Understanding the phenomenological experiences of schema therapy for those with an eating disorder

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ABSTRACT

Schema therapy expands traditional cognitive-behavioral models, weakening early maladaptive schemas and schema modes while strengthening adaptive modes. This study investigated participant experiences of schema therapy for eating disorders, focusing on schema modes and the eating disorder voice, how these maintained disordered eating, and how therapy helped. Semi-structured online video interviews with clients receiving schema therapy for eating disorders (N=10) were analyzed using interpretative phenomenological analysis. Four group experiential themes were developed: (1) *adverse experiences*, typically in childhood and adolescence, (2) *interpersonal relationships*, especially with primary caregivers and the benefits of a good therapeutic relationship, (3) *self-awareness* of schema modes and the eating disorder voice and their impact on participants' eating disorders, and (4) *recovery* using schema concepts, including finding one's inner child, better self-management, and ambivalence about recovering. Overall, schema therapy was perceived as beneficial, specifically regarding participants' awareness of their inner child, development of their eating disorder, and awareness of their eating disorder voice. Participants expressed a growing positive sense of agency, connecting with their inner child's needs and developing a connection to their healthy adult mode. They also felt that schema therapy had equipped them with the tools to strengthen their healthy adult mode, while simultaneously weakening their maladaptive modes.

Introduction

Eating disorders (EDs) are a major mental health concern, with significant morbidity and mortality (Friars et al., 2023) and a high prevalence of childhood trauma and neglect (Olofsson et al., 2020). Up to 69% of clients have comorbid conditions including personality disorders (Talbot, 2015). EDs are difficult to treat, with only between 22.5% and 54% of people responding to first-line treatment (Fairburn et al., 2009). Some third-wave cognitive behavior therapies were developed to work more effectively with the enduring patterns of thought, feeling, and behavior often labeled as "personality disorders." These include dialectical behavior therapy (Linehan, 1993) and mentalizer-based therapy (Bateman & Fonagy, 2016), as well as schema therapy (ST) (Young, 1990).

Schema therapy

Young's (1990) schema model is an expansion of traditional cognitive therapy. It blends Gestalt, cognitive-behavioral, attach-

ment, and psychoanalytic psychologies. ST targets two major components of the theory: early maladaptive schemas (EMS) and schema modes. ST was originally designed for personality disorders (Young et al., 1990), and nowadays, it treats many complex psychological issues including EDs (Simpson et al., 2010). In ST, negative life experiences, especially in childhood, are hypothesized to play a role in the formation of EMS and maladaptive schema modes.

EMS are defined as *"*broad, pervasive themes or patterns, comprised of memories, emotions, cognitions, and bodily sensations, regarding oneself and one's relationships with others*"* (Young et al., 2003, p.7) and can cause problems in accomplishing one's goals and meeting one's needs. Early life experiences are theorized to contribute to the development of EMS, driving problems later in life, including bingeing and restricting (Simpson & Smith, 2019). A systematic review (Maher et al., 2022) suggests that those with an ED or with a high level of ED symptomology report higher scores across all EMS domains than those without. Please see Young et al. (2003) pages 14-17 for comprehensive list of EMS.

Schema modes are considered to be moment-to-moment emotional states and coping responses (Young et al., 2003) and are divided into four categories: child, coping, critic, and adaptive modes. Child modes are parts of the self which have developed in childhood in response to experiences encountered, such as major life events, harsh criticism, bullying, neglect, or abuse. For example, the vulnerable child mode holds the feelings and thoughts the individual experienced when their psychological needs were unmet in early life. The aim of ST is to help the client to access this mode to help them to understand their unmet needs and to nurture their vulnerable child. The vulnerable child mode has been found to be elevated in people with an eating disorder (Talbot et al., 2015).

Coping modes are assumed to be facets of the self that are not fully incorporated into a cohesive personality structure but can operate in a discrete and dissociative manner (Young et al., 2003). Specific to disordered eating, Simpson et al. (2018) introduced the helpless surrenderer and eating disorder overcontroller modes. The helpless surrenderer avoids expressing vulnerability and needs directly, and will seek help passively through withdrawal, compliance, or "quick fix" ED behaviors. At the core of the helpless surrenderer is a feeling of being dependent, helpless, and needing to be rescued. In this coping mode, people often feel unable to find adaptive ways of coping, due to an overwhelming sense of helplessness. The eating disorder overcontroller functions as a form of overcompensation, whereby, perfectionism, achievement, and competitiveness, focus on the body so that eating behaviors are used to provide distance from feelings of vulnerability.

Critic modes contain, and may amplify, early unhelpful messages from other people, often making a person feel unwanted or unworthy. They are often described as echoes from the past as they predominately develop from internalized messages from those around them in early life (Young et al., 2003).

Finally, there are two adaptive modes. The happy child mode is adaptive and exudes playfulness, light-heartedness, and curiosity. The healthy adult mode works to nurture, affirm, and validate the vulnerable child mode, while challenging and reducing maladaptive coping, and critic modes. The healthy adult mode also serves to counteract EMS. Please see Young et al. (2003) pages 273-277 and Simpson et al. (2018) for a comprehensive list of modes and their definitions.

Research suggests that a mode-focused approach could be beneficial in treating EDs (e.g., Edwards 2017a; Edwards 2017b; Simpson, 2010; Simpson & Smith, 2019; Talbot et al., 2015). According to Talbot et al. (2015), ED groups shared comparable patterns of modes, such as coping modes, but also exhibited some noticeable variations. For example, those with bulimia nervosa (BN) distinguished themselves from the community sample and the AN/otherwise specified feeding and eating disorder (OSFED) sample on 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. Additionally, the ED sample was found to have higher maladaptive modes than the community sample and scored significantly lower on the two adaptive modes. Subsequent research also proposed that maladaptive modes are elevated in those with an ED (Simpson et al., 2018). These associations, in conjunction with early success in clinical trials, highlight the notion that a mode-focused approach targeting maladaptive modes and strengthening the healthy adult mode could be beneficial for individuals with EDs (Simpson et al., 2010).

Most relevant research in this area is quantitative, with little qualitative research exploring the meanings that modes have for people with EDs, whereas a qualitative approach can help in understanding the importance and meaning that modes have for people with EDs. Thus, there are questions surrounding how clients receiving ST recognize, identify, and understand their schema modes.

Edwards (2017b) proposes that the primary investigatory tool for modes must be phenomenological, as it allows researchers and clinicians to investigate the dynamic aspects of modes that are important to clients. There are only three such studies to date (Bowker, 2021; Edwards, 2017a; Edwards, 2017b). Edwards' (2017a; 2017b) case study of a client with anorexia supports the value of the mode model in ST and further emphasizes the need for phenomenological research in understanding the idiosyncratic nature of modes for individuals. Further, Bowker's (2021) research revealed common experiences in schema modes such as detached self-soother and the eating disorder overcontroller, regardless of ED diagnosis, but the features and meanings of the modes were again idiosyncratic. There is, therefore, a need to further explore the idiosyncratic nature of modes phenomenologically.

A similar concept to schema modes is the eating disorder voice (EDV). The EDV is largely described as negative about the individual's body shape and conveys critical messages about the importance of engaging in disordered eating behaviors (Williams & Reid, 2012). Critical inner voices are associated with maladaptive attitudes towards weight, shape and eating and contribute to low self-esteem (Noordenbos et al., 2014). There are similarities between the EDV and some schema modes, such as the critic modes (Pugh & Rae, 2019) and the eating disorder overcontroller.

People with an ED tend to begin by making conscious egosyntonic decisions, for example, restricting calorie intake, viewing their EDV as positive and encouraging (Tierney & Fox, 2010). However, as their ED progresses, the EDV is perceived to have a negative, omnipotent nature (Aya et al., 2019). People report ambivalence about the EDV, seeing it as both positive and negative (Williams & Reid, 2009), as they do their ED in general. The EDV can have phenomenological reality throughout the duration of a person's ED, becoming part of their being with many people attributing meaning to this entity. Indeed, people with EDs often recognize it as part of themselves, further suggesting there is a need for research to explore how clients with EDs recognize and identify with their EDV, as well as their modes, and to what extent clients identify with these as parts of the self.

Current study

Phenomenological research allows for the investigation of the dynamic aspects of modes and the EDV that are significant for clients with EDs with the context of ST. The aim of the present study was to understand more about clients' experiences of ST for their ED. Research questions addressed (a) the extent to which people with EDs recognize modes and the EDV in themselves and (b) whether and how they identify with modes and the EDV, and (c) how ST has helped with this.

Materials and Methods

Given the exploratory nature of this research, interpretative phenomenological analysis (IPA) (Smith, 2009; Smith et al., 2022), which seeks to study the personal, lived experience of participants and how they make sense of that experience, was the chosen methodological approach. IPA has previously been used in research with individuals with EDs (Fox et al., 2011; Taborelli et al., 2016), but until recently, has seldom been used in ST research (however, see Bowker, 2021; Edwards, 2017a; Edwards, 2017b).

IPA encourages researchers to engage with its theoretical and epistemological underpinnings while recognizing that they are not philosophers and that their research will often be driven by pragmatic concerns. It is therefore in keeping with the ontological and epistemological position of the authors, which we would describe as "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 (Harre & Moghaddam, 2012).

IPA also acknowledges the researcher's influence in co-constructing the understanding of the experience and the importance of acknowledging one's own biases and positioning. As stated by Gadamer (1975, pp. 271-272), "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 foremeanings."

The first author interviewed participants and transcribed the audio herself to become fully immersed within the data. She has personal lived experience of anorexia nervosa, has received psychological therapy in the past, and considers herself in recovery. These matters were not disclosed to participants, but were considered and discussed in supervision to minimize any vicarious trauma. She also kept a reflective diary during the research to address feelings and facilitate the reflexivity required in IPA.

The second author supervised the first author's research. She has a longstanding interest in human eating, beginning with experimental research on satiety and mood, but no lived experience with EDs. After qualifying as a clinical psychologist, she became more engaged in understanding people's lived experiences of EDs, both clinically and in research. She discovered ST long ago and is using its techniques increasingly with clients because so many have complex problems (including ED) that makes straightforward CBT of limited efficacy.

The third author co-supervised the first author's research. Her research background is in experimental psychological research, with a focus on changes in experiences of memory and other cognitive processes as a function of mental health challenges. She also worked for four years in clinical practice, supporting individuals experiencing a range of mental health challenges, including disordered eating. She has training in CBT, mindfulness-based interventions, and solution-focused therapy, but no lived experience of EDs either herself or with close family members.

The fourth author co-supervised the first author. He began as an experimental psychologist, but early on became interested in discourse analysis, initially to understand human memory. This developed into an interest in using phenomenology in cognitive science. Since qualifying as a health psychologist, his research has increasingly looked at how the human level of experience constructs and creates people's problems.

Participants

Ethical approval was obtained from the University of Hull's Ethics Committee (FHS176), which accords with the Declaration of Helsinki. Ten participants were recruited using a volunteer sample: nine women and one man, mean age 33.2 years (*SD=9.82),* mean self-reported body mass index (BMI) 26.08 (*SD=9.69*) ranging from 17 – 45.

Study participants received pseudonyms, and identifying details were changed in transcripts. Participants' time in ST ranged from three to eighteen months. Eligibility criteria included diagnosis of an ED, treatment with ST, and Body Mass Index <15 during the research (Table 1).

Procedure

Participants were recruited via referrals from clinicians who provided ST for EDs 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. Interview times ranged from 35 to 120 minutes and were audio taped with consent; information that could lead to identification was removed or modified in transcripts to retain anonymity. Participants provided written informed consent and also verbally confirmed consent to take part. All interviews took place over the video conferencing platform, Zoom.

Open-ended questions were developed following a literature review. A topic list was constructed following input from experts by lived experience in a steering group, alongside discussions with the research team which comprised researchers with academic backgrounds and clinical expertise. Questions included: "How do you recognize and identify schema modes within yourself?" and,

Table 1. Participant demographics.

Participant	Diagnosis	Age
Anne	BN	26
Billie	BN	26
Emma	BED	56
Diane	AN	28
Clare	BN/BED	41
Fiona	AN	31
Gertrude	AN	24
Harriet	AN	23
Ian	BED	40
Jane	AN	37

Pseudonyms were provided that were not linked to participants in any way. AN, anorexia nervosa, BN, bulimia nervosa, BED, binge eating disorder.

"In the literature, there is the concept of the EDV, an inner voice that talks about your eating habits to you; would you say you have a name for it?" Please see *Appendix A* for interview questions.

Data analysis

Analysis by the first author used IPA, with review and commentary from the other authors, following steps set out by Smith et al. (2022) to provide an in-depth analysis of individual accounts of meanings and experiences.

Initial notes provided a contextual understanding of the interview, allowing a reflexive noting of the first author's impressions of and her relationship to the data. Secondly, to go beyond the bare verbal accounts, descriptive, linguistic, and conceptual comments were made. Descriptive comments annotate key phrases, descriptions, and emotional responses, which constitute participants' interpretations of events and the meanings attributed to them. For example, how did they describe a particular life event? What did this mean to them? In making linguistic comments, the first author paid specific attention to pauses, repetition, pronoun use, and the use of similes and metaphors, as this allowed for interpretation of meanings behind these linguistic devices. For example, why did a participant laugh after talking about a traumatic event (Was it black humor or something else?), thus, deepening engagement with participants narratives. Finally, conceptual comments included developments of questions about meaning, e.g., if a linguistic device was used, such as metaphor or an idiom, why did this participant use that? What is its significance?

These comments were then organized to develop experiential statements, capturing significant aspects of participants' narratives. For each participant, patterns and relationships were explored by clustering those with meaningful connections into personal experiential themes. For example, if a participant had themes of bullying and abuse in their narrative, these would be clustered together as *adversities*. Transcripts were repeatedly checked to ensure that interpretations were grounded in participants' words. Personal experiential themes were discussed by authors before moving to the next case.

Once all 10 transcripts were analyzed, group experiential themes were developed by looking at the personal experiential themes for each participant and clustering them across participants with emphasis on the claims, concerns, and experiences of participants to ground the analysis in their phenomenological reality. Group experiential themes were compared and discussed by the authors, leading to further refinement, and some relabelling.

Results

The group experiential themes and eight subthemes are summarized in Table 2. The themes capture participants' journey through ST and their growing understanding of schema modes and the EDV at each stage in their journey.

Adverse experiences

This theme illuminates participants' understanding and awareness of the development of their modes and EDV. Participants often reported these developing after an adverse life event, suggesting that modes and the EDV 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, the psychological functions of food and eating is described with all participants experiencing the EDV to a degree.

Sub-theme: trauma and maltreatment

Modes may develop from adverse early life situations to help cope with these events at the time; however, these often lead to significant, yet maladaptive, roles in adulthood. Following a perceived loss of control due to trauma, ED symptoms and modes are theorized to be an attempt at regaining control (Simpson et al., 2018).

Fiona, for example, said "She wasn't really a mum; she was always too busy" and

> I always had a bad relationship with my dad…he worked a lot, as did my mom so they were never home. So, I just used to go and not eat, because no one, no one cared. So, I got away with it….

Here, Fiona implies neglect or even abandonment, while "just used to go and not eat" suggests mitigation of emotional deprivation.

Additionally, Anne described being the victim of trauma and abuse from an ex-partner: "I was terrified…he was a violent guy." Initially, she felt confronted and responded by restricting food intake, as her ex-partner would comment on her appearance: "You'd be so much more attractive if you lost weight." Following the end of the relationship, she received positive comments about her appearance rather than about her leaving the relationship, "When I finally broke up with him, everyone was like 'You've lost so much

Table 2. Group experiential themes and subthemes.

Group experiential themes	Subthemes
Adverse Experiences	Trauma and maltreatment Detachment and dissociation Psychological functions of food and eating
Interpersonal Relationships	Difficulties in family relationships Importance of the therapeutic relationship
Self-Awareness	Attunement to modes Identifying the EDV
Recovery	Finding inner child Managing emotional needs Ambivalence

weight, you look amazing,' blah, blah, blah, and I hadn't noticed." Despite not noticing, this led on to Anne developing an ED.

Clare also reported past trauma: "I was raped when I was nineteen and, we're also finding something might have happened to me when I was a kid as well." This appeared 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." Exploring this further, Clare disclosed that the dragon was a personification of her mother. She surrenders to the dragon and appeases accordingly in a helpless surrenderer mode, 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.

To cope with adverse life experiences, participants described also dissociating or detaching as coping strategies and strongly identified with the concept of detached coping modes.

Sub-theme: detachment and dissociation

All participants experienced detached modes. It is thought that schema modes, particularly detached modes, function on a continuum ranging from a metaphor to articulate one's feelings to complete dissociation from the healthy part of self. Participants in this study experienced detachment to varying degrees. Anne described an "An orb state.... I'd go dead behind the eyes, and I was under water. And everyone else was on the surface." An "orb state" appears to resemble the detached protector mode. Anne described alternating between the roles of detached protector and vulnerable child, as later in her interview, she described needing her vulnerable child to be rescued. Theoretically, the detached protector mode develops to protect the vulnerable child from harm that the child cannot escape any other way (Young et al., 2003). At the extreme, this can involve completely dissociating from one's immediate situation (Barazandeh et al., 2018).

Dissociation was also described by Billie: "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." Billie has psychologically detached from her surroundings in order to prevent traumatic memories and reduce activated EMS. Billie describes feeling afraid when in this mode, but she understands its purpose of reducing the possibility that traumatic memories will be triggered.

However, detachment could occur without dissociation: "Detached protector for me. Up until a year ago was come home, roll a spliff and now binge eat" (Ian). Throughout ST, Ian 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."

Clare could also detach without dissociating, remarking, "I have a detached protector that is queen of everything. I am, so good at just turning off." Clare thus suggests that this coping mechanism allows her to switch her negative or stressful emotions "off." "Queen" implies that this mode is the primary way in which Clare manages her feelings and suggests that it can take precedent over other modes.

Participants clearly articulated a state reminiscent of the detached protector mode which could either simply be detached or be detached to the point of dissociation from the current situation. Although all participants appeared to recognize and understand detached modes, it is the operationalization of detachment that suggests phenomenological distinction between experiences of these modes.

Sub-theme: psychological functions of food and eating

Participants acknowledged the psychological function food and eating has had in their lives. Food was viewed as a source of comfort or distraction, and restriction could be used to cope with mental discomfort. Emma, for instance, said, "I've been quite an emotional eater. So, we all have ups and downs in life, when that happened, I would naturally eat my way out of it."

Similarly, Gertrude described her experience:

> I remember feeling really stressed whilst I was revising one night, and I just ate, and ate, and ate […] 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 because you'll lose all control from there."

For Gertrude, there appears to be a shift from detached self-soother to demanding critic mode, because she insists that she does not lose control. Although feeling "disgusted," Gertrude utilized food to mitigate stress, leading her to soon regret this, shifting into demanding critic mode, feeling as though she has eaten too much. Disordered eating behaviors appear to be coping mechanisms demonstrating participants' understanding of their relationship with food.

Furthermore, participants likened bingeing and purging to drug abuse, emphasizing the severe psychological impact of these behaviors. Anne, for example said, "When I would get the urge to binge, it would be like a heroin crack addict," and Billie used the same metaphor, "On bad days, especially, you have a cupboard full of crack—well, your version of crack." Whereas Anne speaks of her urge to binge in the first person, Billie utilizes the second person to distance herself from this addiction, suggestive of shame. The comparison to an addiction highlights the relief these behaviors bring to both Billie and Anne from the distress they were feeling akin to detached self-soother mode. Though this behavior is dangerous and can have detrimental effects on one's life, they cannot live without it.

Moreover, the impact that one's EDV had on the psychological function of food and eating is explored with participants emphasizing the impact it had on their relationship with food. The EDV can behave in a way that makes people feel that they cannot live without it and is manifested as a way of coping with life adversities, providing a sense of safety and security, as explained by Fiona: "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 because I can't live without it." The voice provides a sense of safety and control when Fiona states she cannot live without it, yet simultaneously, she states, "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." By calling the voice "him," it seems she has mirrored this voice on her father, which is reasonable to assume in her description of her father's actions, e.g., "He used to hit me, my dad." Fiona later states that this is the case: "I probably base him in my dad really." Despite the negatives, she feels as though she cannot live without the voice in the same way that she cannot live without her father.

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

Interpersonal relationships

People with an eating disorder often recall interpersonal difficulties from an early age (Allen et al., 2013), and 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.

Sub-theme: difficulties in family relationships

Participants experienced difficulties in relationships with those close to them, particularly their immediate family. Fiona described her father's inappropriate reaction to her ED, as "He put a load of food on the table and just started shoving it in my mouth." This later led to Fiona feeling low and misunderstood, and she tried to take her own life: "I used to cut myself. I took three overdoses […] and ended up in hospital with it." Fiona's self-harm possibly suggests the operation of a detached protector mode developed as a way to cope with her father's actions towards her. It could be that once this maladaptive coping pattern was embedded, it resulted in the exacerbation of her ED and the consolidation of her EMS.

Additionally, Anne experienced frustration with her mother when she was struggling with her ED. Anne's mother was a therapist, which she mentioned six times during her interview. For example, "her being a therapist, but also not her figuring it out." Anne appears frustrated that her needs were not met by her mother, particularly when it is her mother's job to help others, likely triggering an abandonment EMS.

Another reference to one's mother was made by Clare. As a child, Clare was placed on a diet, and her mother was fixated on weight, which subsequently skewed Clare's relationship with food and her mother:

> I was put on a diet at six. Food was always my go-to thing. When my parents went out, we'd have the babysitter, and I'd eat all the biscuits and blame the babysitter. We weren't allowed food, like kind of, "naughty food," as you might call it, in my house very often [....] So, we used to steal it. You'd put bags of crisps in your arm thing [referring to sleeve] and run upstairs.

Clare describes the food she was not allowed as "naughty food" as she recalls hiding this food and eating quickly so it cannot be taken away from her. Clare described 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." This behavior was secretive, fuelling the belief that food was "naughty." Recalling when she told her mother about her ED, Clare 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," further emphasizing the difficulties Clare experienced.

Similarly, Ian's parents displayed a negative reaction to weight gain:

> Quite embarrassed that they had a fat son.... I remember my dad said to me once when I was young … and tact isn't my dad's strong point, shall we say, and he just said, "We're very concerned that you're putting on weight" [....] He referenced what neighbors would think.

Shortly after, Ian said, "I remember coming out of it sort of a 'I am who I am,' that typical teenage, won't be told anything." This is a powerful statement, portraying independence and perhaps rebellion towards Ian's parents. One could assume that the comment about the neighbors perpetuated the need to soothe himself with food. Ian described his parents as displaying "an uncaring, coldness attitude." To manage these feelings, Ian said he "just tries to soothe himself with food." He refers to himself in the third person, as though he wishes to detach from this behavior and his environment. This is suggestive of operation of a detached self-soother mode to comfort his unmet needs.

It is worth noting that this theme is not blaming families in any way. Rather, it captured participants' experiences with those closest to them and the impact on their EDV, ED, and modes. This is important as modes are likely to stem from early life experiences, thus highlighting participants' awareness of their modes and EDV development. Despite these experiences, a good therapeutic relationship could counter this feeling.

Sub-theme: the importance of the therapeutic relationship

ST was generally perceived as a safe, non-judgemental place: "She [therapist] has saved me massively" (Anne), "I can see that she's working. She's involved, and it's responsive. And she's part of that journey" (Gertrude), 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). Each of these quotes emphasizes the impact a good therapeutic relationship has had on participants.

Participants emphasized the role of ST in allowing them to grow and nurture themselves and in compassion experienced. For example, Fiona said that "The actual nurturing side of stuff because I've never learned anything like that, so it was teaching me how to do stuff," and Clare remarked, "The way she reacts to it is so compassionate and not freaking out. There's no pressure from her, whereas I have felt pressure in the past." For both Fiona and Clare, there is a perceived sense of security. Fiona states how she had not learned to nurture herself as a child; due to ST, she has been able to access her inner child, thus emphasizing the importance of the therapeutic relationship.

Clare expresses a sense of relief as it seems her current therapist is the caregiver that she needed. Clare previously described negative past therapy experiences— "psychologist just like my mom, incredibly critical" —suggesting Clare was seeking a safe environment. "Freaking out" suggests she felt pressure to recover in the past. Describing this experience with her previous therapist, she said that her therapist said, "You've been with me for this time. Why aren't you better?" This is a direct contrast to Clare's current therapeutic relationship.

Emma also discussed the importance and counterbalance 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, does help undo some things. Maybe it wasn't my fault, and I deserve love. And it does have benefits as well.

The repetition of "you matter" opposes what Emma was taught throughout her childhood, i.e., that she did not matter: "If

you did something you didn't realize was defying them [parents], you got a wallop for it." Emma appears to be is distancing herself from her childhood and past by referring to herself in the second person, whereas her current therapeutic relationship demonstrates that she does matter and is worthy, supported by the first-person pronoun.

This subtheme was present in all interviews and highlights the importance of having a safe place for participants to explore their vulnerabilities. It is at this stage that we begin to see participants' awareness of their inner child and modes as part of the self.

Self-awareness

This group experiential theme illustrates participants' growing self-awareness around their schema modes and EDV, looking at the positives and negatives experienced. Two subthemes emphasize the impact of ST on this increased understanding.

Sub-theme: attunement to modes

Many participants experienced an attunement to some of their modes; however, for the purpose of this section, the focus is on the experiences of two participants. During their journey of ST, these participants expressed how they have been able to identify with schema modes, for example:

> Creating a team of people, a support group in your head, we had one that 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)

The description of a "support group" demonstrates that the modes are there to support Billie. One, being "like a mom," suggests a protective nature. Billie refers to fighting her own battles with bullies in school. Therefore, she has created a fighter; leather clothing suggests how strong the character is. Billie does not go into detail about the "wise" one in her team which could mean that the "wise" one is one that 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 and suggests phenomenological reality.

This concept was also demonstrated by Clare:

> I have a team of, nurturers, who are, some are fictional. So, Mrs. Weasley from Harry Potter because I'm a big Harry Potter fan even though I'm not the biggest fan of J. K. 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 Uzi and this boxing guy from my *Nintendo Switch* game, and Hagrid. And then, you have the wise people like Dumbledore.

The people described, except her lecturer, are fictional, thus, suggesting that people in her real life have been unable to meet her needs or protect her. This leads Clare to create her team to soothe her vulnerable child mode, thereby meeting her needs. Beginning with the "nurturers," is indicative that Clare is 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. They are likely to represent healthy coping modes there to protect Clare's vulnerable side. Clare experienced trauma in her life; this could explain where these protectors originated. The analogy of a team suggests that schema modes often amalgamate to help the person with the distress they are experiencing and to bring about the healthy adult mode. It further emphasizes that schema modes are different parts of people, supportive of mode theory. Indeed, participants in this study demonstrated attunement to their modes, indicative of phenomenological reality.

Sub-theme: identifying the EDV

All participants recognized a form of EDV in themselves. Generally, it was experienced as being critical about their weight, shape, and eating habits. Many participants experienced the EDV as resembling one or more modes especially critic modes. As Ian put it, "Although I haven't got a name for it, when it starts going, I go [points to head] that's my inner critic!"

Throughout therapy, participants emphasized becoming increasingly aware of the role of the EDV, exploring the functions it plays. For instance, Diane's EDV would give messages such as, "I didn't need certain things, that things were too high calorie, that other people could have them and I couldn't, [and] that I didn't deserve fresh food and should have moldy food." This is likely to be an operation of a punitive critic mode, punishing her by restricting food intake. Jane conveyed similar experiences, saying, "I couldn't justify spending money on nicer food because it's just for me, and that was a bit of waste." Her EDV is similar to the punitive or demanding critic modes, an internalization, that she does not feel worthy of "nice" food. This is perpetuated by her defectiveness and unrelenting standards EMS whereby she is depriving herself of "nice" foods due to feeling defective. There is also the operation of the eating disorder overcontroller in that Jane is not allowed to have the foods she wants because it is perceived as a waste.

Billie demonstrates a realistic vulnerability; however, as ST has progressed, she states how ST has allowed her to experience a freer way of thinking, challenging her EDV:

> Freedom to allow yourself to do whatever you want to do, and I think that 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 recognized and identified with her EDV. Her EDV mirrors the eating disorder overcontroller coping mode, evidenced by her categorization of food as good and bad. However, she almost immediately retracts "what's good and bad," indicating how this new way of looking at food has changed her perception, challenging this way of thinking and her EDV. Nevertheless, Billie likens her lived experience with an ED to being shackled and trapped. "The freedom from your brain" suggests Billie is working to detach herself from her EDV and learn to live without these shackles that are currently holding her.

Each participant interviewed identified with the EDV. Some identified it as a form of inner critic mode, some as the eating disorder overcontroller, and some felt able to name it and confront it. Some participants were able to recognize when this voice was activated and while working through ST, have been able to challenge the voice and adopt a healthy adult approach. The recognition and identification with a form of EDV is indicative of phenomenological reality. This theme also highlights the potential

feasibility of ST to reduce disordered eating patterns and suggests support for the schema mode model in EDs.

Recovery

Through this lived experience, we see the autonomy participants' experience in their journey to recovery, including what recovery means to them and the challenges that they face. This theme explores the elements of recovery important to participants.

Sub-theme: finding one's inner child

Connecting to one's inner child is important and helpful, but can also be difficult. Participants described a growing sense of control and personal agency throughout their journey, exploring connections to their inner child. For Ian, "the importance of being vulnerable and being vulnerable in a healthy way" signifies that he is allowing himself to acknowledge and understand these feelings. It is through the therapist's acknowledgement of his experiences that he starts to feel safe in exploring his vulnerability. Conversely, Ian reports that he sometimes finds this difficult:

> 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, 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.

Here, Ian is distancing himself from how he was a child, and it is likely that he still has that wall up between adult Ian and little Ian. However, he is keen to identify his vulnerable child and is working towards building an emotional connection with him.

Gertrude said, "I think happy child is when I'm when I'm not even conscious of my train of thought. She's true joy, whereas vulnerable child, she gets joy from the things she learned to get joy from." Gertrude emphasizes the contrast between vulnerable child and happy child, the latter being unconsciously activated and bringing pure joy into Gertrude's life, thus highlighting the importance of accessing and understanding child modes.

In ST, chairwork is a method whereby 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. The aim is to encourage the client to be their own healthy adult and support their vulnerable child. Harriet explains how chairwork has enabled her to be familiar with her vulnerable child, saying that, "the corner chair is the vulnerable child"; however, the idiom of putting her in the corner suggests a strained relationship with this part. Often being in a corner is a difficult situation to come out of, so perhaps she does not want to acknowledge this side. Nevertheless, later in her narrative, Harriet explains how ST has enabled her to understand her vulnerable child and her EMS: "understand myself some more just by kind of like finding out about different schemas and identifying them and then, in turn, because that's kind of allowed me to be more open and more vulnerable, I think it has improved relationships."

This subtheme emphasized the importance of acknowledging one's inner vulnerability. Through this, the needs of the vulnerable child can be met, and the healthy adult can be strengthened. Although the vulnerable child was acknowledged, participants appeared to have difficulties accepting this as part of themselves. Nevertheless, this is indicative of phenomenological reality of this mode due to the recognition of its existence.

Sub-theme: managing emotional needs

Participants highlighted how ST had enabled them to acknowledge feelings that they may have previously inhibited, leading to a greater understanding of their emotional needs, as described by Clare: "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-soothe." She describes the ways in which she soothes her "little side":

> I have a massive [toy] elephant. 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 because I still suck my thumb.

The mechanisms used are concurrent with the age of her little side, demonstrating Clare's working with and soothing her vulnerable child by recognizing these uncomfortable feelings.

Similarly, Diane spoke of how ST 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." This alludes to a strong healthy adult mode in that she has recognized her previous coping modes were primarily maladaptive. Diane mentioned this multiple times in the interview, emphasizing that she no longer utilizes maladaptive coping.

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

> These are schemas that you've developed as a child. You're a child and you don't know 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…that you have because that what you learned as a child and that is just…that linkage for me.

This linkage that has enabled Ian to understand his emotional needs. While speaking, Ian placed his hands together on the video recording, symbolic of bringing Little Ian and Adult Ian together, allowing them to meet, suggesting that Adult Ian is there to look after Little Ian.

This sub-theme thus captured the ways in which ST has enabled participants to understand their emotions, leading to management of emotional needs.

Sub-theme: ambivalence

Ambivalence was experienced by all participants, both regarding ED behaviors and the possibility of recovery. Clare, for example, conveyed ambivalence around purging:

> 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 want to do this," but, on the other hand, that was really great.

Clare begins with the pronoun "you," seemingly detaching from

the experience of purging, in contrast to when she switches to first person and identifies as feeling powerful. Although feeling powerful, she suggests that being unable to hold on to the urge that she is experiencing infers a loss of control. The use of the words "power," "mania," and "great" are positive connotations associated with purging. However, Clare is conflicted. She does not want to purge, but, nevertheless, is overcome by this compulsion to do so.

Moreover, Harriet reflected on her journey, "I can see the path. I just haven't started the path yet", suggesting that her 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 require motivation to keep going. The new path is in the distance, but it is reachable.

Both Jane and Fiona expressed ambivalence, with Jane explaining,

> 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?" I can't do that because I haven't factored that into everything I've had, and I'll have to skip something.

For Fiona,

> It's more management rather than full recovery. I'm just not sure that's programmed into us as people what have issues with food, because I think they get easier, and you change. You learn. And different times in your life you learn that it can impact you more, but I'll never say "never."

For Jane, there is evidence of her ambivalence as she is striving for recovery, yet, simultaneously, reflects on the difficulties. Additionally, Fiona, talks about living with her ED. The use of the word "programmed" implies it is difficult to change her mindset and that she is learning to manage her behaviors, not completely eradicate them. However, she does state, "I'll never say 'never,'" suggesting hope. With both participants, there appears to be a feeling that it can impact on different times in life, and it is how they respond to their ambivalence that they attribute to recovery or associate with recovery.

All participants discussed positively working towards recovery, but none felt that they had completely recovered. All were ambivalent about the desirability of being able to eat without restraint, binge eating, or living without compensatory behaviors.

Discussion

This study sought a phenomenological understanding of experiences with ST for those with an ED, complementing previous primarily quantitative research (e.g., Simpson et al., 2010), focusing on understanding schema modes and the EDV. Participants recognized and identified with various schema modes and the EDV, indicating phenomenological reality. The group experiential themes illustrate participants' growing understanding of schema modes, the EDV, and their ability to relate these concepts to their own experiences. Next, the research questions are considered and discussed relative to the existing literature.

Adverse experiences

Participants reported major adversities prior to developing an ED which were not restricted to childhood. Adversities in this study included parents who reportedly had great difficulty accepting and dealing with their child's developing problem, bullying, and childhood trauma.

EMS and schema modes often develop due to adverse experiences. This is reflected in the current findings. Participants identified the broad phenomenological reality of modes, including the detached protector, the detached self-soother, and the eating disorder overcontroller. These are coping modes, which, as research suggests, are elevated in EDs (Talbot et al., 2015). Participants' narratives suggest that these modes may have developed as coping methods in response to the trauma experienced in early life. In those with bulimic disorders (Clare, Emma, Billie, Anne, and Ian), detached self-soother and detached protector were common maladaptive modes; often, these participants engaged in bingeing or purging behaviors to alleviate distress. For those participants with restrictive disorders (Gertrude, Diane, Fiona, Harriet, and Jane), the eating disorder overcontroller mode was frequently experienced and acted as a coping mechanism to control food, shape, and weight when other areas of life were perceived as out of control. Detachment and dissociation were also experienced. Consistent with Rabito-Alcón et al. (2020) and Goddard et al. (2022), the findings suggest that these behaviors may have developed as coping mechanisms for childhood trauma.

Participants emphasized the role that detachment has played in their lives, e.g., "I have a detached protector who is queen of everything!," "I'm in an orb state," and "I'm in quite a detached space." Participants generally identified with a detached mode, combining both soothing and protecting aspects. Nine of the ten participants in this study described a form of trauma or maltreatment in their childhood. Thus, it could be that detached modes evolved to protect participants in childhood, even if they no longer need them (Young et al., 2003). If detachment developed to protect the participant's vulnerable child from intense emotions, then participants may not have identified with vulnerable child because they had learned to detach from this mode.

Furthermore, narratives portrayed the psychological functions of food and safety and captured the negative view that participants had towards these factors. Although the aim of food was to provide relief (e.g., "I just ate, and ate, and ate."), the subsequent feelings of guilt suggest that this was experienced negatively. Anne and Billie, for example, emphasized how, at times, it felt like they were battling an addiction. Participants also accentuated how they could not live without their EDV despite being aware of how critical it can be, and they described the various ways in which it is experienced: as a devil or demon figure or as an inner critic. This view in particular, was experienced by all, thus, suggesting that it has a psychological function. Similar to modes, it is likely that the EDV developed due to adverse life experiences, further suggesting some overlap in terms of phenomenology.

Interpersonal relationships

Previous research has reported a link between negative caregiver experiences, including emotional abuse and invalidation, and ED pathology (Talbot et al., 2015), and this was evidenced in narratives. Examples include Fiona's father's reaction to her ED, Clare's mother placing her on a diet, Anne's repetition of her mother's role as a therapist while not recognizing her daughter's ED, and Ian describing embarrassment from his father. High maternal over-protection and low paternal care have been linked to defectiveness and dependence EMS (Turner et al., 2015). This was seen in narratives with many participants articulating a defectiveness EMS. Therefore, according to the ST model, EMS re-

flect early adverse interaction patterns and can lead to interpersonal difficulties later in life and the subsequent development of maladaptive modes.

The therapeutic relationship was held to be very important for recovery by all participants. As expressed by Young et al. (2003, p. 183) "The goal is for the patient to internalize a healthy adult mode, modeled by the therapist, which can fight schemas and inspire healthy behavior." This was particularly evident as participants reflected on how they have been able to tune in to their healthy adult side, to both protect their vulnerable child and challenge coping modes. This view was regarded as something specific to ST, as throughout narratives, participants describe their previous therapeutic experiences as not being particularly helpful, thus highlighting the continued importance of research into ST.

Self-awareness

This theme supports and elaborates on the modes identified in ST theory, which are idiosyncratic (Edwards, 2017a). Different participants identified with different modes, and no one scored highly on all modes. Eight of the ten participants reported becoming aware of some of their modes and when they were activated; this was mainly coping modes, with little mention of adaptive modes. The other two spoke more about an inner critic, which may resemble the EDV, or may be interpreted as the manifestation of a punitive mode.

As theorized (Simpson et al., 2018), participants reported not being in touch with their vulnerable child prior to ST. It appeared that their previous functioning had been to hide or compensate for vulnerability, so the therapeutic safe space allowed them to recognize and develop healthy, yet, vulnerable needs. There was little awareness of the vulnerable child mode, and this could be due to the negative connotations that participants associated with vulnerability. Simpson (2019) suggests that many participants with an ED have learned to avoid feelings of vulnerability which are associated with being weak. Often, this is an internalized message from participants' inner critic. This was reflected in narratives as participants described how close others would perceive vulnerability as a weakness, for example, "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. Although participants did not explicitly identify with their vulnerable child, accounts infer that it was present, indicative of phenomenological reality.

Participants also seemed at ease with the basic idea of different modes, or entities, within them and found this a useful approach to understanding themselves. Indeed, some reported utilizing a whole range of "helpers" drawn from life and fiction. Some of these entities resembled some of the theoretical modes.

Everyone was aware of critic modes, and many felt that this was related to their EDV. Personification of the EDV varied from none—until it was discussed in therapy—to extreme personification as a dragon or devil. Despite these extreme personifications, participants felt that the EDV was necessary for them and, in some sense, functional (Fox et al., 2011). From this perspective, it could be argued that the EDV is manifestation of whichever is the strongest mode related to EDs. Therefore, a strong mode can be experienced as a separate, often dysphoric and negative voice, and, at least for EDs, a separate voice may be a sign of underlying modes. Other complex therapies also recognize the EDV, or inner critic, but ST provides a theoretical account of why it exists.

Recovery

This theme emphasized participants' journey in finding their inner child and acknowledges the healthy adult mode as a catalyst in recovery, particularly in nurturing their inner child. Previous quantitative literature, in contrast, suggests that those with an ED have primarily maladaptive modes with weak adaptive modes (e.g., Pietrabissa et al., 2020; Talbot et al., 2015). This could be because these studies utilized quantitative measures, whereas this study adopted a qualitative approach highlighting participant's recognition of their adaptive modes. However, seldom were adaptive modes explicitly mentioned. Rather, it was through interpretation that participants' recognition and understanding of these modes were brought to light. Adaptive modes were acknowledged, but did not appear to be accepted by participants. There was some hesitancy around these modes, particularly the healthy adult mode. Instead, coping and critic modes seemed to dominate.

Nonetheless, all participants expressed ambivalence towards their experiences and therapy, and many seemed reluctant to give up their ED. Ambivalence has long been linked to hindering recovery from an ED (Pugh, 2019; Williams & Reid, 2009) and was supported by all narratives in this study, suggesting an important focus for treatment.

Limitations

The primary limitation is that treatment durations varied. Some participants were in the early stages of ST (three months), and some were further on (eighteen months), which may have impacted their experiences and understandings of schema modes and the EDV. Additionally, participants were disproportionately women, as is often the case across ED research (Gorrell & Murray, 2019). However, future research should aim for a more even split. Nonetheless, this sample was sufficiently homogenous to satisfy the requirements of IPA as each participant reported a diagnosis of an ED. Replicating this study with participants from other cultural or ethnic backgrounds would provide a comparison that could further contribute to our understanding of schema modes and the EDV in EDs and to provide insight into the impact of culture and ethnicity on schema modes and the EDV.

Conclusions

This study addressed the extent to which people with EDs recognize modes and the EDV in themselves, along with how they identify with the concept of modes and the EDV, and, finally, how ST has helped in the increased understanding of these two concepts. All participants recognized some schema modes and the EDV within themselves, experienced as somewhat phenomenologically separate so, as in ST, they could dialogue with them and could create teams of modes to guide them through life adversities. Modes and EDVs' nature and structure were idiosyncratic and varied from being a metaphorical way of thinking about different aspects of the self to being phenomenologically quite dissociated states.

ST enabled participants to recognize and understand these parts or aspects of themselves, as well as putting them in touch with their vulnerable child mode, which they tended to distance themselves from. Improved awareness enabled participants to soothe themselves in an adaptive way, suggestive of a developing healthy adult mode. Participants also described improved under-

standing of the functions of their ED, often as a coping mode, leading to ambivalence about recovery.

Despite the similarities discussed, participant experiences were quite diverse and varied in which modes they recognized. The most common modes were some form of overcontroller or critic mode, related to the EDV, some form of detached protector and, beneath, a vulnerable child mode which the maladaptive modes may have evolved to shield and protect. The results build on preliminary evidence that ST is beneficial in treating EDs and proposes that a schema-focused approach, particularly, the mode model, could be helpful in treating and understanding EDs. Further, the results support the use of phenomenological tools for investigating modes, as this study captured the dynamic aspects of modes that are important to clients. Indeed, the concept of modes is something that participants resonate with. These findings suggest applicability of the mode model to EDs. Future research should further explore idiosyncratic modes and the effectiveness of ST on EDs.

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Online supplementary material:
Appendix A: Interview Schedule.