

Editor's Note: for the interested reader, an outline of the structure of the case study of Kelly is shown in Appendix 1, and a glossary of technical terms is shown in Appendix 2.

Kelly's Circle of Safety and Healing: An Extended Schema Therapy Narrative and Interpretative Investigation

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ABSTRACT

This is a narrative case study of the psychotherapy of Kelly (pseudonym) that describes processes that took place within the last 17 sessions of a longer therapy of 67 sessions over a period of 26 months. A phenomenologically grounded and coherent account takes readers on an experiential journey that enables them to live through aspects of the process at least partially. These processes began in session 52 in which Kelly saw an image of a circle of caring people within which a series of child parts of herself were able to find a sense of safety and holding. Over the course of the sessions, eight different child parts approached and eventually entered the circle, each representing a different dissociated set of early schema patterns, each with its own related emotional distress. Through dialogue work and imagery rescripting, the predicament of each child and her unmet needs were brought into focus. This served as the basis for providing corrective emotional experiences that led to the child parts feeling able to voluntarily step into the circle. The material serves as the basis for theoretical-interpretative investigations with a focus on the phenomenology of memory and transformation in experiential psychotherapy. This is organized under several themes: (1) complexes, schemas, and internal working models; (2) autobiographical memory and the working self; (3) the "theater of consciousness" and the "theater of the imagination"; (4) understanding the figures that entered Kelly's healing circle; (5) how far back can we remember? (6) reparenting, corrective experiences, and imagery rescripting; and (7) coping decisions and demanding and punitive features in coping modes. A brief conclusion aims to contribute to our understanding of the phenomenology of corrective experiences and psychological transformation.

Key words: corrective experience; early maladaptive schema; imagery rescripting; schema therapy; schema mode; case studies; clinical case studies

1. CASE CONTEXT AND METHOD

Introduction

This case study is centered around a narrative that portrays processes that took place within 17 sessions of the schema psychotherapy of “Kelly.” I was the therapist, and during this time, in line with the schema therapy’s use of emotion-focused work with imagery (this process is explained below in section 6. Course of therapy), an image of a circle emerged for Kelly within which many fragmented child parts were to find safety and healing. The process is of considerable interest clinically and theoretically. The first aim of this article is to tell the story, to create a narrative that takes the reader through key features of an unfolding experience. Very often, in research that interprets processes in psychotherapy, the presentation of interpretative steps obscures the phenomenology of the processes being interpreted so that readers never really engage with it directly. The way the narrative is constructed is intended to achieve a fundamental aim of phenomenology, which is to take readers on an experiential journey that enables them to live through the process at least in a partial way.

The second aim of this article is to explore the larger clinical and theoretical ramifications of a therapeutic experience like Kelly’s.

Research Methodology: Client, Therapist, and Sources of Data

This article constitutes a naturalistic case study structured as a systematic case study as pioneered by this journal and summarized by Edwards (2019a). The case study is based on voice-recorded sessions with Kelly who consulted me for psychotherapy and whom I saw in my private practice for 67 sessions. Two research interviews were conducted by me after the final session, which were also voice-recorded. Notes were made on all sessions at the time. Thirty-two of the sessions plus the two research interviews were transcribed. There was additional material in the form of email correspondence. To protect Kelly’s privacy, pseudonyms are used, and limited identifying information is included. Kelly subsequently gave informed consent for the use of the material for publications and conference and workshop presentations.

The Methodology of Generating the Case Study of Kelly

Kelly’s case study consists of two phases, as described below.

The Narrative Phase

From the above-described narrative material, two data condensations (Miles et al., 2014) were written. The first, reported in sections 2-7 below, is a narrative that is selective and thematic, based on session notes, session recordings, session transcripts and the interviews with Kelly. It presents, in summary form, material directly relevant to the process through which, in imagery, a series of child parts of Kelly were identified and found their way into a circle of

people where they felt safe. The narrative is phenomenological in that it takes the reader on a journey through aspects of Kelly's unfolding experience as it was lived in the therapy sessions (and outside them too). It portrays a series of experiences that largely speak for themselves in terms of what was unfolding and how, and that reflect intricate therapeutic processes in which implicit memories were accessed and transformed. The aim is to achieve "thick descriptions that include the detail, complexity, context, subjectivity, and multifaceted nature [of the experiences being presented]" (Fishman, 2013, p. 406), and that communicate to readers in a manner that is "compelling" and that "discloses, transforms and inspires" (Finlay, 2011). Galvin and Todres (2013, p. 150) call for "a more aesthetic phenomenology," which not only expresses what has been found, but conveys it to others in an impactful way that creates "a human connection between the reader and the phenomena that is descriptively portrayed" (p. 151). There is some interpretation in the narrative in that some experiences were understood using concepts within the schema therapy model that I shared with Kelly, and which we both used to conceptualize aspects of the process as it unfolded.

The narrative was constructed from session transcripts in a process that is an extension of interpretative phenomenological analysis (IPA; Finlay, 2011; Smith & Osborn, 2003). IPA is usually based on research interviews. Therapy sessions have several features in common with research interviews. As Smith and Osborn (2003, p. 51) observe, in the process of data collection in IPA, "participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world." This involves combining an "empathic hermeneutics with a questioning hermeneutics" in that the interviewer asks searching questions intended to elicit meanings that are implicit, out of the participant's awareness.

Unlike most research interviewers, however, schema therapists also use a range of active interventions that are intended not only to disclose implicit meanings but to change them. This is particularly true of the kind of guided imagery and dialogue interventions used here. They could be thought of as experiments intended to coax out hidden aspects of experience, just as, for example, the classical double slit experiment in physics was designed to coax out hidden aspects of the phenomenon of light (Rae, 2004). These methods could be understood as the extension of a questioning hermeneutics and might appropriately be called a "provocative hermeneutics." There are precedents for this within IPA research (Elmi-Glennan & Mercer, 2018; Furman, 2006). The combined effect of these stances of empathic hermeneutics, questioning hermeneutics, and provocative hermeneutics is to give rise to a set of texts—the recordings of the therapy sessions and transcripts of them—that are particularly rich in psychologically disclosing material.

Subsequently, I engaged with the material in various ways, presenting some of it, including segments of some of the recordings, at conferences and workshops. The focus of this study is the last 17 sessions, the transcripts of which (as well as of some of the earlier sessions) were read carefully and repeatedly consulted.

In the description of the last 17 sessions below, following the practice within schema therapy, the figure of Kelly as a distressed child is sometimes referred to as her Vulnerable Child, and Kelly, as she is now, when introduced into the scene, is “Big Kelly.” Session numbers are referred to as “S#.” All names are, of course, pseudonyms. Sessions are referred to as S1 (= session 1) etc. Material quoted verbatim is indicated by inverted commas, omissions of repetitions or superfluous material are indicated by (...), and linking words are added in square brackets. 1

The Theoretical-Interpretative Phase

In this phase, which is presented in section 9 below, the narrative was used as the basis for examining two areas: (1) the nature of memory and remembering as it occurs in experiential psychotherapy and its relationship to current understanding of autobiographical memory; and (2) the processes of changing memory structures to bring about the kinds of fundamental change that we call schema healing.

2. THE CLIENT

Kelly is a professional woman who was 36 years old when she began this therapy process. Born to a very unstable and abusive mother, and a largely ineffective and emotionally absent father, she had embarked on a 5-year psychotherapy when she left home to go to University in another town. This had supported the process of separating from her parents and for building her relationship with Rick, whom she met in her second year at University. Rick was strong and stable and able to confront Kelly's mother. A few months later, despite her parents' objections, she had moved in with him and they married shortly before her 23rd birthday.

When Kelly began therapy with me, she was in her mid-thirties. She and Rick were in a stable marriage and had two small children under 6. Kelly had had some further therapy sessions with another therapist before the birth of her second child. She had gained a great deal of insight through her previous therapies but felt this had not gone far enough. She knew that my approach to therapy was experiential and that I worked with imagery, and this is what she wanted now. As she put it,

I am now determined to work at a deeper level [than I had before]. The insight stuff wasn't enough. ... I needed somebody who would push me. ... I wanted to be challenged... I started to feel a bit claustrophobic with all the “kindness” [from the previous therapists]. ... I wanted to see the messy bits and ... to work with them.

3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

My Background in Schema Therapy

I was fortunate to be introduced to schema therapy by its founder, Jeffrey Young, in 1984, several years before anything was formally published and I followed the development of

schema therapy closely from then on. This was long before I first saw Kelly, and by the time I first saw her for therapy, the International Society of Schema Therapy (ISST) had been founded and had established a process for certification as a schema therapist, and I was an ISST certified supervisor and trainer.

Psychotherapy and Phenomenological Research

Psychotherapy involves extended engagement on the part of the therapist with the experience of the client. While the aim is not primarily to gather data for research, as Freud (1926, p. 255) observed, there is “an inseparable bond between cure and research. Knowledge brought therapeutic success. It was impossible to treat a patient without learning something new; it was impossible to gain fresh insight without perceiving its beneficent results.” As Freud implied, the clinical method used in psychotherapy involves a process of data gathering, an investigation of the client’s experience that often yields rich qualitative data that may access deeper structures of meaning than that gathered from research interviews. It can therefore provide a rich foundation for phenomenological research.

The Schema Therapy Model

The clinical and theoretical basis for the therapy was the schema therapy model. This is an integrative therapy within which psychodrama with imagery or chairwork plays a significant role (Farrell et al., 2014; van Vreeswijk, Broersen, & Nadort, 2012; Young et al., 2003). The narrative, constructed from transcripts of session recordings, incorporates a series of imaginal scenes in which parts of Kelly’s self are separated out, and appear as distinct figures. Kelly had a natural affinity for this and would see vivid images within and outside of therapy. These are not just images though, as the imagery was embedded within a complex of activated emotion and felt experience that was often intense.

Schema therapists look for early maladaptive schemas, emotionally charged meaning structures learned in early childhood in adverse situations of unmet need, that are often at the root of current problems. Based on clinical observations of his clients, Young identified 18 of these which capture central problematic themes or patterns that are likely to be the focus of therapy. These are listed in Table 1. These can be measured by the Young Schema Questionnaire, first validated for 16 schemas by Schmidt et al (1995). Subsequently all 18 schemas were measured by the YSQ-3, the short version of which, the YSQ-S3, has been validated in several languages (for a recent review, see Phillips et al, 2019). Kelly’s responses to the YSQ-S3 are summarized below in section 4.

Schema therapists also identify and separate out different self-states or voices within the client. Several of these “schema modes” are explicitly referred to in the narrative. There are four broad categories of schema mode. First, the client is in a Vulnerable Child mode (or other Child modes such as Angry Child) when there is an experiential connection to early maladaptive

schemas either through somatic or emotional experience or through imagery that portrays specific childhood episodes. Kelly was in this kind of mode for a good part of these therapy sessions.

Second, Parent modes are introjects of attitudes and messages from parents or other authority figures that appear as voices in the present (though not necessarily in the actual voice of the parent). Kelly experienced both Punitive Parent and Demanding Parent voices.

Third, Coping modes are ways individuals learn to cope with emotional distress in the Child, attenuating it or shutting it out altogether by Avoidant coping (detaching from emotion, avoiding reminders, distracting attention away from it); Overcompensator coping (taking control and presenting a front that is strong and self-sufficient); or Surrender coping (fitting in and focusing on others' needs).

Fourth, the Healthy Adult is the term used to refer to a mode of balanced and mature functioning (Edwards, 2022; Young et al., 2003). All these kinds of modes were identified at various points in the narrative.

The aim of schema therapy is to promote schema healing by making a connection with the memory of the Child whose needs were not met and providing a corrective experience so that the chronic experience of unmet need is resolved (Young et al., 2003). This begins with "emotional bridging" (Hackmann et al., 2011) or the affect bridge (Watkins, 1970). Emotional states triggered by events in the week serve as a starting point, followed by questions such as, "Is this feeling familiar?" and the invitation to the client "to go back in time to when you felt it before." This can evoke painful childhood memories.

The therapist then guides the client through an imaginal corrective experience using imagery rescripting (see Glossary in Appendix 2) to address the problematic experiences in these memories and guided by the principles of process-experiential and emotion focused therapy (Elliott & Greenberg, 2007). In imagery rescripting, such episodes of unmet need are redramatized in such a manner that the child's needs are appropriately met, for example by the therapist, or the client him or herself, offering the child consistent and empathic care and firm protection from maltreatment and abuse which were not provided at the time (Arntz, 2011, 2012, 2014b; Edwards, 2007). An important contribution to this is the client's relationship with the therapist, who takes the lead in offering care to the child in the memory when the client cannot yet do this for him/herself. For example, the therapist may enter the scene, confront the abusive parent, telling him/her that s/he is not competent to raise a child and provide for his/her needs, and then offer the child empathy, care, and guidance.

It is important to identify Coping modes when they appear as these prevent access to the Child states. Once identified the therapist works to bypass them to get to the Child that the coping mode is shutting down, something illustrated on several occasions in Kelly's narrative.

Parent modes also create obstacles to schema healing. The Child is locked into a dyadic relationship with the introjected Parent (a Parent-Child mode dyad) and this makes reparenting impossible (Edwards, 2022). This is why, on several occasions, in Kelly's case, I as the therapist confronted and sent the Parent away. This freed the Child to receive parenting from the therapist, and, also, from Healthy Adult Kelly herself.

In section 9, at the end of this article, the theoretical understanding of the processes described in the case narrative will be examined more fully in light of schema theory, attachment theory, research on autobiographical memory and dissociation, and current debates about the theory and practice of schema therapy.

4. ASSESSMENT OF THE CLIENT'S PROBLEMS, GOALS, AND STRENGTHS

As mentioned above, at the beginning of therapy Kelly was a 36-year-old married mother of two who worked as a professional woman. Having had a previous 5-year psychotherapy when she left home to go to University, Kelly was now, many years later, now ready for therapy "at a deeper level."

Presenting Problems, Clinical Features, and Diagnosis

Diagnostically, Kelly did not exhibit severe symptoms overtly. The Beck Depression Inventory-II (Beck, Steer, & Brown, 1996) and the Beck Anxiety Inventory (Beck & Steer, 1993) were administered at the 15th session and scores on both were in the minimal category. Although there were many traumatic memories very close to the surface, these did not appear as obvious flashbacks, particularly at the start of therapy, so I did not consider a diagnosis of PTSD. However, Kelly's narrative presents evidence that the regular triggering of emotionally overwhelming memories contributed to her everyday difficulties. Many of these were not obviously life-threatening, but, several were, as will be seen, including one occasion when she feared that her mother would kill her sister.

Anger was a significant problem for Kelly. She was concerned that at times she felt contemptuous and even vicious, and she sometimes felt so enraged by her children's behavior that she was afraid she might shake and hit them like her mother had done to her. Kelly also continued to have frequent severe headaches that had been a part of her life since early childhood.

The Young Schema Questionnaire—Short form (YSQ-S3; Young 2005) was administered at the beginning of therapy. Clinically this is used to identify themes likely to be salient for the case conceptualization. Each of the 18 schemas is tapped by 5 items rated on a scale from 1-6, where 5 = "Mostly true of me" and 6 = "Describes me perfectly." This gives a

maximum score of 30 on each schema. There was one prominent high scoring schema, Unrelenting Standards, with a total of 25.

However, interpretation of the YSQ is largely qualitative and particular attention is paid to high scoring items, even though the score on the scale as a whole may not be particularly high. Kelly's high scoring items are summarized in Table 2. The Unrelenting standards is usually associated with a strong Overcompensator coping mode, involving a Perfectionist or Obsessive-compulsive Overcontroller. A high score can result in the respondent underrepresenting some schemas, so that clinically salient schemas are not accurately reflected in the YSQ scores (Cutland Green & Balfour, 2020). Kelly's responses provide an example of this. There were a few items with high scores (5 or 6) on several schemas even though in most cases the total score on the scale (shown in parentheses) was not particularly elevated: Abandonment (18), Mistrust (13), Enmeshment (16). Other schemas that were evident in the clinical material in the first two sessions, and which were not evident from the YSQ, are listed below in section 5 on case formulation.

Family History

Growing up, Kelly had never felt safe or loved and was full of intense emotions she could not understand or fully control. An intelligent and capable woman who, at primary school, had been made head girl, despite the emotional chaos going on at home, she had learned to be self-sufficient, cover up her feelings and, although she felt confused and precarious a lot of the time, did well at school and university and established herself as a respected professional. Kelly's mother was unstable, sometimes suicidally depressed, often angry and emotionally abusive. As a very little girl, Kelly recalls being told by her that she was greedy, selfish and lazy. In one session, she re-experienced being a toddler hiding behind the chairs under the kitchen table while her mother was in a rage. Kelly recalls being held and shaken by her mother. She saw her older sister, Sarah, being hit and scratched by their mother, thrown against a cupboard, and on one occasion feared her mother might kill Sarah whom she was frog marching out of the room.

Her father never protected the children from his wife's assaults and would sometimes appear in imagery as an inane presence smiling at her from a distance down the passage. Kelly learned to be a good girl, while Sarah took the rebellious path and was regularly beaten by their father with a strap that hung conspicuously near the front door. Her mother was at times severely depressed. Kelly recalls pleading with her mother to take some pills to make her better because she was crying; Kelly was 3 years old. Kelly was emotionally neglected. At age 12, she recalls feeling envious of a school friend whose mother packed her a lunch box every day. Kelly and her sister got themselves up in the morning, made their own breakfast, and never had a lunch box. At age 15, while her parents were away for two weeks, she recalls staying with Diane, a neighbor, and experiencing a secure loving home for the first time.

The seeds of the enmeshment that were picked up by items 27 and 45 in the schema questionnaire (see Table 2) lay in her mother's having had a child to meet her own needs. Her mother had thought, "You will be the one who understands me." The extent of this was portrayed in a dream Kelly had had at the age of 19. She sees two heads in conversation—her own and her mother's. Her mother tells Kelly that Kelly must have both legs amputated; although Kelly's mother is sad about this and realizes it is hard, she is quite clear that this is what is best for Kelly. Kelly pleads with her not to make her do this. The camera then pans to her mother full length. Her mother is sitting in a wheelchair without any legs. This seems to symbolize the way her mother, at core, and behind all her threats and demands, was emotionally crippled and a helpless victim, and, therefore, not a role model to be emulated.

Strengths

Despite her neglectful and abusive background and feeling confused and precarious a lot of the time, Kelly had achieved well at school and University and was now a high functioning professional who continued to function effectively throughout the period of the therapy. She had a well-developed capacity for reflection and psychological insight.

Kelly had profited from her previous therapy and was strongly motivated to engage with others in a more collaborative manner and to learn to deal with the painful emotions she regularly experienced. In addition, she had received training in working with children, in understanding them psychologically, and in how to be an effective parent.

This foundation enabled her to engage emotionally at a deep level right from the start in therapy. For example, in the first sessions of therapy she easily was able to bring in her painful inner feelings and memories as she became emotionally engaged with a Vulnerable Child, who was unseen, uncared for, repeatedly mistreated, and disappointed, often desperate; and with an Angry and Rebellious Child.

5. CASE FORMULATION AND APPROACH TO THERAPY

A case conceptualization in schema and mode terms was developed after the first two sessions. There was a Vulnerable Child who felt alone and isolated (Emotional Deprivation and Social Isolation schemas); shamed and humiliated (Defectiveness/Shame schema); and terrified of her mother's aggression (Vulnerability to Harm or Illness schema). There was also an Angry Child, angry at her needs not being met and having to shut down her feelings because there was no-one to take them seriously. These Child Modes were associated with Parent Modes: Kelly's mother's behavior was at different times invalidating, punitive, blaming, shaming, terrifying, and guilt-inducing, playing the helpless victim (see Edwards [2022] for an expanded view of Parent Modes that go beyond the basic modes of Punitive, Demanding, and Guilt-Inducing.)

Kelly's father was confusing. He was a seemingly benign but ineffectual presence that failed to protect her from her mother and was also at times punitive. A major Coping mode for

Kelly was a Strong and Independent Overcompensator (see Edwards, 2022) whose script was to find a way to manage and “make it work.” This was supported by a Perfectionist Overcontroller who felt responsible for getting things done perfectly and without mistakes, and a Compliant Surrender mode that negated Kelly’s own needs and focused on fitting in with others. There was also a self-soothing Coping mode, Playing Alone Kelly, who, as a child, could play intricate games with toys alone by herself for hours. Less frequently, Vicious Kelly, a self-righteous, angry Scolding mode would appear. This mode externalized her Angry Child, directing it at others. Although Kelly had made considerable progress in getting her needs met in her relationship with Rick and her children, these Coping modes still stood in the way of her resolving the pain in her Child modes and of getting her needs met more broadly and they contributed to perpetuation of the underlying schemas.

6. COURSE OF THERAPY, WITH A FOCUS ON THE DEVELOPMENT OF KELLY’S CIRCLE OF SAFETY AND HEALING

Overview of the Process of the Therapy Regarding Kelly’s Role in Imagery Rescripting

From the beginning, Kelly trusted me. She freely accessed and shared the experience of her Vulnerable Child, and I helped to articulate the dimensions of her experience. She was thus able to connect experientially to childhood memories with ease and relive the associated emotions. This provided the basis for embarking on imagery rescripting, which would play a major role in the process, as will be illustrated in the narrative that follows. This was first used in session 6. Some of the memories she connected with were very early. For example, in session 12, she re-experienced being a baby of 6 months. I did not formally explain the rescripting process to her but, when I introduced the various active aspects, she engaged naturally with them. Kelly brought with her many resources that allowed the process to unfold in the way it did. These included the gains she had made in her previous psychotherapies, her being in a stable and supportive marriage, and her having received training in working with children, in understanding them psychologically, and in how to be an effective parent.

Kelly had a natural capacity for working with imagery and she could see the images and work with them without closing her eyes. She was also able to divide her attention so that there was always a part of her that could witness the content and emotions in the intensely painful and often frightening memories we worked with, while remaining present and grounded. This is what Rothschild (2000, p. 130) calls “dual awareness,” and Heron (2001, p. 93) “free attention,” where part of Kelly’s attention was immersed in reliving a memory while the other part was a meta-awareness, outside of this, mindfully recognizing that she is currently safe in the presence with the therapist. This is widely recognized as essential for the reprocessing of emotionally charged memories (Heron, 2001; Rothschild, 2000).

Kelly’s dual awareness was paralleled by a similar dual awareness on my part. A great

deal of my attention would be directed at attuning to Kelly's unfolding experience and the emotional states she was in and their meaning, while I was also mindfully aware of being the therapist who was holding the space and facilitating a deep process.

Clients' capacity to work with imagery in this way has been frequently described in the psychotherapy literature and, though often encouraged in the hypnotherapy tradition, is in no way restricted to it (Edwards, 2011). This experience will be examined in more detail in section 9 where the concept of a theater of the imagination will be introduced and illustrated by the case material which follows now.

Sessions 1-50: The First Two Years of Therapy and the Emergence of a "Circle of Safety"

There were 50 sessions in the first two years during which we worked with everyday triggering events in her life, bridging back to the schema patterns and memories that had been activated, and using imagery rescripting to provide the Child in these memories with reparenting. Beginning in session 52 (S52), Kelly saw an image of a circle of caring people (which I'll refer to as her "Circle of Safety") within which a series of child parts of herself were able to find a sense of safety and holding.

Processes in the sessions before S52 had paved the way for this development. We had been working with Kelly's fierce independence that covered a deep mistrust. In S45, I had pointed out that she was willing to let Big Kelly care for her Vulnerable Child in various situations, and she would let me coach Big Kelly in how to care for the child part of her, but she would not let in my care directly, or that of Rick. In S45, I suggested that, in imagery, Kelly invite Rick to come into a childhood scene. When she allowed him in she felt relief. She followed this up with imagery between sessions and reported at S46 that she had experienced the child enjoying sitting on Rick's lap and feeling his physicality and strength. Kelly had also used my feedback to approach friends and ask about their experience of her self-sufficiency and received confirmation that they sometimes felt hurt when she pushed away their care.

A few sessions later (S49), I explicitly offered my care. Kelly had connected with a memory of herself as a toddler hiding in terror under the kitchen table. There were other frightening memories, but this was the prominent one. Little Kelly is trying to figure it out. Her mother hates everything about her. There is nothing obvious causing her mother's rage so it must be that she, Kelly, is the cause. I offer to come into the scene. I tell her there is nothing wrong with her, that this sort of thing should never happen to a little girl, and that I would not let her mother hurt her any more, and wanted her to know that she was now safe. Although her impulse is for Big Kelly to go to the child, she realizes it is a relief to have me there, though the Child still keeps me at a distance. I reflect on the Child's frozen terror. Given her experience of her parents why should she trust anyone else? But I feel a softening starting to happen.

In S50, Kelly connects with this terrified toddler again. In a rescript, I come into the kitchen scene and confront her Mother. I point out how she is terrorizing her children to the point that Kelly fears for her life and that of her older sister, Sarah. I will not allow this to go on and will protect Kelly now. The toddler hears this but experiences it is a bit of a blur, away in the distance. I offer to come under the table with her and talk to her, to stay with her and protect her. I tell her I understand that she does not want to need anyone but that she is a child who does need connection with a trustworthy person. She does not want me under the table, but she can see my legs and finds that reassuring. We agree that I will stay there, and she can get used to me. She does not want me to leave.

Sessions 51-52: A Circle of Healing for the Terrified Toddler

Six weeks pass—it is the summer holiday—but in S51 the process picks up where it left off. I tell the toddler under the table she cannot do this by herself, and she will need to come to trust me if she is to move forward. Now she realizes she can never feel safe in this house, she needs to be somewhere else. Big Kelly and I talk about this, and Big Kelly suggests the house of Diane nearby where she stayed for two weeks (later at age thirteen). This is a wholesome home; Diane was caring, interested, unpretentious, and there was a sense of safety. We take Little Kelly and Sarah there. She sees a kaleidoscope of images of Little Kelly from an infant in arms all the way up to the three-year-old. Kelly is starting to take in that this is something new. I tell her she will never have to go back there. Her Mother is angry, her Father passive and resigned. But they do not have the power to reverse this.

This scene stays with Kelly and during the week she brings Rick into it too and Big Kelly seems less substantial, perhaps because she is handing over to Rick and me. In S52, as we connect with this again, I ask what the child needs. She starts to talk about needing “consistency,” a “sense of solidness” from me and Rick that can

create a cocoon around me that keeps me safe, [where I can] ... chatter or play [without any demands being made on me.] ... I want to sit almost, almost, in a circle of, of those kind of people, I just want to be in the middle of, surrounded by ... that solidness... [So] I can feel what it's like to be protected and safe.

Kelly is clear that only Rick and I can make the circle. I suggest Diane, but she is not suitable. However, Kelly is able to replicate the two of us so that we form a circle of people who surround the three-year-old.

Looking back, there had been a steady process of homing in on the conditions that could furnish Kelly such a grounded experience of safety. In this moment, it coalesced into something substantial with the image of the circle. This heralded the profound process that would unfold over the remaining sessions, in which a range of challenges, obstacles, and painful dilemmas would have to be negotiated. The first confronts her right away. She wants Sarah with her. But under the onslaught of her mother's rage, and repeated physical and emotional assaults provoked

by Sarah's own rebelliousness, it seemed that her sister had dissociated bit by bit. It was as if she gradually disappeared as a personal presence until she was no longer there as a person Kelly could connect with. This had been confusing for Kelly, since Sarah was the one person that she had felt a loving connection with. I help Kelly articulate the confusion and face the grief at losing her sister.

Sessions 53-55: A Terrified 8-Year-old

S53

In S53 Kelly tells me that the Toddler is still in the circle, but another Terrified Child is standing outside. She is 8 years old and anxiety has been a constant background to her life. Kelly sees a cascade of childhood memories of frightening incidents. Two images from the TV had terrified her: an advertisement for throat lozenges with Dracula in it, and a dark cowed figure who died of lung cancer—part of an anti-smoking campaign. The school raincoats with hoods hanging in the passage outside her bedroom reminded her of these images, and she was frightened to get up at night. She cannot tell her parents and these images appear in nightmares.

The Child lets me sit with her and I let her talk about her fears. I explain that Dracula was a fictional figure. She tells me she thinks there is something wrong with her because she is constantly vigilant and anxious: she feels unsafe walking home from school, especially after warnings about children being abducted. She would surely have met criteria for PTSD had she been assessed then. But now, she has come out of the house and is by the circle with me. She wants to tell the stories of the things that frightened her before entering the circle and join the smaller Child who is already there.

S54

In S54, Kelly is uncharacteristically detached and actively dismissive of the process. During the week, her daughter had been upset about something, but had not confided in her, Kelly had felt shut out. Rather than experience the pain of this, she switched into a coping mode and became scolding. I invite her to experience the avoided Vulnerable Child feelings. It is the child outside the circle from S53, feeling hurt and wanting to reach out, but having no-one she can safely turn to. So, she is detached, mistrustful.

Kelly can see two other figures contributing to this. One is angry and critical, a Punitive Parent, the introjected voice of her mother. But there is another disdainful part, telling her that her feelings are silly and to be discounted. It is confusing because this part has similarities to her mother, even evokes an identification with her, but Kelly experiences it as part of herself. She can see now that its role is to protect her from reaching out to someone who would later betray her. Because this protective part is also a child, I call it a Protector Child. The Protector Child is now conflicted: she thought she was helping, but now she is keeping the child from entering the circle. She asks, if I let her to enter the circle, "What's going to happen to me? ... Am I just going

to disintegrate? ... I don't want to be rejected because I really care about her [i.e., Kelly].” I affirm her care and her strength and ability to protect and suggest she can invest these resources differently now. Kelly sees her Healthy Adult self making an alliance with the Protector Child.

But the Child outside the circle still “feels quite frozen” by the impact of the Punitive Parent. I confront her mother, firmly naming the appalling way she has treated Kelly. I tell her to go away and that I will not allow her back. If she tries to return, I tell her, I will stop her. She sees her Mother storming off into the house and Kelly wants to barricade her in and put a fence round it so she knows she will be safe.

However, this Child is still not ready to step into the circle. She carries other memories: an unresolved school friendship with a peer called Penny that started when she was 10. Kelly felt accepted by Penny and trusted her. But five years later, there was a conflict in the peer group and Penny and Kelly were on different sides. Penny cut Kelly out completely and Kelly was heartbroken. Although they continued to have some contact even after school, the safe warm connection was shattered. The session ends: the Child, still frozen and very confused, remains outside the circle.

S55

S55 reveals more of what is keeping this child from entering the circle. During the week she had had an image of her Punitive Parent wearing her (i.e., Kelly's) clothes. She is masquerading as Kelly's Healthy Adult. Kelly is outraged. This is the introject of the mother, not the Protector Child, and I suggest Kelly ask her to be honest and dress up in her own clothes. In an interesting sequence, her mother appears in various different clothes, but eventually Kelly tells her firmly, “Go back into the house and get into your own clothes.” Kelly is surprised by the outcome: “She goes quite quietly, with no retaliation, almost like her power was in the deception and once the deception's been labelled”—the power is gone.

Then Kelly reports how her daughter's best friend has been poached by another girl, and she is helping her deal with her feelings about this. This, of course, resonated with the end of Kelly's relationship with Penny and I ask about the Child outside the circle. The Child is intensely anxious, dealing not only with the loss of Penny but with other feelings she can't put words to yet, going back to the start of high school. At the first assembly, it is mentioned that Kelly had been Head Girl in her primary school. She feels an intense pain and struggles to breathe. She remembers how, in struggling to cope, she learned to deliberately hyperventilate to avoid activities that scared her (like swimming). Two years before the rift took place, Penny had escorted Kelly to the school office after she started hyperventilating in a math class; but she was obviously irritated. Penny's attitude contrasted sharply with a different experience, at the beginning of that year, when Kelly had experienced a normal loving home when she had stayed with Diane. This had disturbed and confused her and perhaps it was this that she could not put words to.

I speak to the anxious child outside the circle, using the word “we” to refer to Big Kelly and myself.

We care about you, ... we want to help you ... It's okay to feel something you can't explain. ... We care about how alone you've been with all of this... about someone who we can see has had no or very little proper parental care ... and needs it like any other child. And you can see the circle there which is a safe place, ... And, in the circle, you don't have to explain yourself ... You might even like just to step in there and feel safe. ... You might not need to stay outside here much longer. And, right now, you feel so overwhelmed and so confused, so desperate. And we're going to do everything we can so that you feel as safe as the other little girl who's there, ... and don't have to carry this anymore.

Kelly sees the Anxious Child dip her finger into the circle. The Child already in the circle turns to her, smiles, gives her hand a squeeze then carries on with what she is doing. I reiterate that she does not need to understand or explain what she is feeling in order to go into the circle. “I think I might go in and just sit there for a bit,” she says. And it’s the end of the session.

Session: 56: A Defective 9-Year-Old Coping With Impossible Demands

In S56, Kelly reports having too much work coming her way and feeling responsible for taking it on rather than directing it elsewhere. There is a demanding voice that says,

You can do it and you should, and the fact that it's stressful is immaterial – you can do it, you always have ... [At the same time], you may not compromise your kids, ... so you must find some other way of doing it.

She can see that it is a Demanding Parent to which both parents contributed. From her father, the message is: “You must do for yourself so that I don't have to do anything for you,” while her mother’s message was, “You must do for me, you must look out for me and make it work.” But this was not straightforward because sometimes her mother was happier if she, Kelly, was competent and successful, but at other times, when Kelly made mistakes, her mother found a meaningful role, and felt better being the one who was competent and effective, and was more present. So, Kelly had to navigate the inconsistency:

You don't know which way it's going to go... it makes her feel better to be the one who's competent or successful... but then sometimes it irritates the hell out of her [with the result that] ... I don't know what to do next.

A further complication was that her parents tried to protect Sarah from Kelly’s achievements so as not to discourage her or show her up. So, Kelly was not praised for them.

To cope with this, Kelly developed a hypervigilant and over-responsible self-sufficiency. When I ask what it would be like to give this up now, she identifies two advantages of coping like this: “It keeps me on my toes,” otherwise she might “slack off, ” and it burns up calories

and prevents her from gaining weight. But the downsides include her chronic tension, particularly in her neck, and an irritability that makes her vulnerable to switching into a critical scolding mode, something that recently happened at a party for her children, and for which she dislikes herself.

As Kelly articulates all this, she is in touch with a deeper feeling. It is as if she is looking out through the eyes of this 9-year-old who is trying so hard, yet somehow what she does is never good enough. I ask if she can see the circle. She says it is a relief to be reminded of it. The circle is outside on the grass, but she is standing on the cold grey tar of a netball court. I say,

It does feel very barren out there, very cold, and very threatening. And very confusing because you don't know what you're supposed to do and you want to do what you're supposed to do and you want to know that you're okay ... And there's another world ... the world of the circle that you can see ... that's just full of natural life and spontaneity. And when you are ready to, you can just step out of that world into this one. You're invited ... you're welcome, and you won't have to keep trying anymore because in this circle ... you'll be seen and cared for ... and loved ... just as you are.

The child prefers to stay outside as she's not sure how it works in there. I explain to her that she does not need to know. Outside the circle she will never have any sense she can get it right. If she steps into the circle, however, "there you don't have to make anything happen ... Whatever you find yourself doing when you get there will be enough ... will be right." Soon after this, she enters the circle and watches the other child. Then she feels very tired and soon after this remembers how, when she had first met Rick, she would go to his flat, go to the bedroom and sleep for hours. She experienced a "feeling of just wanting to curl up in a safe space and just absorb it and not have to do anything." So now this child just wants to lie with her head on Rick's lap. Meanwhile I have been feeling very sad and name how lonely it has been for her. But this is a problem. Rick cares and protects, but, if she cries, he will want to fix it. Having me as part of the circle changes that. I can accept and help her put words to the sadness. In this way Rick and I complement each other in giving this Child what she needs.

Session 57: A 3-Year-Old Peacemaker

At S57 Kelly described a visit from her mother's brother, Mike, and his wife. Unlike her mother, Mike was balanced and caring, and Kelly had always felt safe with him. Unlike a previous visit by Mike, Kelly's neck tension had been bad, and she would have liked to be alone. But she does not feel she has the right to ask for what she needs—to do so would be greedy, and it is easy to overstep the line.

This feeling bridges back to memories of being age 3, where Sarah overstepped the line again and again, attracting harsh punishments. To protect Sarah, Kelly would crawl on to her father's lap to distract him and her mother from Sarah's behavior. I ask Kelly to picture this 3-

year-old. Kelly tells me the house is like a playing field with complex rules she does not understand and invisible lines she must not cross. She can't move without tripping over one of them.

I tell her I want someone to go and take the child out of there and ask if she would like Mike, Rick or me to do it. She says no one can come in, or if they do it will be like a military operation by commandos with a lot of protective gear. I tell her I am not afraid of her mother or father and that I will look after myself. She eventually gives me permission and I come in, pick her up, and take her to Mike and Rick. Then I show her the circle. I tell her that her needs are normal and healthy. The 3-year-old does not hesitate to go into the circle and Mike becomes part of the circle too. The three of us complement each other with respect to what we each offer the children within.

At the next session (S58) Kelly tells me that this is the same Child we had worked with in S22 when she had recalled her mother crying desperately, and 3-year-old Kelly, feeling responsible for making her better, pleaded with her to take some pills she believed would help her. Before leaving, Kelly comments that we will need to make the circle bigger to accommodate all the children who need to come into it.

Session 58: A 7-Year-Old Responsible Self-Sacrificer

In S58, Kelly reviewed the severe headaches she had had since primary school. Throughout her childhood, she had seen numerous doctors and specialists, been sent for a CAT scan, and had regular chiropractic sessions. Her parents had ignored the recommendation that she needed to see a psychologist. She can see how the headaches contribute to her irritability, but they had become so familiar that she had never brought them as a focus of therapy. I was surprised, as she told me how frequent and intense they were. In S55, she had mentioned she was experiencing a noticeable reduction in them. It was becoming clearer how these, and the tension in the neck, were related to the ways she had coped as a child. As she put it,

it was the price that I was paying for keeping things reasonably okay in the family... I have headaches and everybody else is reasonably stable.

This had started with the 3-year-old Peacemaker who was now in the circle. But the task had been taken up by a more resourceful 7-year-old who knew she could do it and believes she still can. I say to Kelly,

I find myself wanting to take her by the shoulders and shake her and say, "This is absolutely crazy. You're very brave and very strong and very determined but this is insane."

But for Kelly it is perfectly logical. She has concluded that she is the strongest of the four members of the family,

So if somebody's going to have to give up something in order to make this work ... it's absolutely obvious it's me.

During this dialogue, I have been feeling sad. When I share this with Kelly, she wants to avoid it. Exploring this we find it is because it's associated with her feeling worthless. I speak to the Child and tell her,

It's painful to come to a place where you believe "my needs aren't important, my needs aren't worthy," ... but I'm glad you have ... because it enables me to tell you that your conclusion is wrong. ... You are worth caring about. ... Your needs are important. ... You don't have to have headaches for the rest of your life. I really admire how strong you are, how intelligent you are, how you figured this out, but you are wrong that you are worthless. You are worthy of love and care.

I point her to the circle and tell her there is a place for her there too. She feels as if the 3-year-old is inviting her. I reiterate that she is invited,

whether or not you look beautiful or ugly, whether or not you are happy or sad, whether or not you are secure or insecure.

But the Coping Child who has "always managed things by ... working out what is required from me in order to fit in or belong" feels secure in her school uniform and is expecting to have to take responsibility for the children already in there. Who would she be without that role? She is not supposed to need that kind of care at this age: "[I'm] too big for picking up, I'm not small and cute" (like the 3-year-old). This is symbolized by the circle being too small and it takes a further 20 minutes of dialogue work to get to a point where the circle is in a wide grassy space without any obstructions, and this 7-year-old has let go of her responsibilities and stepped inside.

Session 59: An Ugly Duckling and a Head Girl

In S59, Rick is away, and Kelly gets in touch with the pressure of coping on her own. Although she knows she will cope, she wishes there was some fallback position if she doesn't. Underneath she feels desperate, but not entitled to have anyone look after her. She senses an older child who feels "I am too big to sit on somebody's lap," too big to be in the circle. She is doing well at her academic work and in various activities and her capabilities are evident to all around her. She feels surprised when a boy points out that other boys are trying to impress her.

The following year, she is made head girl of the primary school. Part of her is taking this in, but another 10-year-old part feels like an "ugly duckling" who does not know she is to become a swan. This child still carries the unmet needs of her younger self, displayed in her sucking her thumb and stroking her hair so the ends split. Her mother is proud to be "the mother of the head-girl and ... the mother of the successful child," but shames her for her "ugly thumb [with a callus on it] and ugly frizzy hair."

I gently normalize her needs and point out to her mother how she is contributing to Kelly's difficulties. I tell her to get out of Kelly's life. As we investigate this further, Kelly feels the pain of her deep sense of being "ugly and useless and flawed." I speak firmly to her mother again and then to Kelly.

The shame comes from your mother shaming you again and again and again. But that's your mother, it's nothing to do with you. You're just a normal little girl ... and even though you're 10 years old there's some parts of you that are still five years old and three years old because your mother never cared for you properly.

Kelly listens tearfully, as I continue,

I've sent your mother away. All that shaming that she laid on you, it stops now.

Kelly responds,

I was just thinking that I might ... try the whole circle thing and sit near ... Uncle Mike ... While he's been visiting, I've seen him respond to my kids in a way that makes me feel like [he's not focused on] their externals ... he's got a good sense of what's normal for children.

We explore this some more. The head girl is now in the circle feeling supported by Uncle Mike, who is behind her. The ugly duckling 10-year-old is in front of her, deeper in the circle.

Session 60: An 8-Year-old in a Bubble

In S60, Kelly describes becoming disapproving, controlling, and punitive on seeing a child being angry and destructive (wanting to break toys). Kelly describes becoming "tight," "inflexible," "petty," and embarking on "character criticism" of the child. She realizes this mode is learned from her mother, but "doesn't fit with who I am" and her friends are taken by surprise when they see it.

I tell her I call this mode a Scolding Overcontroller. I initiate chairwork (see Glossary in Table 2) and ask her to address the mode, starting with,

You are rigid and petty and completely out of character. I don't need you.

The Overcontroller replies,

You can't afford to let things slip ... if you let these small things go, they will become big things ... You can't go around being flexible all the time ... the more you don't recognize it, the more important my role becomes.

Now there is a marked affective shift, as Kelly connects with the emotion that the Overcontroller is coping with. She feels like a child who is in trouble and easily bridges back to 8 years old. She has moved to a higher grade where teachers are stricter than before. On at least

two occasions, a substitute teacher lost control of her temper and started hitting children in the class. This was particularly confusing for Kelly who had been treated as a favorite by this teacher. Kelly felt she was “having to walk a tightrope.” Fortunately, the teacher was eventually withdrawn from the job.

After a few minutes, I suggest we find this Child and ask her, “What does she need now?” There is a paradoxical experience. The Child is palpably present. I can feel her. But Kelly cannot. “She is very remote,” she says. So I speak to the Child:

I can see you. I can see how terribly confused you are, and frightened. ... Being in that school, ... being in those corridors, ... being with that teacher. I can see that's terrifying you... I can see how precarious you feel. And you felt like this at home ... because your mother's so unpredictable and ... now this new teacher and she's unpredictable and ... it's very frightening because you don't know ... what she's capable of. ... You know you've got to try and be the good girl ... and you've got to set some standards for yourself. And you know that if you can do that ... things will sort of be okay It doesn't take away the ... confusion and fear, and shame... You feel completely alone It feels like there's no one on your side... no one who cares about you, no one who can see you. But I can see at least some of you now. I'm glad that we've come here ... because I don't like to see a little girl suffering like this.

Kelly can now connect with this Child, but what she describes has a dissociative quality. She feels as if, as she goes about her school day “doing all the things I need to do,” she is floating in a bubble and “not actually touching the ground.” “It doesn't feel real. I'm just going through the paces,” she says. The bubble does not really protect her because “there's no safe space,” no sense that there is anyone

who has thought about me or, or cares about me. I don't feel like I take any of that with me when I go into this world.

For several minutes I empathize with her predicament. Being good and avoiding trouble (Compliant Surrender mode) works up to a point but does not get her fundamental needs met. Her un-nurturing mother is actively intrusive and punitive. Her father has become a vague ineffectual presence. Her sister has effectively disappeared as a person to connect with. I begin to talk to Little Kelly about finding a way to get her needs met now. This will involve no longer relying on the Overcontroller and Compliant Surrender modes that she had used to cope. I show her the circle and invite her in.

Kelly sees the Child in an upstairs corridor looking through a large glass window at the circle below. Over the next ten minutes I talk her through my coming up to fetch her and holding out my hand to lead her down. She tells me she will need to bring her bubble. When I ask her to tell me more about that, I feel a deep affective shift, as if she is now much smaller; her voice becomes very childlike. So now I pick her up and carry her down the stairs, out to the circle, and

place her in it. It's the end of the session. I ask if there is anything else she needs. With a voice like a very small child's, she says,

I'm very aware that I keep my bubble ... And, and that I don't want to do anything other than to just sit in my bubble in the circle.

Session 61: Embryo

At the beginning of S61 Kelly described something important about the dynamic life of her circle. "The 3-year-old is so completely okay in the circle and just very self-sufficient." This worries Kelly. Shouldn't she be doing something for her? Then she realizes the Child in her is quite content in the same way as her son when he is playing. He is in "a good space" because he knows that "when he starts to yell for a sandwich somebody will provide, and, in the meantime, he'll just do his thing."

Now, she starts to reflect on the Child in the bubble. "It almost feels fetal in a way...", she starts to say, and at once there is an affective shift and her voice becomes increasingly soft and quiet. I encourage her to stay with the experience and she continues,

[it's] almost like an aborted fetus... Like the bubble sort of becomes a sac ... it doesn't feel like it's alive really... It doesn't feel like something that could be resuscitated.

Then she feels confused. This is the confusion of a child in school experiencing a deep dissociated memory from the very beginning of her life, but with no understanding of what the experience is about. Then there is a different memory, of when she had miscarried a child herself. She becomes tearful as she says,

I had this huge sense of needing to be able to communicate to the baby how much it was wanted ... and how we had wanted the opportunity to care for it and love it.

It seems clear now that this message was also a message to this part of herself that had felt unwanted from the very beginning.

I encourage her to connect with the experience and she sees an Embryo of about eight weeks. Kelly says, quietly,

There's just the sense of "you can't be." You know, "you can't actually be real, ... I can't really be pregnant ... You can't grow, you can't inconvenience ... you just can't be."

Now her voice becomes increasingly urgent,

Like you've got to stop.

The source of this must be what her mother must have experienced when she realized she was pregnant. Kelly recalls her own very different experience of her own pregnancies. At

about six weeks, she was bodily aware of being pregnant and feeling a sense of excitement mixed with responsibility. She said,

I can say to my kids, “we were glad you were coming, right from the moment we knew. We wanted you right from the moment we made a decision that we were going to have a baby ... from the very moment I knew that you were in there...”

Now her voice is very soft, vulnerable, childlike.

[But] I had none of that.

She is now in touch with the absolute quality of the rejection. Nothing she can do will make her acceptable. Sobbing deeply, she says, “You're just not wanted ... so I guess you die.” For several minutes, I work gently introducing the idea that this part dissociated but is still there. It is not dead, because she can feel its presence. In due course I ask her to listen to the voice of the part inside the sac. The message is,

I don't know what to do because I can't do this on my own, I can't develop without a mother. I need the environment. ... Kind of... like... I'm stuck.

I discuss with Kelly how this part can find the maternal care she missed. In due course she realizes that she as an Adult can go into the circle with the sole task of focusing on the Embryo, “looking after it like one hatches an egg almost; making sure that it was warm and that [there was] a maternal figure close to it.” She continues, “I could do that because I've got the backup,” meaning that the support of the men holding the circle make it possible.

We spend several minutes giving affirmative messages to this Embryo part and at one point, I say, speaking for Big Kelly,

You're a very special and beautiful part of me ... and I thought you were dead, ... and I'm so pleased you're not. I am so pleased you are still alive and so grateful. I really want you, I really care about you ... and I really need you.

Kelly responded,

When you said that, the other children in the circle kind of engaged with that. It's almost like there is a sense that this is a community and ... this kind of addition is going to be a part of that community .

In the last twelve minutes of the session, we work consolidating all of this and soon the Embryo has become a small Infant. Life in the circle does not operate in real human time.

Sessions 62 - 67: Resolutions Within the Circle

During the remaining six sessions, Kelly continued to talk about everyday events at work, and with her family and children as well as encounters with her parents, all of which evoked and

fed into the process in various ways. In two of the sessions, we worked on her grief for sister Sarah. Little Kelly feels desperate, having lost the one warm human connection she has had, and I help to separate her out from Big Kelly, who still cares for Sarah and can hold the pain of only being able to express what she feels for her infrequently and indirectly.

In two sessions we work with a primitive maternal introject. Kelly connects with the Embryo again and feels a deep disgust. But it is her mother's disgust, not hers. The Big Kelly in the circle looking after the Embryo (now a baby in an incubator) has unwittingly brought this imprint from her mother with her. So, must Kelly now leave to keep the circle safe? We discover that she has resorted again to her old self-sufficient mode, supporting herself by sitting with her back against a wall.

I ask her to image the men holding the circle putting their hands on her back and this allows her to tell her mother to go. Her mother is a spectral figure who drifts away over the edge of the circle. But she keeps drifting back. In the next session we find out what is keeping the connection going. Kelly now sees her mother as a tragic empty shell, lost, needing the care she never received herself. But Kelly's circle is not the place for her to find it. I work with Kelly to find a light and compassionate presence beyond the circle that her mother can go to where she can find a circle of her own.

In S66, Kelly described a mindful awareness of the children in the circle that resulted in her being less volatile around her parents. When visiting them, as she enters their house, she sees the image of the circle with the children within it.

I was intrigued and sort of watching it and just realizing how, although I was aware of a whole lot of child aspects of me there ... they weren't activated at all. They were just observers to that encounter... it wasn't about them being buffered by the circle so they weren't triggered, it was actually that they were just generally not triggered, they were there with me because they're parts of me, but they were watching this whole experience of me visiting my parents, like they might watch me, you know, if I'm sitting watching a movie—and they're watching me watching the movie. ... I was just aware that there was nothing ... to pull them or trigger them at all ... They were just there.

Furthermore, the life of the circle is evolving. In S67, we see that it is not just a one-way process of giving to the children that need to be cared for. The children are enriching in themselves, contributing depth and quality to Kelly's adult life and experience. As Big Kelly, she sees herself walking around the circle as if she were running a playgroup. The part in the incubator has stabilized so she can leave it for a while and circulate. She's quite relaxed about this,

I feel very comfortable just being ... moving around with them and chatting, whatever... and being with that 3-year-old child is very positive for me. There's something about her that's

just seriously enticing ... quite an amazing little person. So, I quite like to hang out around her.

Nearly three months later, in a post therapy interview (see section 8 below), Kelly confirms this experience. The image of the circle is there in the background and she can tune into it when she needs to. If someone behaves in a way that might trigger one of the Children in the circle, Kelly would be aware of which one it was and "I would be able to do something in order to make sure it didn't affect [her]."

7. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION

Apart from the use of the YSQ-3 questionnaire (see Table 2) and the Beck Depression and Anxiety Inventories near the beginning of therapy, there was no formal monitoring of symptoms. I was qualitatively monitoring Kelly's response to the therapy session by session, and it was clear that she was seriously engaged with the process throughout as, at the start of each session, she would regularly describe experiences in the week related to the process (either new trigger situations or progressions of the imagery).

I did not receive supervision during the therapy, but I was reading the schema therapy and other related literature, including that on developmental and complex trauma (Courtois and Ford, 2009; Pearlman and Courtois, 2006; van der Kolk, 2005; van der Kolk and Courtois, 2005) that I used as a guide as how to respond as the sessions unfolded. I also sometimes listened to recording of sessions as a form of self-supervision.

Detailed feedback from Kelly, obtained at the end of the therapy, is presented in the next section.

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

Qualitative Feedback on the Process and Outcome of the Therapy From Post-Therapy Interviews

Detailed evaluative feedback was obtained from the two one-hour research interviews conducted one week apart just over two months after the therapy was over. In these Kelly commented on the benefits of the therapy. The first thing she mentioned was that

I stopped feeling cold... I don't think I really feel it much at all now.

She also reported how,

I feel bigger. I don't feel that sort of shrinking, reduced feeling. I feel a lot more comfortable in my own skin.

She also described being less irritable, which was feedback she had received from Rick. There was a new relationship to her emotions, particularly anxiety and anger. As she put it in describing the therapy:

I felt like I was experiencing the feelings in their true form rather than in a mutated form.

This is a way of expressing that she was experiencing primary emotions rather than secondary emotions, a progression which is specifically aimed at in process-experiential/emotion-focused therapy (Elliott & Greenberg, 2007). This change in her experience of emotions was associated with an increased sense of congruence. Before the therapy, she said, she was

often operating in the world and doing the stuff that needs to be done but feeling fearful and anxious in doing it, and maybe nobody would even know that, but nevertheless [I was] feeling that; whereas now I feel a lot more in line with what I'm doing and what I'm feeling.

She mentioned that although she still suffered from headaches, they did not trouble her as much as before. She could now see how her headaches functioned as part of her family-of-origin's family system. She said,

Everybody became invested in my having headaches. It was almost like it's not just my decision I will have headaches and that will help everybody; it was almost like everybody then said, okay, that's fine with us, let's go with that. And the whole system kind of colluded.

There were three aspects to this. First, it distracted her mother from other conflicts and gave her a role as someone who cared for and helped her daughter. As Kelly put it,

That was one of the few things that Mom could do. She liked sitting in waiting rooms and talking to doctors about her daughter.

Second, it meant that Kelly herself received some attention herself, a secondary gain.

Third, it also allowed Kelly to express her anger towards them. She expressed it like this:

If it is inconvenient, does not suit you, just deal with it.

These insights had changed her experience of and attitude to the headaches in a positive manner, even though she still experienced them.

Asked about her experience of the process of the therapy, Kelly described S45, in which I pointed out her fierce independence and that she was not able to allow me to care for her Child

as a “massive turning point.” Her response was related to how she felt about me and my relationship with her. We had been working regularly with intense and deep emotion in the imagery work. She said,

I knew from the imagery work that you were genuinely interested in trying to achieve that—so it didn't feel hollow.

Later, she observed,

You don't often, sadly, get to interact with somebody who's also trying to be really authentic. So, your bluntness, for example, is really valuable because you know where you stand. And it helps that I've always experienced that with you.

What I said had resonated and she experienced it as “a wake-up call.” She soon realized how her self-sufficiency stood in the way of her getting her needs met and that this was something she could do something about, which she started to do, with Rick, with her friends, and within the therapy itself. An associated experience was,

I don't feel like I had to look after you; I feel like you can look after yourself.

This of course is what every child needs from a parent.

Kelly also commented on how the images made her emotions more tolerable. This seemed to be because the images located those emotions as understandable responses to events and to the way she was being treated by the adults (or others) around her. When a feeling was triggered in the present it had previously felt like “this jumble of stuff.” Now, however, experiencing the feeling as part of an image and a memory made sense of the feeling. This was an antidote to the invalidation she had grown up with. The image allowed her to have her experience in a way that she could not before. At the time it had felt as if her experience was being negated by everything that was going on and by the fact that it was not how her mother or father were experiencing it.

Related to this was my being able to attune to her experience and put it into words for her. As she put it,

You were my “words man” and I couldn't do that [for myself].

This emphasizes the importance of being able to verbally formulate experience in order to fully claim it. Adler (1938, p.16) had observed that much of what Freud had thought of as repressed was rather, “withheld from the understanding.” In 1940, Sullivan had expressed the same: “Much of what is ordinarily said to be repressed is merely unformulated” (Stern, 1997, p. 185).

Helping with this verbal formulation is what a loving and attuned parent will do for a child. My providing this was an important aspect of reparenting. Kelly remarked that she felt as if

there's something that I actually couldn't do, [that] was being offered. ... If I was struggling to speak, ... you spoke on my behalf. Sometimes the extent of the experience came through by seeing it through somebody else's eyes. If I'd put it into words, I would have been softer or minimized it, taken the edge off it somehow.

Kelly also observed how she experienced me as being able to shift to different roles in our work together in a manner that she described as "seamless." We could be looking at an event in the week, and then I would easily move to directing her to bridge back to imagery and memory.

At other times Kelly described that I would be "very pragmatic." For example, when she spoke of times she had wondered how I experienced her or what I thought of her, I had responded with, "Oh, would you like to know?" This honesty about the relationship in the present was new to her and different from her other therapies. As she observed,

I don't feel like it's helpful to people to make it always about transference ... [In the past] I don't think I allowed myself to think a great deal about the actual relationship.

So reparenting was not just happening in the rescripting but in how we related all the time. She commented,

It was kind of a bit freaky for me to feel that this might be genuine, that I might be genuinely cared for.

And even now she still feels a bit uncomfortable acknowledging this. But she can see it is real; she still experiences the same circle and has no desire to add to it or change it, which is in itself, an indicator of the meaningfulness of the relationship.

Finally, Kelly described the impact of the loving support she received from Rick, and the impact of regularly sharing some of her experience of the sessions with him. Rick supported her engaging in this intense process as "a good decision," and Kelly felt that it was

important for him to have some sense of what I was doing that was bringing this emotion for me, that he didn't just have to live with it and not know.

She also felt validated by his seeing "how real it was."

Further Qualitative Feedback on the Process and Outcome of the Therapy

Further feedback was received one year later in email correspondence about a conference presentation I was preparing. Kelly commented that she still sees the circle with four children in it. These are "Incubator Kelly," the 3-year-old; and two from "middle childhood": the one who felt like an "ugly duckling" who is around 9, and the very anxious one who looks about 12. "Big Healthy Kelly" provides a clear mothering presence and sense of "enjoyment of it all." There is also, at times, a specific, dedicated mother Kelly, "that cares exclusively for Incubator Kelly."

Kelly concludes:

The outside of the circle is still you, Rick, and occasionally my uncle. ... You are joined by bands of very bright light, symbolic of a spiritual presence.

9. THEORETICAL REFLECTIONS AND CLINICAL IMPLICATIONS: THE PHENOMENOLOGY OF MEMORY AND TRANSFORMATION

Introduction

The complex unfolding of the processes described in the narrative provides a phenomenological foundation for examining many current questions about the nature of change in psychotherapy, and, in particular, of the impact of the kind of deep experiential work described here. This concluding section, therefore, examines several questions and theoretical issues that are pertinent to experiential psychotherapy in general and to schema therapy in particular, situating them within the framework of concepts in the contemporary literature.

Schemas, Complexes, and Internal Working Models

First, the concept of schema, so central to the practice of schema therapy, will be examined and defined within its historical context. Since at least the late nineteenth century, psychotherapists have been aware that they are working with memories and memory systems. From the beginning of psychology as a separate academic discipline, it was understood that memory condenses information into abstracted patterns that form an underlying structure out of which experience arises. The term "schema" was used to refer to these abstracted patterns by Kant (1724-1804), and this concept became central in the work of Herbart (1776-1841), who is often considered the first philosopher to develop a truly psychological theory. He in turn, influenced Wundt, whose writings had a "prevalence of these Herbartian terms: assimilation, accommodation, ... mental representation, apperception, schema and threshold" (Blumenthal, 1985, p.26).

Following Bartlett's (1932) classic work on memory, the term schema became a central concept in British cognitive psychology (Oldfield & Zangwill 1942, part 3), and is, of course, prominent in Piaget's (1896-1980) developmental psychology. The term was applied to clinical

phenomena by Adler (1930) who, anticipating the concept of early maladaptive schemas, observed that children develop their own “schema of apperception” that embodies “the opinion which the child has gained of himself and the world.” There is thus considerable overlap between the psychological complex as conceptualized by Jung and Adler and the early maladaptive schema system. Schemas, therefore, provide a basis for conceptualizing what Stein and Young (1997, p. 162) refer to as “an understandable patterning of cognition and affect that has developed from the past and that structures current experience.”

The search for such underlying structure was central to Merleau-Ponty's (1942) phenomenology. He explicitly referred to the complex as “a durable structure of consciousness, arising from a childhood situation that could not be mastered at the time.” This “durable structure” is the basis for Stein and Young's “understandable patterning,” and we can use phenomenological research of the kind presented here as a way of advancing our understanding of it.

In attachment theory, the psychological structures that underlie this patterning were reframed by Bowlby as “internal working models.” He understood that these were based on memories of what the child had experienced, particularly in relationships with attachment figures. They are derived from “the representational models of his parents that he has built up during his childhood” and incorporate how “a person construes the world about him, and ... how he expects persons to whom he might become attached to behave” (Bowlby, 1988, p. 73 [gendered language in original]). It is a central tenet of the schema therapy approach that when significant core needs are not met by the attachment figures, the schemas that develop are maladaptive. Situations which, as Merleau-Ponty puts it, “could not be mastered” are characterized by adverse conditions for the infant or growing child in which significant developmental needs are not met. Parental neglect, failure to attune to the child's needs, unpredictability, lack of safety and protection, physical, emotional, and sexual abuse, and failure to appropriately support appropriate self-expression, self-regulation and the development of independence give rise to dysfunctional internal working models, or early maladaptive schemas. These specific early maladaptive schemas that are a central focus in schema therapy are broad patterns or themes within these working models that create significant problems in later life. They are, as Young et al. (2003, p. 7) observe, “comprised of memories, emotions, cognitions and bodily sensations.” Strictly speaking, however, the body sensations, emotions, other sensory elements and cognitions are themselves components of the memory and are similar to what are referred to as flashbacks in the literature on posttraumatic stress disorder.

Thus, each of the Child parts of Kelly that appeared outside the circle, and eventually moved into it, represent structurally different internal working models. Each model responded to different aspects of significant needs that were not met. Each model, in different ways, was overwhelmed by the adversity which confronted her, each dealing with the challenges and demands of a particular developmental stage, and each finding ways to survive and cope. Each Child part was stuck, unable to update, in spite of the very different situations and relationships

of Kelly's present life, until, through coming to awareness within the therapy process and the therapy relationship, they were each able to make their needs known so that they could be symbolically and experientially met.

Autobiographical Memory and the Working Self

The concept of autobiographical memory provides a bridge between the concepts of internal working models and maladaptive schemas, on the one hand, and the complex memory processes that therapists engage with in the kind of experiential work described in the Kelly material. Phenomenological researchers have rightly criticized conventional research on memory that focused on artificial laboratory tasks for failing to address the lived experience of memory within the lifeworld.

However, since the 1980s, the growing body of research on autobiographical memory has changed that (Berntsen & Rubin, 2012a), and furnished a substantial revisioning of the psychological understanding of memory that is much more life-world oriented (Berntsen & Rubin, 2012b; Mace, 2019). Conway's theories in particular cast considerable light on the kinds of memory processes described we are concerned with (Conway & Pleydell-Pearce, 2000; Conway et al. 2019; Habermas, 2012) and include the kinds of memory processes that are central to psychotherapy (Conway, Singer et al., 2004; Habermas, 2012; Singer & Conway, 2011).

Conway locates the kind of moment-to-moment conscious experience that can be introspected in what he calls the "working self." This is focused on goal directed activity. It uses short term memory that holds information being used to solve a current problem and draws on long term memory in ways that are relevant to its current goals. The goals of the working self come from the conceptual self, which is an organization of "abstracted knowledge structures that exist independently of specific temporally defined incidents" (Conway 2005, p. 597) and are the product of the individual's personal and cultural learning. This underlies each individual's sense of their identity, long term goals and values and place in the world. Together with the working self, it makes up the self-memory system.

For psychotherapy clients, the working self is self-awarely engaged with whatever process is taking place in the session. This takes place against the background of "abstracted knowledge" about the purpose of being in therapy in the context of their long-term goals and values. Experiences of remembering childhood events in therapy come from the Remembering-Imaging-System (RIS) which furnishes the working self with "*depictions* of the past constructed" from a "complex underlying knowledge base" (Conway & Loveday, 2015, p. 579) in which meaning has been extracted from experience and largely stored schematically. Memories presented by the RIS are, therefore, reconstructions, "*psychological mental representations* and should not be compared to ... videos, photographs, or any other sort of recording" (Howe et al, 2018, p. 8).

The autobiographical knowledge base, from which these are constructed, has two broad segments which function rather differently. Pascal's (1623-1662) famous dictum, "The heart has its reasons that reason knows not of," reflects a division between two systems now recognized as central to cognitive science, that Teasdale (1993, 1997) calls the implicational and propositional systems. The former is earlier phylogenetically (it evolved earlier), and ontogenetically (it comes on stream earlier in development), is shared with other mammals, encodes in terms of sensory information, and is holistic in character. The propositional system is phylogenetically and ontogenetically later, distinctive to *homo sapiens*, encodes information using language, and is linear, logical and rational. The two systems map on to the classic distinction between primary and secondary process (Singer & Conway, 2011). Only implicational encoding is connected to emotional schemas which is why rational analysis and logical argument cannot shift problematic meanings in the implicational system.

In Conway's model of autobiographical memory, episodic memory corresponds to Teasdale's implicational system. Memories that are largely episodic are immediate and "experience near." and contains "summary records of sensory-perceptual-conceptual-affective processing" that are abstracted and are mostly "not literal records" (Conway 2009, p. 2305-6), though there may be "episodic elements" (p. 2308) that correspond to specific sensory experiences.

The images that Kelly experienced during therapy sessions (and that often continued outside it), and the accompanying sensory and emotional states, are not faithful reproductions of specific episodes, but portrayals of schematic constructions based on multiple specific episodes. They have their origin in the episodic memory system, but are

transient constructions and although they may to some degree represent the past, they are time compressed and contain many details that may be inferred, consciously and non-consciously at the time of their construction (Conway & Loveday, 2015 pp. 579-580).

The fact that Kelly's images were not accurate memories may be a problem for someone giving evidence in a courtroom (Howe et al., 2018). However, it is mostly not a problem in the context of the kinds of processes Kelly experienced, where what is important are the themes and patterns of the underlying early maladaptive schemas that are perpetuating her current difficulties.

There are, therefore, two very different kinds of remembering that occur during psychotherapy, an experience-near, emotionally charged, re-experiencing or reliving, and an experience-distant narrative memory which draws on the language-based, temporally organized rendering of one's life story of the conceptual self. This is built around various themes (e.g., family, career, hobbies, and holidays).

Information in the conceptual system, initially drawn from episodic memories, has been abstracted and reorganized into a complex language-based system (Teasdale's propositional

system) and gives rise to memories that are “experience distant.” Conway (2005 p. 596) observes that “People can remember experiences as varied as period of work, a holiday, period of illness, a house they once lived in” with little or no access to specific episodic memories. As in Kelly’s therapy, the schema therapist, therefore, may listen to the explicit narrative, but may then explicitly direct attention away from the story to allow the client to connect with underlying feelings in the episodic system.

The Theater of Consciousness and the Theater of the Imagination

This distinction can be elaborated by considering Baars’ (1994) concept of a “theater of consciousness,” which parallels Conway’s “working self.” The conscious intention and direction in any goal-directed activity is like a stage which we can observe and explore through introspection. However, outside of that awareness, we are able to access automatic and habitual routines that govern courses of action and can, as Baars puts it, draw on “vast domains of knowledge” (p. 17).

This stage can be the site of more abstracted, propositional activity, or more emotionally engaged, implicational activity. Baars’ own research-supported model examines the former and the theory is sufficiently operationalized for simple cognitive activities, such as solving problems and puzzles to be effectively simulated on a computer. Access to memory is controlled by the needs of the working self and the goals and tasks it is engaged with (Conway, Meares & Standart., 2004). So, when solving simple problems, as in Baars’ research, or focused on specific practical aspects of the external world, access to memory is restricted to areas relevant to the particular activity.

In experiential psychotherapy, by contrast, therapists deliberately cultivate a mode of the working self that opens up access to episodic memory and associated emotions in a manner that is very different from much everyday remembering. At the start of psychotherapy people may say, “I don’t remember much about my childhood.” But after engaging with experiential processes, they may be surprised at just how much remembered material there is that they had lost access to.

The experiential therapist, therefore, invites and guides the client into a mode that is what therapist and story-teller, Clarissa Pinkola Estes (2005), calls the “theater of the imagination.” In dramatically telling traditional folk tales, Estes induces her listeners to immerse themselves in an unfolding drama, and, as if at a theater, engage with the action and identify with the characters: their hopes and fears, their conflicts, their struggles and resolutions.

The metaphor of the theater of the imagination captures much of what it was like for me, as therapist, and Kelly, as client, as the child figures emerged so vividly, were helped to articulate the previously unvoiced nature of their painful experiences, and, in the dramatic enactments of the rescripting process, negotiated challenges and obstacles until they reached the

holding environment of the healing circle. The schema therapist invites the client to step away from the consciously storied narrative of the conceptual self, to focus on body sensations and emotions, and to allow images to form in Conway's Remembering-Imaging System. The theater of the imagination is therefore a specialized activation of the theater of consciousness in which access to episodic memory, with its range of emotional valences, is heightened, and Conway's Remembering-Imaging System is activated.

Understanding the Figures That Enter the Circle

Because this vivid experience of the child (together with the other characters in the client's memory or in the rescript) is so central to the process of promoting corrective experiences, it is important to understand its nature. Kelly did not have one inner child, but several distinct child parts, each with a recognizable age range and psychological theme.

Conway and Loveday (2015) point to the distinction between correspondence and coherence in remembering. Correspondence refers to accuracy, the extent to which it is "true to the event." Coherence refers to the extent to which a memory is "true to the self" in the sense that it is "coherent with other memory representations and self-beliefs" (p. 578). A memory is coherent when it portrays the central meanings of the underlying schemas.

When Kelly recalls hiding under the table and seeing her mother's hate-filled eyes glaring at her, the color or dimensions of the table are of limited importance, as is the question as to whether the episodic element of her mother's glaring eyes was experienced on a specific occasion when she was hiding under the table. Whatever the degree of correspondence of this set of episodic images to a particular event, it coherently dramatizes a repeated experience of a little girl terrified of her mother's aggression. In schema therapy it is just these generic patterns or schemas that we are interested in, rather than the specific details. So, it is not a problem that, as Conway and Loveday (2015 pp. 579-580) observe, "all memories are to some degree false in that they do not represent past experience literally."

This allows us to understand the nature of the several Child figures that appeared in imagery as separate and distinct, each with Kelly's own experience; her own beliefs about self, others, and the world; and Kelly's own ways of coping. These are not memories based on single episodes nor even of discrete time periods. They are coherent working models schematically synthesized from clusters of memories with the same background structure and experiential theme.

In S51, when the Terrified Toddler is taken to the safe house of the neighbor Diane, the cascade of images Kelly sees of herself ranging back to an infant in arms tells us that the image of the toddler springs from many thematically related memories and associated emotions and somatic experiences. Grof's (1976) term "condensed experience system" (CO-EX) elegantly captures the composite nature of this underlying structure.

There is a similar experience in S53 when Kelly connects with the Terrified 8-year-old and there are flashes of a host of frightening memories, some of which come into focus as the session progresses. The appearance of the Terrified Toddler and Terrified 8-year-old as developmentally distinct figures points to there being two separate memory structures, one within a developmentally more primitive cognitive organization (ages 0-3), the other within a more advanced cognitive organization, perhaps incorporating language (ages 4-8) (see Conway 2005).

Similarly, for Kelly the 3-year-old Peacemaker and the 7-year-old Self-Sacrificer portray two developmental phases of coping with an unstable and abusive home environment through subjugation (focusing on the needs of her caretakers, subordinating her own needs) and self-sacrifice (working to meet the caretakers' needs and keep the peace). It is relatively easy for Adult Kelly to see that the 3-year-old could never, by herself, keep the peace, rescue her sister, or find a safe place. However, the 7-year-old is more resourceful and no longer "small and cute," and it takes some work to persuade the Adult Kelly that she too is also a child who needs care and can give up her responsible coping and experience the unconditional space of the healing circle.

The distinctive feature of the "Defective 9-year-old coping with impossible demands" is Kelly's experience of the intense vigilance she needed to manage the several conflicting demands made on her. For the 10-year-old "Ugly Duckling," the focus is shame and social exclusion. The defectiveness/unlovability is a schematic theme that has appeared before, implicit in the first two terrified figures subdued by her mother's punitiveness and shaming, more explicit in the Defective 9-year-old and the 7-year-old Self-Sacrificer. But, in those figures, it was not the main focus. Now it is.

Symbolic imagery in the narrative can also be understood in terms of the distinction between coherence and correspondence. The image of her mother wearing Kelly's clothes is a coherent depiction of an underlying experience of enmeshment, her difficulty separating out her mother's voice and attitudes from her own. Also symbolic is the enlargement of the circle, something that Kelly mentions as needing to happen at the end of S57. This seems to be related to acknowledging the emerging needs of middle childhood. The 7-year-old Self-Sacrificer has taken her subjugation for granted. She believes she is too old to need loving attention and care. The 10-year-old Ugly Duckling believes the same: "I am too big to sit on somebody's lap." These figures needed help acknowledging their own needs for that kind of care and, when they do, the circle moves out of from behind the house to a wide grassy meadow and becomes large enough to accommodate them too.

There are two examples of child figures who are having to cope with the distress of a much younger child. The over-responsible 10-year-old, who is soon to become Head Girl, takes refuge in her role and school uniform, while another younger child, who is sucking her thumb and stroking and splitting her hair, leaks through the overcompensation and irritates her mother.

A more striking layering is seen in the 8-year-old in the school corridor experiencing herself in a bubble. At first Kelly experiences being “in trouble” and the memory of the abusive teacher. We might expect a return to the Shamed Child affected by the Punitive Parent.

Then a sudden affective shift gives access to the deeper source of the bubble experience. But the true meaning of this does not emerge at once. When I bring Kelly down from the classroom, and even when I place her in the circle, she is still out of touch with what the bubble means. I am too. I have mistakenly surmised that it might represent some sort of detached coping that she would be able to drop once she began to feel safe. Only in the next session did it become clear that the 8-year-old's feeling of unreality arose from what were in effect flashbacks to traumatic imprints from the very beginning of her life.

How Far Back Can We Remember?

Our current understanding of autobiographical memory allows us to approach empathically images such as Kelly's Bubble and Embryo that appear to portray memories from before birth. Otto Rank (1924) had argued that the trauma of birth had a considerable negative impact on what we would now call early schema formation. He claimed to have helped clients to overcome the trauma through re-experiencing a second birth in imagery (Keller, 2019). Winnicott (1949) also described similar processes related to memories of birth trauma.

Half a century ago, claims by psychotherapists that personality could be impacted by trauma at birth or even before (Janov, 1973; Lake, 1966) were ridiculed by researchers who claimed that the infant brain did not have the hardware to record such events. Despite this, Lake (1966, p. xix) claimed that he had worked with several cases where vivid accounts of specific birth injuries, or problems with delivery, experienced in therapy were “so unmistakable in their origin [and were] afterwards confirmed by the mother or other reliable informants.”

Since then, there continue to be accounts by therapists of encountering and working with what appear to be memories from birth or before (e.g. Findeisen, 2017; Grof, 1978, 1980; Kalef, 2018; Rucker & Lombardi, 1998). In line with this, within the research community, as Bauer (2004, p. 369) observes, there has been “a veritable sea change in perspective on the mnemonic abilities of infants and very young children... Substantial progress has been made in describing the development of a capacity that not long ago was thought not even to exist.”

We now know that “the ability to form EEs [Episodic Elements] is hardwired and functioning prior to birth” (Conway, 2009, p. 2311). Newborns differentiate speech and faces and expect responsive social interaction. There is evidence for intrauterine learning since newborns have been shown to prefer their mother's voices (DeCasper & Fifer, 1980; de Casper et al., 1994; Spence & Freeman, 1996); prefer voices speaking in the mother's native language rather than another language (Moon, Cooper & Fifer, 1993); and recognize the theme tunes of soap operas their mothers watched while pregnant (Granier-Deferre et al., 2011). Recent

epigenetic studies have shown how maternal stress during pregnancy impacts on the regulation of gene expression by methylation of genes (which effectively turns them off). This and similar processes are in effect a kind of memory. Children of pregnant women trapped in an ice storm in Quebec Province, Canada, for over a month in 1998 showed demonstrable effects of maternal stress on DNA methylation across the entire genome, thirteen years later (Cao-Lei, et al., 2015). Finally, ultrasound studies of twins *in utero* (Piontelli, 1992) showed that patterns of interaction observed before birth continued into the twins' lives after birth. She concluded, "There is a subtle link of behavioral and psychological continuity extending from fetus to infant and from infant to child" (p. 234).

Throughout childhood, the capacity to recall particular events increases, but events of early childhood are increasingly less recalled. This phenomenon, observed by Freud in 1905 as a kind of mysterious amnesia (Bauer, 2012), may be due to two features of how autobiographical memory works. First, recall of events depends on cues and this is increasingly provided by the development of autobiographical narrative memory. As this evolves through childhood, the amount and complexity of recalled events systematically increases (Bauer, 2012). Second, Conway (2005, pp. 602-3) suggests that the way goals change with development is a significant factor. "The goals of the infant and young child, through which experience is encoded in memory, are so different, so disjunct from those of the adult that the adult working self is unable to access these memories."

Reparenting, Corrective Experiences, and Imagery Rescripting

Reparenting, a central intervention in schema therapy, means providing the Child, trapped in memories of neglect, misattunement and abuse, a corrective experience in which her needs are met. Echoing Alexander and French's (1946) concept of the corrective emotional experience, Winnicott (1954/2016) argued that when clients experience themselves as they did when very young, this "carries with it the opportunity for correction of inadequate adaptation-to-need in the past history of the patient, that is to say, in the patient's infancy management." Such correction, Winnicott implies, can address unmet needs going right back to the beginning of life. These corrective experiences can be provided by the therapist relating to the client in manner that was different from that of his or parents.

Alexander (1963, p. 287), who was Hungarian and had started his work with Ferenczi, later acknowledged Ferenczi's influence on the idea of the corrective experience. This was expressed in Ferenczi's clinical diaries where he argued that the therapist needs to offer the client "at least as much caring attention, or a genuine intention to provide it, as a severely traumatized child must have" (Ferenczi & Dupont, 1988, p. 28). Winnicott's "holding environment" is more than just a safe place in which the child cannot be hurt. It is an interpersonal space where protective figures offer care and where specific needs can be understood and catered for. It is the "secure base" in attachment theory where the child is free to explore and play because "mother is

at home.” It is a space in which the child is no longer alone and where her needs can be experienced and met.

The narrative of Kelly's therapy illustrates the complexity and subtlety of the processes that can take place within the imagery rescripting process. Rescripts can be planned beforehand in a collaboration between client and therapist (Arntz, 2014a). However, in Kelly's case, rescripting arose from a responsive process. This was a process of implicit negotiation between (a) the therapist, who closely monitored Kelly's experience from moment to moment; and (b) Kelly herself, who provided feedback through the images she reported, her emotional expression and body language, and the words she used in the dialogue and verbal commentary. There was, as Elliott and Greenberg (2007) put it, a creative tension or dialectic for the therapist between following and guiding that was “analogous to a dance in which each partner responds to the other by alternately following and leading” (p. 244).

In the early phases of imagery rescripting we may provide some of that safety, but not yet all of it. In S57, when the 3-year-old Peacemaker entered the circle. Kelly recognized her as the same child we had worked with some 16 months before (in S22). I had done a rescript then in which I had frozen her mother, and this had had a significant impact as it led to a series of spontaneous images of the child venturing into different parts of the house and exploring and playing. But this 3-year-old still needed more. It was only much later that Kelly found the holding environment that her healing circle could provide. Its creation, and the process of Kelly's different Child parts finding their way into it, emerged as part of a longitudinal trajectory of change that unfolded over many sessions and over many weeks and months (the actual time between S45 and S67 was over 6 months).

Three factors probably contributed to the emergence of the healing circle. First, Kelly experienced significant safety and care from Rick. Rick had stood up to her mother right from the beginning, and, in S56, she recalled how, as a student, nearly 20 years previously, she used to rest and sleep when she visited him.

Second, I had by now established myself as someone who could offer such a “holding environment.” The narrative provides examples of how I was able to accept, empathize with, and give words to Kelly's deep unspoken feelings and, in contrast to Rick, not rush to fix anything. Kelly repeatedly told me that an important contribution I made was that I could, as she put it, “speak for the child.” Offering attunement, empathic understanding, and verbal articulation of experiences which, for the child, are still unformulated (Stern, 1997) is an important dimension of reparenting.

The third factor was a preparatory step that had already taken place in the therapy relationship. It is often argued that in the process of schema healing the client first allows the therapist to reparent their Child, and then, having internalized that, can increasingly do this for themselves. However, in earlier sessions, it was Big Kelly, not me, who had reparented the

Child, and it was only after I had confronted Kelly on her prematurely independent, self-sufficient coping, and she had engaged with that, that she was able to accept the deeper level of unconditional care that the circle portrayed. This laid the foundation for Kelly's recognition of her need for "consistency ... a sense of solidness ... a cocoon around me that keeps me safe" that the circle expressed.

"Safe place imagery" is widely used in trauma-focused work with terrifying memories (Young et al., 2003, p. 13). It provides a means of switching to an alternative experience when emotional arousal becomes too high—the classic principle on which Wolpe's (1961) systematic desensitization is based. The narrative speaks to two aspects of this. The first is the interpersonal nature of that safety. Winnicott's holding environment is not just physically safe. There is safety in the steadiness and depth of the care of those that provide it. The second is that we can establish safety for one dissociated child part while other parts remain unsafe. Although, after S52, the Terrified Toddler was safe, there were 8 more figures still to be identified and brought within Kelly's Circle of safety healing ambit, each of which needed specific kinds of reparenting to establish the safety they needed.

Rescripts in which the therapist confronts neglectful or abusive parents with their failure to meet their child's needs offer the Child the protection the parents failed to provide. This standard intervention (Arntz & van Genderen, 2009, p. 84) is an essential prerequisite for reparenting to take place. Kelly remarked in the research interview that "in terms of telling my parents off—that kind of stuff—I've never experienced anybody who's been prepared to do that." Rick had done that, but, as she put it, she would be "flapping round the edges, trying to make peace ... cramping his style." I was, of course, confronting her internalized parents from her childhood and I established myself as determined in that task. And it meant a lot that "somebody is prepared to actually do that; see the need—actually act and then do it effectively."

Structurally, the inner child is in a dyadic relationship with the internalized toxic parent. There is a parent-child mode dyad in which the experience of the child is defined by the behavior of the parent on an ongoing basis (Edwards, 2017, 2022). While the child is so enmeshed, reparenting is not possible. It was therefore a decisive step when, in S51, Kelly recognized that the Terrified Toddler could never feel safe in that house and allowed me to carry her out, and, when in S57, she allowed me to come in and rescue the 3-year-old Peacemaker. Similarly, in S59 my confronting Kelly's mother on the mother's self-righteous shaming allowed the Head Girl to seek care from Uncle Mike. Only by breaking up the existing parent-child dyad can the Child be brought into a relationship with a reparenting figure.

Coping Decisions and Demanding and Punitive Features in Coping Modes

The progressive nature of trust building is illustrated in S54 when Kelly comes in feeling dismissive and skeptical. The circle had been created for the Terrified Toddler, but now another child part has been triggered, a 3-year-old with no one to reach out to. Preventing her from

feeling safe are two figures that are differentiated from one another. There is an introject of her angry, critical mother, whom she could never reach out to—a Punitive Parent. There is also a coping part who shuts down the vulnerability of the child to protect her from the disappointment and betrayal she would experience if she did reach out. This latter mode probably emerged as a result of a coping decision of the form, “I can’t afford to be vulnerable and reach out or I will get hurt and be betrayed.” In Transactional Analysis, this has been called a script decision (Goulding & Goulding, 1979). The resulting coping mode is an Overcompensator, but it is also a Child, in that it formed in childhood and its cognitive and emotional processes reflect an early developmental stage. For this reason, I call it a Protector Child or a Coping Child (Edwards, 2017, 2019b, 2022).

The appearance of the Punitive Parent and Protector Child as separate illustrates the source of a confusion often encountered in mode analysis (Edwards, 2022). Punitive or critical messages may belong to a Parent mode or to a Coping mode. In this case, the Punitive Parent was clearly an introject of her mother and Kelly recognizes she should be confronted and sent away. By contrast, Kelly experiences the Coping mode as part of herself, as it is a consequence of her childhood coping decision. Kelly’s image of her mother wearing Kelly’s clothes illustrates the challenge involved in differentiating these two modes. There is an experiential confusion within Kelly herself as she is not clear whether the punitive voice is alien (her mother, a Parent mode) or part of herself, something she values as important to her, a result of her own coping decision.

In implementing the coping decision to attenuate or shut down the feelings of the Vulnerable Child, Kelly appears to have drawn on existing resources that included the Punitive Parent introject. So, the messages of the Punitive Parent become incorporated into the Protector Child coping mode and are strategically used to shut down the Vulnerable Child. This is symbolized by the image of her mother wearing Kelly’s clothes. Working with this image involves re-evaluating the punitive messages, recognizing that they are not helpful, and making a new decision that she does not need them any more to shut down her Vulnerable Child feelings. The process reaches a clear conclusion when Kelly tells her mother, “Go back into the house and get into your own clothes.” She is not only rejecting the Punitive Parent, but also reversing her childhood coping decision—what Goulding and Goulding (1979) call “redecision.” The process of the therapy had led to Kelly’s appreciating that she now had new ways of coping that were not available when the coping decision was made. These include the unconditional space of the healing circle and the process culminates in the 3-year-old entering the circle herself.

A similar confusion can be seen in the 9-year-old who appears in S56. She is in thrall to her Demanding Parent, with confusing and competing demands from both parents: she must cope on her own so as not to make any demands on her father, and she must be successful to make her mother proud and not shame her. But also she must not be seen to be successful, so that Sarah won’t feel upstaged. Furthermore, sometimes if Kelly fails, her mother can obtain gratification from presenting herself as the helpful caring mother.

So the message the session began with, "You can do it and you should, and the fact that it's stressful is immaterial." This is not merely an introject of her parents' demands, it is a coping mode that resulted from a decision about how to navigate those demands. It includes Kelly's thought, "I've got to do something bigger and better next time because maybe then they'll actually acknowledge it." So here too a parental introject (Demanding Parent) and a Coping mode (a responsible, hypervigilant, self-sufficient, Overcontroller) need to be differentiated phenomenologically. Of course, both modes impose what Rogers (1959, p. 209) called "conditions of worth" and contrast with the acceptance and unconditionality offered by Kelly's healing circle. This conditionality means that these modes are obstacles that prevent the child from entering the safety circle. They have to be fully confronted and addressed to clear the way for the child to enter.

Conclusion: Towards a Phenomenology of Corrective Transformation

The schema therapists's goal is to foster schema healing (Young et al., 2003). This can be achieved by promoting and co-operating with transformational processes (Fosha, 2009) by which problematic, embedded meanings are corrected and fundamentally changed. Imagery rescripting and limited reparenting play a significant role in this by potentiating new meanings; enabling new perspectives on old appraisals (Mancini & Mancini, 2018); updating old working models; and enabling the development of more differentiated ones. The narrative of Kelly's therapy presents a descriptive phenomenological account of such processes.

These processes are, in turn, similar to those that often occur within schema therapy and other process therapies, such as AEDP (Fosha, 2018) and PE-EFT (Elliott & Greenberg, 2007). Fosha (2018, p. 87) emphasizes the capacity for "wired-in healing within" and "neuroplasticity [in] action." Similarly, Farrell et al., (2014, p. 230) conclude, "Childhood wounds can heal ... The healing attachments that were not made back then can still be made now, thanks to the brain's amazing plasticity." This implies that there are permanent changes at the physiological level, which are attributed to processes of "memory reconsolidation" by Ecker (2015; Lane et al., 2015). Not all clients can tolerate such an intense process, but Kelly's natural capacity for dual awareness that was noted in section 5, above, enabled her to do this.

The processes described in the narrative lend support to the perspectives and principles on which experiential therapies are based. They are also understandable within a contemporary understanding of autobiographical memory. Thus, the processes in Kelly's case show how there is a remarkable and heartening convergence between (a) the phenomenology of the kind of complex transformative experiences that can occur in psychotherapy; and (b) an understanding of how memory is lived not only in the normal lifeworld, but in the enhanced theater of consciousness evoked by this kind of experiential psychotherapy.

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Table 1. The 18 Early Maladaptive Schemas*(Adapted and abbreviated from Young, 2005)*

Schema	Brief definition
Emotional Deprivation	Anticipates that one's desire for a normal degree of emotional support will not be adequately met by others.
Abandonment	Experiences significant figures as unreliable in offering care and support because they are emotionally unstable and unpredictable, or erratically present because they might die imminently; or leave in favor of someone better.
Mistrust/ Abuse	Anticipates that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage. Usually involves the perception that the harm is intentional or the result of unjustified and extreme negligence.
Social isolation/ Alienation	A sense of being isolated from the rest of the world, different from other people, not fitting in or being part of any group or community.
Defectiveness/ Shame	A sense of being defective, bad, unwanted, inferior, or invalid in important respects; or that one would be unlovable to significant others if exposed.
Failure	A sense that one is a failure, that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers, in areas of achievement.
Incompetence/ Dependence	Believes that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others.
Vulnerability to Harm or Illness	Exaggerated fear of imminent catastrophe. Fears may be of external catastrophes such as elevators collapsing, being victimized by criminals, airplane crashes, natural disasters, or of medical catastrophes such as heart attacks or AIDS, or emotional catastrophes such as going crazy.
Enmeshment	Excessive emotional involvement and closeness with one or more significant others (often parents), at the expense of full individuation or normal social development. Often believes that at least one of the enmeshed individuals cannot survive or be happy without the constant support of the other.
Subjugation	Excessive surrendering of control to others because one feels coerced. This is associated with the perception that one's own desires, opinions, and feelings are not valid or important to others.
Self-Sacrifice	Excessive focus on voluntarily meeting the needs of others in daily situations, at the expense of one's own gratification. This is often associated with an acute sensitivity to the pain of others.
Emotional Inhibition	The excessive inhibition of spontaneous action, feeling, or communication, usually to avoid disapproval, shame, or losing control of one's impulses.
Unrelenting Standards	An underlying belief that one must meet very high internalized standards of behavior and performance. Typically results in feelings of pressure or difficulty slowing down; and in hypercriticalness toward self and others.
Entitlement/ Superiority	Believes that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interaction.
Insufficient Self-Control / Self-Discipline	Pervasive difficulty in exercising sufficient self-control and frustration tolerance to achieve one's personal goals, or to restrain the excessive expression of one's emotions and impulses.
Admiration / Recognition seeking	Excessive emphasis on gaining approval, recognition, or attention from others, or fitting in at the expense of developing a secure and true sense of self. One's sense of esteem is dependent primarily on the reactions of others .

Table 1. Continued

Schema	Brief definition
Pessimism / Worry	A pervasive focus on the negative aspects of life (pain, death, loss, disappointment, conflict, guilt, resentment, unsolved problems, potential mistakes, betrayal, things that could go wrong, etc.) while minimizing or neglecting positive or optimistic aspects. This is frequently associated with chronic worry, vigilance, complaining, or indecision.
Self-punitiveness	Believes that people should be harshly punished for making mistakes. Usually associated with intolerance towards those people (including oneself) who do not meet one's expectations or standards, and with difficulty forgiving mistakes in oneself or others.

Table 2. Kelly's High Scoring Items on the Young Schema Questionnaire (YSQ-S3)

Schema	Item		Score
Self-Sacrifice	11	I'm the one who usually ends up taking care of the people I'm close to.	5
	65	I've always been the one who listens to everyone else's problems.	6
Subjugation	28	I feel I have no choice but to give in to other peoples' wishes, or else they will retaliate or reject me in some way.	5
	82	I have a lot of trouble demanding that my rights be respected and that my feelings be taken into account.	5
Enmeshment	27	My parent(s) and I tend to be overinvolved in each other's lives and problems.	5
	45	It is very difficult for my parent(s) and me to keep intimate details from each other, without feeling betrayed or guilty.	5
Abandonment	74	Sometimes I am so worried about people leaving me that I drive them away.	5
Mistrust	21	I feel that I cannot let my guard down in the presence of other people, or else they will intentionally hurt me.	5
Unrelenting standards	31	I try to do my best; I can't settle for "good enough".	5
	49	I must meet all my responsibilities.	6
	67	I feel there's constant pressure for me to achieve and get things done.	6
	85	I can't let myself off the hook easily or make excuses for my mistakes.	5

APPENDIX 1. OUTLINE OF THE CASE STUDY OF “KELLY”

1. CASE CONTEXT AND METHOD

Introduction

Research Methodology: Client, Therapist, and Sources of Data

The Methodology of Generating the Case Study of Kelly

The Narrative Phase

The Theoretical-Interpretative Phase

2. THE CLIENT

3. GUIDING CONCEPTION WITH RESEARCH AND CLINICAL EXPERIENCE SUPPORT

My Background in Schema Therapy

Psychotherapy and Phenomenological Research

The Schema Therapy Model

4. ASSESSMENT OF THE CLIENT’S PROBLEMS, GOALS, AND STRENGTHS

Presenting Problems, Clinical Features and Diagnosis

Family History

Strengths

5. CASE FORMULATION AND APPROACH TO THERAPY

6. COURSE OF THERAPY, WITH A FOCUS ON THE DEVELOPMENT OF KELLY’S CIRCLE OF SAFETY AND HEALING

Overview of the Process of the Therapy Regarding Kelly’s Role in Imagery Rescripting

Sessions 1-50: The First Two Years of Therapy and the Emergence of a

“Circle of Safety”

Sessions 51-52: A Circle of Healing for the Terrified Toddler

Sessions 53-55: A Terrified 8-Year-old

S53

S54

S55

Session 57: A 3-Year-old Peacemaker

Session 58: A 7-Year-old Responsible Self-Sacrificer

Session 59: An Ugly Duckling and a Head Girl

Session 60: An 8-Year-old in a Bubble

Session 61: Embryo

Sessions 62 - 67: Resolutions Within the Circle

7. THERAPY MONITORING AND USE OF FEEDBACK INFORMATION

8. CONCLUDING EVALUATION OF THE THERAPY'S PROCESS AND OUTCOME

Qualitative Feedback on the Process and Outcome of the Therapy From Post-Therapy Interviews

Further Qualitative Feedback on the Process and Outcome of the Therapy

9. THEORETICAL REFLECTIONS AND CLINICAL IMPLICATIONS: THE PHENOMENOLOGY OF MEMORY AND TRANSFORMATION

Introduction

Schemas, Complexes and Internal Working Models

Autobiographical Memory and the Working Self

The Theater of Consciousness and the Theater of the Imagination

Understanding the Figures That Enter the Circle

How Far Back Can We Remember?

Reparenting, Corrective Experiences and Imagery Rescripting

Coping Decisions and Demanding and Punitive Features in Coping Modes

Conclusion: Towards a Phenomenology of Corrective Transformation

APPENDIX 2. GLOSSARY OF SCHEMA THERAPY TECHNICAL TERMS

Term	Definition
Angry Child	An experience of anger as a primary emotion, where some or all the anger is connected (usually implicitly) to memories of mistreatment in childhood.
Chairwork	A simplified form of psychodrama developed by Perls (e.g. 1973) in which parts of the self are separated out into one or more chairs. It has been widely used in many forms of psychotherapy since, including in emotion-focused therapy. It has played a central role in schema therapy from the beginning (see for example, Kellogg, 2004).
Child mode	A mode of functioning in which the individual is connected to primary emotions in the episodic/implicational memory system.
Coping mode	A mode in which the individual is more or less disconnected from the painful emotions in the Child, that attenuates or blocks them out altogether.
Early Maladaptive Schema	A problematic psychological pattern or theme that develops early in life (can start at birth or before) in response to adversity which results from significant core needs not being met at the time. 18 such patterns have been identified by Young and are measured by the Young Schema Questionnaire (YSQ).
Healthy Adult	A mode, or set of related modes, in which an individual is responding in a rational and psychologically mature manner.
Imagery rescripting	An experiential technique in which an individual is guided to relive a distressing or traumatic memory or scenario (often from childhood) and the therapist redirects the imagined events so that the individual experiences protection, support, understanding and guidance, in a manner that is corrective of the needs that were unmet in the original situation. This is a central technique in schema therapy but it has been increasingly researched and used within cognitive behavior therapy since the term was introduced by Smucker et al (1995). See for example, Arntz, 2011, 2012, 2014a and b; Brewin et al, 2009; Holmes et al, 2007; Ohanian, 2002.
Limited reparenting	Offering the client reparenting (see below) within the limits of what is appropriate within a therapy relationship.
Parent mode	A mode in which an individual is experiencing, explicitly or implicitly, the problematic presence of a parent (or other authority or caregiving figure) internalized from the past, with the specific attributes such as being punitive, critical, guilt-inducing, overanxious or neglectful.
Parent-Child mode dyad	A structurally connected Child mode and Parent mode in which the experience of the Child is the direct result of the emotional states and behavior of the internalized Parent.
Protector Child	A mode that appears in imagery as a Child, but it is a Child in a coping mode, not a Vulnerable Child or an Angry Child. Also referred to as a Coping Child.
Psychodrama	A method developed by Moreno (e.g. Moreno, 1939) whereby a theatre is created on which separate parts of the self can be discriminated and enacted as different characters so that the experience of each part and the relationships between them can be understood and worked with. By extension the term imagery psychodrama refers to the same kind of process being enacted in imagination.
Reparenting	The process of meeting the unmet needs of the client's Child through offering nurturance, care, empathic understanding, validation, guidance (including limit setting) and protection. This is offered by the therapist through the way s/he relates to the client throughout and explicitly through rescripting. In the process the client also learns to reparent his/her own Child.

Term	Definition
Rescript (noun)	The content and sequence of steps in the process of rescripting.
Rescript (verb)	The process of guiding and executing a rescript
Schema	A broad term for a psychological structure that governs habitual patterns of experience or behaviour. In schema therapy, it is often used as shorthand to mean “early maladaptive schema” (see above).
Schema mode	A distinct and recognizable mode of functioning of the individual.
Schema therapy	A systematic and integrative approach to psychotherapy that is centred round case conceptualization in terms of unmet childhood needs, early maladaptive schemas, coping modes, and schema perpetuation, and draws on diverse therapeutic interventions from cognitive, behavioural, emotion-focused/experiential, and psychodynamic/relational therapies.
Vulnerable Child	An experience of a distressing primary emotion, such as abandonment, loneliness, or worthlessness, some or all which is connected (usually implicitly) to memories of adversity and unmet needs in childhood.