feel like lashing out or hurting someone for what he/she did to me
	9. I destroy things when I'm angry
	10. I have rage outbursts
	11. My anger gets out of control
	12. I have been so angry that I emotionally hurt others (e.g. by shouting at him/her)
	13. I say what I feel or do things impulsively, without thinking of the consequences
	14. It feels impossible for me to control my impulses
	15. I act first and think later
	16. If I feel the urge to do something, I just do it
	17. I don't discipline myself to complete routine or boring tasks
	18. I can't bring myself to do things that I find unpleasant, even if I know it is for my own good
	19. It's not worth the effort to plan how you'll handle situations
	20. If I can't reach a goal, I become easily frustrated and give up

	21. I feel loved and accepted
	22. I feel at peace on my own
	23. I feel content and at ease
	24. I feel connected to other people
	25. I don't deserve anything that gives me pleasure (e.g. eating, play, nurturance)
	26. I'm a bad person
	27. I don't allow myself to do pleasurable things that other people do because I'm bad
	28. I deny myself pleasure because I don't deserve it
	29. I demand high standards of my body to avoid being judged
	30. I sacrifice pleasure, health, or happiness to meet my own standards
	31. My life revolves around getting things done and doing them right
	32. I know that there is a 'right' and a 'wrong' way to do things; I try hard to do things the right way, or else I start criticising myself
	33. I feel that I am basically a good person
	34. I assert what I need without going overboard
	35. I have a good sense of who I am and what I need to make myself happy
	36. I feel able to learn, grow and change
	37. I let other people get their own way instead of expressing my own needs
	38. In relationships, I let the other person have the upper hand
	39. I try very hard to please other people in order to avoid conflict, confrontation or

	39. I try very hard to please other people in order to avoid conflict, confrontation or rejection
	40. In relationships, I have to give more to compensate for my lack of worth
	41. I feel distant from other people
	42. If people try to come too close I keep them at a distance
	43. I feel detached (no contact with myself, my emotions or other people)
	44. I don't care about anything; nothing matters to me
	45. My eating behaviours (i.e. restriction, bingeing, purging, exercising) help me to detach from difficult emotions
	46. I like doing something exciting or soothing to avoid my feelings (e.g. working, gambling, eating, exercise, shopping, sexual activities, watching TV)
	47. I work or play sports intensively so that I don't have to think about upsetting things
	48. I want to distract myself from upsetting thoughts and feelings
	49. I'm quite critical of other people

	50. I feel I shouldn't have to follow the same rules that other people do
	51. Thinness is a way in which I can be better than others
	52. I'm demanding of other people
	53. By dominating other people, nothing can happen to you
	54. I belittle others
	55. If you don't dominate other people, they will dominate you
	56. I always look for ways to outsmart others, to ensure that they cannot take advantage of me or hurt me in any way
	57. I want people to understand me without me having to say anything
	58. I need people to listen to me and make me feel better
	59. It's too hard to make changes to my behaviour
	60. I feel angry and desperate when people can't see I need help
	61. Feeling in control of my eating 'trumps' any problems or disappointments going on in my life
	62. Controlling my eating gives me a physical and mental 'high'
	63. Controlling my eating makes me feel in control of everything
	64. Controlling my eating stops me being too needy

Appendix D: Young Schema Questionnaire (2) Short Form

Young Schema Questionnaire (2) – Short Form

Name ____Date__________

INSTRUCTIONS:

Listed below are statements that a person might use to describe himself or herself. Please read each statement and decide how well it describes you. When there you are not sure, base your answer on what you emotionally **feel**, not on what you **think** to be true. Choose the **highest rating from 1 to 6** that describes you and write the number in the space before the statement.

RATING SCALE:

1 = Completely untrue of me

2 = Mostly untrue of me

3 = Slightly more true than untrue

4 = Moderately true of me

5 = Mostly true of me

6 = Describes me perfectly

1. _____ Most of the time, I haven't had someone to nurture me, share him/herself with me, or care deeply about everything that happens to me.

2. _____ In general, people have not been there to give me warmth, holding, and affection.

3. _____ For much of my life, I haven't felt that I am special to someone.

4. _____ For the most part, I have not had someone who really listens to me, understands me, or is tuned into my true needs and feelings.

5. _____ I have rarely had a strong person to give me sound advice or direction when I'm not sure what to do.

*ed

6. _____ I find myself clinging to people I'm close to, because I'm afraid they'll leave me.

7.______I need other people so much that I worry about losing them.

8. _____ I worry that people I feel close to will leave me or abandon me.

9. _____ When I feel someone, I care for pulling away from me, I get desperate.

10. _____ Sometimes I am so worried about people leaving me that I drive them away.

*ab

11. _____ I feel that people will take advantage of me.

12.______I feel that I cannot let my guard down in the presence of other people, or else they will intentionally hurt me.

13.______It is only a matter of time before someone betrays me.

14. _____ I am quite suspicious of other people's motives.

15. _____ I'm usually on the lookout for people's ulterior motives.

*ma

16. _____ I don't fit in.

17. _____ I'm fundamentally different from other people.

18. _____ I don't belong; I'm a loner.

19. _____ I feel alienated from other people.

20. _____ I always feel on the outside of groups.

*si

21. _____ No man/woman I desire could love me one he/she saw my defects.

22. _____ No one I desire would want to stay close to me if he/she knew the real me.

23. _____ I'm unworthy of the love, attention, and respect of others.

24. _____ I feel that I'm not lovable.

25. _____ I am too unacceptable in very basic ways to reveal myself to other people.

*ds

26. _____ Almost nothing I do at work (or school) is as good as other people can do.

27. _____ I'm incompetent when it comes to achievement.

28. _____ Most other people are more capable than I am in areas of work and achievement.

29. _____ I'm not as talented as most people are at their work.

30. _____ I'm not as intelligent as most people when it comes to work (or school).

*fa

31. _____ I do not feel capable of getting by on my own in everyday life.

32. _____ I think of myself as a dependent person, when it comes to everyday functioning.

33. _____ I lack common sense.

34. _____ My judgment cannot be relied upon in everyday situations.

35. _____ I don't feel confident about my ability to solve everyday problems that come up.

*di

36. _____ I can't seem to escape the feeling that something bad is about to happen.

37. _____ I feel that a disaster (natural, criminal, financial, or medical) could strike at any moment.

38. _____ I worry about being attacked.

39. _____ I worry that I'll lose all my money and become destitute.

40. _____ I worry that I'm developing a serious illness, even though nothing serious has been diagnosed by a physician.

*vh

41. _____I have not been able to separate myself from my parent(s), the way other people my age seem to.

42. _____ My parent(s) and I tend to be over involved in each other's lives and problems.

43. _____ It is very difficult for my parent(s) and me to keep intimate details from each other, without feeling betrayed or guilty.

44. _____ I often feel as if my parent(s) are living through me--I don't have a life of my own.

45. _____I often feel that I do not have a separate identity from my parent(s) or partner.

*em

46. _____ I think that if I do what I want, I'm only asking for trouble.

47. _____ I feel that I have no choice but to give in to other people's wishes, or else they will retaliate or reject me in some way.

48. _____ In relationships, I let the other person have the upper hand.

49. _____ I've always let others make choices for me, so I really don't know what I want for myself.

50. _____ I have a lot of trouble demanding that my rights be respected and that my feelings be taken

51. _____ I'm the one who usually ends up taking care of the people I'm close to.

52. _____ I am a good person because I think of others more than of myself.

53. _____ I'm so busy doing for the people that I care about, that I have little time for myself.

54. _____ I've always been the one who listens to everyone else's problems.

55. _____ Other people see me as doing too much for others and not enough for myself.
*ss

56. _____ I am too self-conscious to show positive feelings to others (e.g., affection, showing I care).

57. _____ I find it embarrassing to express my feelings to others.

58. _____ I find it hard to be warm and spontaneous.

59. _____ I control myself so much that people think I am unemotional.

60. _____ People see me as uptight emotionally.
*ei

61. _____ I must be the best at most of what I do; I can't accept second best.

62. _____ I try to do my best; I can't settle for "good enough."

63. _____ I must meet all my responsibilities.

64. _____ I feel there is constant pressure for me to achieve and get things done.

65. _____ I can't let myself off the hook easily or make excuses for my mistakes.
*us

66. _____ I have a lot of trouble accepting "no" for an answer when I want something from other people.

67. _____ I'm special and shouldn't have to accept many of the restrictions placed on other people.

68. _____ I hate to be constrained or kept from doing what I want.

69. _____ I feel that I shouldn't have to follow the normal rules and conventions other people do.

70. _____ I feel that what I have to offer is of greater value than the contributions of others.
*et

71. _____ I can't seem to discipline myself to complete routine or boring tasks.

72. _____ If I can't reach a goal, I become easily frustrated and give up.

73. _____ I have a very difficult time sacrificing immediate gratification to achieve a long-range goal.

74. _____ I can't force myself to do things I don't enjoy, even when I know it's for my own good.

75. _____ I have rarely been able to stick to my resolutions.

*is

Appendix D: Eating Disorder Inventory-3

EDI-3
Item Booklet

David M. Garner, PhD

DIRECTIONS

Enter your name, the date, your age, gender, marital status, and occupation. Complete the questions on the rest [of] this page. Then, turn to the inside of this booklet and carefully follow the instructions.

Name ____________________ Date ____ / ____ / ____

*Age ______ Gender ______ Marital Status ______ Occupation ______

A. *Current weight: ______ pounds
B. *Height: ______ feet ______ inches
C. Highest past weight (excluding pregnancy): ______ pounds
   How long ago did you first reach this weight? ______ months
   How long did you weigh this weight? ______ months
D. *Lowest weight as an adult (or lowest weight as an adolescent if not yet age 18): ______ pounds
   How long ago did you first reach this weight? ______ months
   How long did you weigh this weight? ______ months
E. What weight have you been at for the longest period of time? ______ pounds
   At what age did you first reach this weight? ______ years old
F. If your weight has changed a lot over the years, is there a weight that you keep coming back to when you are not dieting? ______ Yes ______ No
   If yes, what is this weight? ______ pounds
   At what age did you first reach this weight? ______ years old
G. What is the most weight you have ever lost? ______ pounds
   Did you lose this weight on purpose? ______ Yes ______ No
   What weight did you lose to? ______ pounds
   At what age did you reach this weight? ______ years old
H. What do you think your weight would be if you did not consciously try to control your weight? ______ pounds
I. How much would you like to weigh? ______ pounds
J. Age at which weight problems began (if any): ______ years old
K. Father's occupation: ____________________
L. Mother's occupation: ____________________

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Copyright © 1984, 1991, 2004 by PAR. All rights reserved. May not be reproduced in whole or in part in any form or by any means without written permission of PAR. Con[tains] the original EDI items developed by Garner, Olmsted, and Polivy (1984). This form is printed in purple ink on white paper. Any other version is unauthorized.

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WARNING! PHOTOCOPYING OR DUPLICATION OF THIS FORM WITHOUT PERMISSION IS A VIOLATION OF COPYRIGHT LAWS.

[o]n the Answer Sheet. The items ask about your attitudes, feelings, and behaviors. Some of the items relate to foo[d] [o]r eating; other items ask about your feelings about yourself.

For each item, decide if the item is true about you **ALWAYS (A)**, **USUALLY (U)**, **OFTEN (O)**, **SOMETIMES (S)**, [R]**ARELY (R)**, or **NEVER (N)**. Circle the letter that corresponds to your rating on the Answer Sheet. For example, if you[r] [r]ating for an item is **OFTEN**, you would circle the "**O**" for that item on the Answer Sheet.

Respond to *all* of the items, making sure that you circle the letter for the rating that is true about you. [D]**O NOT ERASE!** If you need to change an answer, mark an "X" through the incorrect letter, and then circle the [c]orrect one.

1. I eat sweets and carbohydrates without feeling nervous.
2. I think that my stomach is too big.
3. I wish that I could return to the security of childhood.
4. I eat when I am upset.
5. I stuff myself with food.
6. I wish that I could be younger.
7. I think about dieting.
8. I get frightened when my feelings are too strong.
9. I think that my thighs are too large.
10. I feel ineffective as a person.
11. I feel extremely guilty after overeating.
12. I think that my stomach is just the right size.
13. Only outstanding performance is good enough in my family.
14. The happiest time in life is when you are a child.
15. I am open about my feelings.
16. I am terrified of gaining weight.
17. I trust others.
18. I feel alone in the world.
19. I feel satisfied with the shape of my body.
20. I feel generally in control of things in my life.
21. I get confused about what emotion I am feeling.
22. I would rather be an adult than a child.
23. I can communicate with others easily.
24. I wish I were someone else.
25. I exaggerate or magnify the importance of weight.
26. I can clearly identify what emotion I am feeling.

(continued)

27. I feel inadequate.
28. I have gone on eating binges where I felt that I could not stop.
29. As a child, I tried very hard to avoid disappointing my parents and teachers.
30. I have close relationships.
31. I like the shape of my buttocks.
32. I am preoccupied with the desire to be thinner.
33. I don't know what's going on inside me.
34. I have trouble expressing my emotions to others.
35. The demands of adulthood are too great.
36. I hate being less than best at things.
37. I feel secure about myself.
38. I think about bingeing (overeating).
39. I feel happy that I am not a child anymore.
40. I get confused as to whether or not I am hungry.
41. I have a low opinion of myself.
42. I feel that I can achieve my standards.
43. My parents have expected excellence of me.
44. I worry that my feelings will get out of control.
45. I think my hips are too big.
46. I eat moderately in front of others and stuff myself when they're gone.
47. I feel bloated after eating a normal meal.
48. I feel that people are happiest when they are children.
49. If I gain a pound, I worry that I will keep gaining.
50. I feel that I am a worthwhile person.
51. When I am upset, I don't know if I am sad, frightened, or angry.
52. I feel that I must do things perfectly or not do them at all.
53. I have the thought of trying to vomit in order to lose weight.
54. I need to keep people at a certain distance (feel uncomfortable if someone tries to get too close).
55. I think that my thighs are just the right size.
56. I feel empty inside (emotionally).
57. I can talk about personal thoughts or feelings.
58. The best years of your life are when you become an adult.
59. I think my buttocks are too large.
60. I have feelings I can't quite identify.

(continued)

66. I am ashamed of my human weaknesses.
67. Other people would say that I am emotionally unstable.
68. I would like to be in total control of my bodily urges.
69. I feel relaxed in most group situations.
70. I say things impulsively that I regret having said.
71. I go out of my way to experience pleasure.
72. I have to be careful of my tendency to abuse drugs.
73. I am outgoing with most people.
74. I feel trapped in relationships.
75. Self-denial makes me feel stronger spiritually.
76. People understand my real problems.
77. I can't get strange thoughts out of my head.
78. Eating for pleasure is a sign of moral weakness.
79. I am prone to outbursts of anger or rage.
80. I feel that people give me the credit I deserve.
81. I have to be careful of my tendency to abuse alcohol.
82. I believe that relaxing is simply a waste of time.
83. Others would say that I get irritated easily.
84. I feel like I am losing out everywhere.
85. I experience marked mood shifts.
86. I am embarrassed by my bodily urges.
87. I would rather spend time by myself than with others.
88. Suffering makes you a better person.
89. I know that people love me.
90. I feel like I must hurt myself or others.
91. I feel that I really know who I am.

Appendix E: Client Interview Schedule

Version 2, 01.03.2021

Experiences of your eating disorder:

Please take me through your journey of your eating disorder…

Explore relationships in childhood with parents/peers

When did you first notice a problem with food?

Prompt: Was there a particular situation that you think could have triggered these problems (e.g., injury, death of a loved one, bullying)

Experiences of treatment:

What had your experience of treatment been like before schema therapy?

Prompt: what treatment have you experienced/how did you find it?

How would you describe your experience with schema therapy?

Prompt: how did it make you feel? How did it compare to...?

Understanding of schemas and schema modes

Therapy will have discussed different schemas: How do you understand schemas?

Which schemas do you recognise in yourself?

Therapy will have discussed different modes: How do you understand schema modes?

Which schema modes do you recognise in yourself?

Experience of schema modes:

How do you recognise and identify schema modes within yourself?

Prompt: Which ones and do you recognise when you switch modes? How does that mode link to your eating disorder?

If you do not recognise modes in yourself, then how have you used schema therapy to get better?

How have your modes changed during therapy?

Experience of eating disorder/anorexic voice:

In the literature, there is the concept of the eating disorder voice, an inner voice that talks about your eating habits to you; would you say you have a name for it?

Does your eating disorder ever feel like another person talking to you or making your do things?

If so, how do you feel schema therapy has addressed this?

Schema Therapy and Recovery:

What are the most significant changes you have experienced during schema therapy?

Prompt: how has this helped in recovery?

How would you define recovery?

Prompt: Where would you say you are in stage of recovery?

Would you say the COVID-19 pandemic has affected your recovery?

Would you say your quality of life has improved?

Prompt: How satisfied are you with your quality of life?

Prompt: How satisfied are you with yourself/personal relationships?

Prompt: Would you say you are able to accept your bodily appearances?

How does your eating disorder affect your life now?

Appendix F: Follow-Up Interview Schedule

Version 2, 23.03.2022

Thank you for taking the time to come back and do another interview with me. I really appreciate it. This interview will ask you about your experiences since we last spoke and explore how you have experienced schema therapy.

Do you have any questions?

Anything you tell me will be anonymised and confidential unless you are at risk to yourself or others.

General:

Firstly, I'd like to know how your experience with schema therapy has been since we last spoke, it's been (insert time for each participant since first interview).

For you, what has been the biggest change?

Positive or negative? And how has schema therapy helped/hindered that?

Schemas:

Looking at your schema scores from last time and this time, it seems that ***insert schema name*** has decreased/ increased/ stayed the same.

Do you recognise that in yourself?

Why do you think that is? If not, why?

How has this had an impact on your eating disorder?

Moving on to schemas modes now:

Looking at your mode scores from last time and this time, it seems that ***insert mode name*** has decreased/ increased/ stayed the same.

Do you recognise that in yourself?

Why do you think that is? If not, why?

How has this had an impact on your eating disorder?

Eating Disorder Voice:

Following on from this, I'd just like to ask some questions about the eating disorder voice. We spoke about this last time; it was sometimes referred to as the inner critic.

How would you describe your experience with the eating disorder voice now?

and do you think this is because of schema therapy?

Covid/Recovery:

Has the pandemic affected the way in which you have received treatment?

How has your experience been with schema therapy since the lockdown lifted?

What would you say has been the most helpful thing about schema therapy and how has it helped with your eating disorder?

How would you say your eating disorder affects your life now?

Appendix G: Poster for recruitment of Schema Therapists

Seeking Schema Therapists to contribute to a study on:

'Understanding the phenomenological experience of Schema Therapy in those with an eating disorder'

Are you a schema therapist working with people with an eating disorder? Would you be willing to contribute to a research study aimed at improving our understanding of the way schema therapy works for this population?

If so, I would love to hear from you!

I am recruiting schema therapists for my PhD to investigate their experiences of treating eating disorders using schema therapy! It is hoped this will further our understanding of schema therapy as a treatment for eating disorders.

Please email me on alice.cunningham@gmail.com or a.cunningham-2018@hull.ac.uk if interested.

Ethical approval has been granted by the University of Hull ethics committee.

Appendix G2: Interview Schedule Schema Therapists

Version 2, 10.05.2021

First of all, I'm interested in your work before you trained in schema therapy:

How did you get into working with people with EDs?

Tell me about your experiences treating eating disorders before ST?

Now, turning to schema therapy training…

How did your training in ST come about?

Was training influenced by any particular experiences with clients?

What do you find most useful about ST?

What do you find most difficult about ST?

How do you use ST with EDs?

What did you learn about your own schemas and modes during training?

Can you think of a client where your schemas or modes got in the way of therapy?

I'm also interested in your views of schemas and modes amongst people with eating disorders

What are the most common schemas and modes in clients with EDs?

Do you feel these vary depending on the type of ED?

Are there schemas or modes that make it particularly difficult for the ED client to recover?

During ST, how do you start to see improvement or recovery in ED clients?

How has lockdown and remote working affected your ST work?

Appendix H: Summary of Reflexive Diary

I have lived experience with AN and was treated with CBT many years go. I have been in recovery for ten years; this was not disclosed to participants as to not influence responses, or to possibly trigger any overwhelming emotions. Throughout my PhD, I continually monitored my own EMSs and schema modes by completing the YSQ-2SF and SMI-ED at roughly six-month intervals.

My highest EMS consistently was Unrelenting Standards. I do not view this as a negative as I believe the properties encased within this EMS have gotten me where I am today and perceive it as adaptive. Mode wise, Healthy Adult, Eating Disorder Overcontroller and Detached Self-Soother were my highest; Healthy Adult was consistent throughout the process whereas coping modes fluctuated depending on my need. For example, I ran a marathon in 2022 for an eating disorder charity and was driven by my Overcontroller to train for this challenge. At the start of the marathon, the announcer said, *'we all have our reasons for doing it,'* in that moment, I realised I was doing it for myself and for every other person who has battled with an eating disorder. Additionally, Detached Self-Soother has enabled me to detach from my surroundings lose myself in a good book or workout. Both modes helped me during my PhD.

Client Study

From a personal reflexive point of view, there were times when the interviews had a profound impact on me, I consider this to be due to my own experiences and the sensitive nature of the topic. Throughout, I was working for a mental health crisis team so believe I was able to manage the nature of conversations, but at times, I left the interview pondering if the participant was ok and if I was ok. For example, one participant had a very similar story to my own. They would engage in purging and said *"you wouldn't do that if you didn't hate yourself;"* it was helpful to discuss this with my supervisors after and reflect on my own journey.

Participants provided in-depth details of their lives, including traumatic experiences they experienced when they were younger. Some participants reflected on how they had

experienced previous suicidal thoughts; although difficult to hear, I believe that the skills I had developed by working for a crisis team helped me manage my emotions. The rawness and honesty participants shared with me was incredible and I feel honoured to have been the person they have shared this with. A further participant commented *“where your mind is at is no correlation to where you sit on the scales,”* this statement sticks with me now, especially given the recurrent emphasis on BMI for treatment.

I kept my subjectivities and any preconceptions around eating disorders or treatment away from the interviews as to not influence responses. Nevertheless, I did find it difficult to completely ‘bracket-off’ from interviews, which could be attributed to my past lived experience; equally, I think this also helped as I could empathise more with participants. I do not think it is possible to bracket off completely. I consider that I was able to establish and build rapports with each participant. However, I think that the shorter interviews impacted me because I felt that I was clock watching to ensure they were ‘long enough,’ triggering a Defectiveness/Shame EMS. Whereas, upon reflection, I was incredibly grateful for participants giving up their time for me to do this research.

Moreover, at times there were issues due to internet connections. Each interview in this study and subsequent studies were completed on Zoom due to the Covid-19 pandemic. In some ways, this was beneficial as I could contact people from around the country; there is also the downside of a rapport is often better established in person, particularly if a camera is off.

Generally, I believe this study went well and findings have been presented at conferences. There were times when it was emotionally difficult for personal reasons, but this further reminded me of why I am doing this work and how far I have come in my own journey. I believe my own experiences have helped shape the research in a positive way.

Follow-up Study

This study took place around 12-18 months on from the first; there was 50% attrition which did impact me and perhaps triggered a Defectiveness/Shame EMS. Nevertheless, I was

grateful for participants taking time from their day to speak to me again. As with the first study, I did not disclose my past or any treatment I had received to not impact the interviews in any way. Each participant interviewed remembered me and a rapport was quickly re-established. As with Study One, all interviews were conducted over Zoom, which did lead to some practical issues such as a time lag at times, but this was easily managed and I advised participants that if my Wi-Fi did go off, I would be back shortly.

At times I found comments impacted me, particularly one participant who when they had gained weight, was asked by peers *'what went wrong.'* I found this difficult to bracket-off from and was visibly shocked, so much so that the participant acknowledged my disbelief. I do not believe it is possible to completely bracket-off from phenomena. I agree with Merleau-Ponty's stance that humans exist through 'being-in-the-world' and can only perceive things through this subjective being, thus, it is not possible to completely bracket-off.

Repeatedly reading and listening to sensitive information can take its toll emotionally. I do not think this has impacted my own recovery in way; nor do I believe this thesis impacted me on my journey of recovery from AN, quite the contrary. It has driven me to reflect on my own journey and how I can utilise my experiences to help others.

Therapist Study

I was slightly apprehensive prior to these interviews and think my Defectiveness/Shame and Unrelenting Standards EMSs were triggered as I wanted to get it 'right.' I do not think this was obvious in the interviews.

This study was conducted entirely on Zoom. This was advantageous on one hand as it enabled me to contact and interview schema therapists from around the world, including Scotland and Australia. Nevertheless, there were drawbacks as sometimes internet connections lagged due to my router being temperamental, which did distract my attention in interviews as I was focused on sorting out the connection; and in one interview, my laptop shut down without warning. This caused panic, thankfully, the interviewee had waited, but this showed the

unpredictable nature of technology. From a researcher reflection, I prompted each participant when appropriate and asked further questions if I believed more detail could be added; rapports were established, and answers were lengthy and coherent from each participant. I do not believe I negatively impacted the research. In contrast to client interviews, I felt increasingly able to bracket-off, but again, did not disclose my history of treatment or of AN as to not deflect from the participants experiences or influence their responses in any way.