



From Panic Disorder to Complex Traumatic Stress Disorder: Retrospective Reflections on the Case of Tariq

by David Edwards

Abstract

This is a phenomenological-hermeneutic case study of Tariq who initially presented with panic disorder. It documents how, as therapy proceeded, the underlying meaning of his initial panic deepened as its roots in traumatic memories of childhood emerged. There were four spaced phases of treatment over four years. The first focused on anxiety management; the second was conceptualized within schema-focused therapy, and evoked and worked with childhood memories using inner child guided imagery; in the third and fourth phases insights gained led to an authentic re-engagement with family members in relationships that had been problematic. The panic attacks resolved and there were two dreams representing a reconfiguring of his relationship with his deceased father. The first two phases were the focus of an unpublished case study presented at a conference in 1995. This article incorporates material from that study and looks back at the case both in light of developments in phases two and three and also in light of theoretical developments in our understanding of complex trauma since the initial presentation.

Tariq approached me for treatment of panic attacks in the early 1990s. This was about the time that Judith Herman's (1992) *Trauma and Recovery* was published, although I did not read it myself until ten years later. In this book, she proposed the concept of complex posttraumatic stress disorder and provided some provisional criteria. She also pointed out that many clients presenting with emotional instability in various forms have a history of trauma that has not been recognized. "All too often," she observed, "neither patient nor therapist recognize the connection between the presenting problem and the history of chronic trauma" (Herman, 1992, p. 123). This turned out to be the case with Tariq.

When anxiety management interventions had limited impact, the focus of Tariq's treatment shifted to a series of traumatic childhood incidents. The case was conceptualized in terms of Young's (1990) schema-focused therapy and the case was written up for a

conference presentation (Edwards, 1995). This article describes Tariq's clinical presentation and treatment, based on the original case study, as well as further information, obtained when Tariq returned to therapy over a year later. It also offers an interpretative reflection. Since Herman's (1992) book was written, a wealth of accessible literature has appeared (for example, Courtois & Ford, 2009) on the way in which repeated trauma can give rise to a range of clinical presentations. Young's (1990) schema-focused therapy has also evolved considerably. The single publication (Young, 1990), which was into its third edition a few years later (Young, 1999), was precursor to dozens of books and articles on what is now called schema therapy (van Vreeswijk, Broersen, & Nadort, 2012; Young, Klosko, & Weishaar, 2002). This has become a significant treatment for complex trauma presentations including borderline personality disorder (Farrell, Shaw, & Reiss, 2012; Farrell, Shaw, & Webber, 2009; Giesen-Bloo et al., 2007).

Schema-focused case formulation and intervention

Early maladaptive schemas (EMSs) are structures of emotionally charged memories and associated cognitions that developed in childhood in situations where basic needs were not met. These are the source of everyday cognitive distortions and irrational or intense emotional responses. EMSs are early, in that they are often laid down in early childhood, and maladaptive since they give rise to problematic symptoms either directly or because of dysfunctional coping that develops to keep them out of awareness. In schema-focused cognitive therapy, EMSs are assessed and then activated and restructured using imagery and dialogue techniques such as those developed in Gestalt therapy. Their incorporation into cognitive therapy had already been described in the 1990s by Young (1990) and the present author (Edwards, 1989, 1990).

Professional interest in the disjunction between intense emotions or irrational behaviours evoked by seemingly neutral everyday situations goes back to the origins of psychotherapy in the 19th century. The English surgeon Dendy had used the term 'psychotherapeia' in 1853 and in the decades following there were detailed accounts of dissociative phenomena and recognition of the role of trauma in their genesis (Ellenberger, 1970). In the cognitive literature, Kelly's (1955, p. 83) theory of personal constructs included a "fragmentation corollary" according to which "a person may successively employ a variety of construction subsystems which are inferentially incompatible with each other." Foa and Kozak (1986) proposed that traumatic events which evoke intense fear and give rise to 'fear structures', primitive non-verbal cognitive systems that give rise to automatic appraisals of threat when triggered by stimuli related to the original trauma memory. These structures are separated from the rest of the cognitive organization and information, and cognitions they contain are not integrated with information derived from other experiences and are therefore not reality tested. Treatment therefore needs to bring the information in the fear structure into contact with corrective information, a task that calls for more than rational argument since the fear structure is a non-verbal system. On the same lines, Stiles' assimilation model is based on the supposition that "problematic experiences ... are experiences that are not adequately contained by the available schemata" (Stiles et al., 1990, p. 412) so that it is the task of psychotherapy to promote their assimilation.

The metaphor of healing the inner child

One approach to addressing the dissociated residue of past unresolved situations or unintegrated painful events is through the metaphor of healing the inner

child (Missildine, 1963). Phenomenologically, this is more than a metaphor because when early schemas are activated, clients may experience themselves as childlike or behave in a childlike fashion and it is easy to engage them in dialogue work in which the child expresses its experiences and in which the therapist can counsel the child in a caring and empathic way. Long before Alexander and French (1946) wrote about the importance of a corrective emotional experience, Ferenczi (1929, p. 124) had written of how:

(possibly as a result of unusually profound traumas in infancy) the greater part of the personality becomes, as it were, a *teratoma* [tumour], the task of adaptation to reality being shouldered by the fragment of the personality that has been spared. Such persons have remained almost entirely at the child-level, and ... [what they] need is really to be adopted and to partake for the first time in their lives of the advantages of a normal nursery.

Although largely ignored by his psychoanalytic colleagues, Ferenczi's (1929) insights are at the heart of inner child work which emerged as a synthesis of theories from psychoanalysis, analytical psychology, transactional analysis, gestalt therapy and the humanistic experiential therapies (Abrams, 1990; Bradshaw, 1990; Capacchione, 1991; James, 1977; Rowan, 1990; Stone & Winkelman, 1988). This corrective emotional experience calls for a process of symbolic reparenting. While this can be promoted through the relationship with the therapist, inner child work uses imagery psychodrama to cultivate positive inner figures.

Although inner child work can be adapted to the wide variety of clinical presentations and childhood experiences that need to be addressed, there are five basic steps. First, the childhood schema is activated by means of experiential techniques such as emotional focusing, guided imagery, 'chairwork' (Young, 1990), or drawing and other art forms (Capacchione, 1991). Second, the child describes her/his experience, pain, and unmet needs to an empathic listener who might be the therapist or the client as he or she is at present or one or both parents, provided they have an empathic side to them. Third, the child's experience is normalized as the kind of response a child would be expected to have in the situation. Fourth, the therapist challenges and contradicts explicit or implicit messages from the parents that were psychologically harmful, points out the negative consequences for the child, and authoritatively expresses alternative ideas that are conducive to healthy psychological development. Finally, empathic parent figures are brought in who

can appropriately acknowledge the needs and feelings of the child and support their natural development. The actual parents may mature and rehabilitate themselves, but where this is not feasible, they can be replaced with images based on real people with nurturing and empathic qualities (which includes the therapist). Sometimes, images of new parents emerge spontaneously.

These steps create conditions in which the emotional damage done by the original parents or other role-players is uncovered and understood and the process of healthy development that was arrested is restarted and cultivated.

Aims and method

Method

This is a phenomenological-hermeneutic case study. The process of psychotherapy offers a rich source of data that is of particular interest phenomenologically. In the presence of an attentive and compassionate listener and guide, clients enter a process of exploring their experience (which of course includes their behaviour) which can continue and deepen over months. In the process, many of the conditions and stages of phenomenological research as described, for example, by von Eckartsberg (1998) or Smith and Osborn (2003) are followed. The therapist/researcher works with the client to investigate his/her experience and explicate this experience. There are also dynamic elements not usually present in interview research. First, the therapist uses active interventions which an interviewer would not use. However, these typically engage with the client's lifeworld and catalyze a deeper understanding of this lifeworld. Second, there is a longitudinal process as the client's experience changes and the transformation process itself can form part of what is being investigated. This longitudinal trajectory has the advantage of addressing one of the central concerns of phenomenology. Giorgi and Giorgi (2003, p. 27) noted that "the capacity to live through events ... greatly exceeds our capacity to know exactly what we do or why we do what we do". Similarly, Smith and Osborn (2003, p. 64) observed how researchers attempt to "capture and do justice to the meanings of the respondents," but these meanings may not be "transparently available." In the process of therapy, new questions arise and are answered and new horizons open up which repeatedly shed fresh light on the client's lifeworld and disclose new depths to his/her experience of this lifeworld. Over time, the therapist's and client's understandings change as each sees how the initial experiences were located in hidden meaning structures which make increasing sense of what was at first presented.

At the same time, there is a process of ongoing interpretation on the part of therapist and client as they try to make sense of the unfolding experience. This hermeneutic dimension is made explicit in the writing of a case study and is evident here in three ways: 1) The initial case formulation used a current theory to make sense of the raw material of the client's behaviour and experience; 2) interpretation became a focus of scrutiny as the case unfolded and the formulation was tested and refined or revised in light of the unfolding phenomenology of the client's experience; 3) in the present case study there is a further hermeneutic step: a case that began some twenty years ago and was written up shortly afterwards is reviewed from a distance in light of more recent clinical perspectives.

The final step for von Eckartsberg (1998) is the communication of results to the researcher's community "in shared expert language or their professional idioms" in a way that presents "the structure of a phenomenon, articulating what 'it really is' as a human meaning" (p. 23). A psychotherapy case usually brings forth more than one phenomenon. By means of a narrative together with interpretive commentary, the case study researcher can articulate complex structural relationships between interrelated phenomena that emerge during the course of therapy. Readers who persevere to the end can judge for themselves whether this has been credibly achieved in this presentation of the case of Tariq.

Aims

Formally stated, this case study has four aims. The first aim is to show how a developmental perspective on Tariq's symptoms of panic disorder emerged and was used as a basis for conceptualizing the case in schema focused terms. The second aim is to show how this was used as a basis for integrating guided imagery psychodrama into the treatment and how this set in motion a process of change. The third aim is to examine whether therapy contributed to meaningful change and, if so, how it did so. Finally, the fourth aim is to look back at a case treated two decades ago through the framework of current theories about complex trauma.

The client

Tariq, an Asian professional man in his early thirties, who was divorced but in a steady relationship, sought treatment for panic attacks. He was seen for a total of 30 sessions, in four phases spaced over nearly four years. He was assessed and treated for panic disorder, but when this had limited impact, experiential work led to the emergence of important childhood memories that led to a schema focused re-conceptualisation. He subsequently gave written

permission for the use of the case material for research and publication. Names and some identifying information have been changed to ensure his privacy. Some sessions were tape-recorded and a narrative of the treatment reconstructed from session notes made during and after sessions with the help of the tape-recordings.

Case narrative

Context and presenting problem: "Am I going insane?"

It was during a national squash tournament that Tariq received a phone call with news that his sister, Janita, had been hospitalized with a "breakdown." He usually dealt with the anxiety of competition well. He felt the usual "butterflies" beforehand, but once the game started, he had a single-minded concentration that enabled him to focus so well that he did not allow anything to disrupt his performance. A few weeks earlier, he had visited Janita who lived in another city with his mother. He deeply disapproved of her on account of a series of defiant and irresponsible behaviours: an affair with a married man at the age of 14 which she shamelessly pursued in front of their parents; as a young teenager speaking to their father on equal terms and humiliating him by ignoring his authority; a short lived marriage and a divorce; and abandoning responsibility for the daughter of this marriage, whom she left entirely in the care of their mother. He had felt so angry that he had refused to talk to her during his visit.

As he listened to the phone call, he felt overwhelmed. However, as he walked away he knew that even this would not interfere with his playing, or this is what he thought he knew. In the next game, he began making mistakes. Still he thought: "Nothing is going to shake me!" Things got worse. "What's happening? I am a guy that can handle pressure." Despite this, his performance just fell apart. Afterwards he berated himself: "Don't look for excuses. You should have punched through."

After this, his confidence was shaken and he had frequent attacks of mounting panic. Sometimes he felt afraid to play squash in case an anxiety attack ruined his game. He would think: "I don't have the mental reserves any more to really concentrate like I used to". He became anxious merely from thinking that an attack of mounting anxiety could strike at any time out of the blue. "I can't afford to let it come creeping in," he thought, "I have to eliminate it entirely to feel safe". He worried about his sister, that he was responsible for her breakdown because of his not speaking to her over the holiday, that he still felt angry with her and it did not seem appropriate to be angry with someone who was so ill. He also worried

that he would become responsible for looking after her if his mother were to become sick or die, and that this could become a lifelong burden. Finally, he believed that these anxiety attacks were the beginning of a progressive mental illness that would almost certainly lead to his going insane just like his sister.

Phase 1: Sessions 1-6 – Assessment and anxiety management

These sessions included a detailed assessment and standard cognitive therapy procedures. We identified antecedents to the anxiety attacks: times when his mind was not busy such as driving the car or lying in bed waiting to fall asleep; having an argument at work; and thinking or hearing about Janita. He collected the key cognitions already referred to and we worked on getting distance from them and reevaluating them. I encouraged him to accept the anxiety and learn to modulate it instead of insisting on eliminating it entirely. There was good collaboration and he made progress with everyday anxiety management. However, Tariq was not satisfied. He wanted the anxiety out of his life. Although he felt more in control, the therapy was not fast enough for him. He dropped out and went to a psychiatrist for medication.

Phase 2: Sessions 8-10 – Drop out and return

Eleven months later, having experimented with different doses of four medications and wrestled with a range of unpleasant side effects, he was back, wanting to deal with the anxiety "once and for all". This was ambitious since he was moving to another city in less than three months. He wondered if I could use hypnosis to speed up the process. We contracted for four further sessions of cognitive therapy to be followed by four sessions of 'hypnotherapy' if I felt it would be appropriate.

More of the phenomenology of his fear of going insane emerged. A TV movie about a person who had a breakdown sent his anxiety soaring and he stopped watching the movie. He had been told that his mother had had some sort of breakdown soon after his birth, but had been unable to find out more. Two members of his family had Downs Syndrome, and one had frequent seizures as well. While he was growing up he had often spent time with them and wondered if what they had was contagious and could have been passed on to him. Although a graduate and a professional, he had never corrected this misinformation and had no differentiated understanding of psychopathology. He felt relieved when I explained that Downs Syndrome was a genetic disorder that was not contagious and that at his age any genetic disorder he himself might have had would have manifested long ago.

Although these experiences seemed to account, at least in part, for his fear of going insane, the fear seemed unshakeable. A few nights later, while trying to fall asleep (a vulnerable time for him as he would start rehearsing anxious thoughts), he again began to think: "Am I losing it ... going out of control ... going insane?" He had images of himself breaking a window and trying to jump out, something Janita had done when she had her breakdown. In session 10 I used a chair dialogue to contrast the part of him that knew rationally that he was not about to go insane and the part that was convinced he was. The rational part was desperately weak, even with considerable coaching from me. It was no wonder that it could not compete at vulnerable times such as when his mind was not occupied, or when he was preparing for a tournament. The scared part won the argument hands down. I asked if he could imagine what this powerful scared part looked like and he saw a demon with horns and tail.

Phase 2 continued: Sessions 11-12 – Imagery work and the meaning of the demon

Now we proceeded to the 'hypnotherapy'. He already believed that his irrational thoughts were "imprinted on his subconscious" and that through hypnotic suggestion they could be weakened or erased. After a relaxation induction, I gave suggestions that using the skills he had learned he would easily be able to manage his anxiety and that when he had the thought that he was going insane he would easily be able to remind himself that this was not the case, that anxiety attacks are not a precursor to a breakdown and that what had happened to his sister was completely different from what he was going through. I asked him to imagine the demonic figure sitting in its dark corner and to see himself shining a torch on it which caused it to slowly dissolve. I gave him the tape to practice with at home.

However, at the next session (session 12), he told me that he had used the tape once but refused to use it again. The suggestion that he was not going insane triggered intense anxiety. He thought: "What if thinking like this only makes the belief that I am going insane even stronger and etches it ever more deeply on to my unconscious mind?" It was as if in response to being told, "There's nothing to be afraid of" there was another voice that answered firmly, "Yes there is, my fear is real!"

After a relaxation induction, I suggested he see an image of this part of him that was insistent on maintaining the fear. He saw the little demon, mischievously enjoying worrying him. I asked the demon to reveal what it was that it needed us to take seriously. At once, a series of memories of childhood unfolded, mostly of around age 6-7: waking in the

night and going to his parents' room, telling them his stomach was sore, it was not sore at all but they would not listen if he were to tell the truth that he was feeling scared; left alone in a car while his father went into his office to fetch something and feeling terrified that he would be attacked and kidnapped; and being left in the house with his two sisters and feeling responsible for protecting them if any catastrophe happened, and feeling inadequate to do this.

These memories revealed the basis for his vulnerability to anxiety attacks. His parents were extremely punitive and deliberately induced fear in order to maintain discipline. He recalled the humiliation he felt when his sisters noticed bruises on his legs from being beaten with his mother's slipper. The family had a live-in servant whose boyfriend was a policeman and regularly visited in uniform. One day Tariq lost some parts from his tricycle. His parents asked the policeman to warn Tariq that if he did not find them all he would arrest him and put him in jail. Tariq, who had no idea that his parents had put the policeman up to it, was terrified. He recalled how Janita was similarly threatened: her father told her that if she misbehaved an alcoholic hobo who hung about on the street would come and get her.

In addition to this routine fear induction at home, his parents emphasized how dangerous the world was and were overprotective. After school, his father fetched him; he was not allowed to take the bus like other children. When he had a cold, he was confined to bed and medicated at once. At the beach, his parents, who could not swim, warned the children, "Don't go near the water, or you will drown." On top of this, his experience of fear was systematically invalidated by his parents. If he cried, he was branded a "cry baby" and mocked in front of the family. Whenever he expressed fear, he was explicitly told, "There's no reason to be scared" and his father often called him "sissy." His father (who had died about ten years ago) had been a respected public figure, active in political work and social upliftment. Tariq had eventually decided, "I can't be a weakling in the shadow of this powerful man." In due course, he had successfully walled off these negative experiences and found a way of also being strong and unshakeable.

Phase 2 continued: Sessions 13-14 - Guided imagery and rescripting

Tariq reported that the guided imagery of the previous session had "stirred up a pot." The idea that we had awakened a split off child part of him seemed to him both positive and negative. On the one hand, it offered a hope of cure in a way that the previous therapy had not. On the other, it introduced three new fears, each of which required to be addressed. First, he thought, "If I stir up all these old childhood fears,

will I reinstate them?" This could be translated into, "If I give up the schema compensation, will I be left with nothing but the frightened child I used to be?" I pointed out that the only way to eliminate the anxiety is to tackle the schema and not to take refuge in the compensation, the capable adult persona that perched on such shaky foundations. Second, he asked, "Am I normal to have this fixated frightened child sitting inside me like this?" I told him that I regularly worked with people whose social persona seemed to others to be strong and intact but who harboured much that was unresolved from childhood. Finally, he asked, "If I let myself look at this, will this damage my relationship with my mother? Will I hold her responsible for my anxiety and become angry with her?" I pointed out that even if he did go through a period of feeling angry with his mother this need not hurt her in any way because, since he did not live near her and was about to leave the country, he could choose whether to express it to her or not.

Encouraged that the guided imagery work of the previous session was getting to the underlying causes of his anxiety attacks, and feeling at peace with these responses, he was keen to continue. After a relaxation induction, I suggested he would return to an early scene related to his present day anxiety. At once he saw himself aged 4 or 5 playing with his tricycle. He could see the policeman, and knew that pieces of the tricycle were missing. He imagined what it would be like to be taken and locked away in jail. How lonely and isolated he would be with no contact with his family. He tried to push the fear away. In the background were other memories too, from later on, when police on pass raids came at night, intimidating the family and demanding to be let in. Now he felt terrified, seeing the policeman in his uniform warning him that he would be taken away if he lost the tricycle parts.

I suggested he introduce his mother into the scene and tell her how terrified he felt. In response he spoke as his mother, telling the young Tariq how these were just threats to get him to behave himself and were not based on any real possibility that he would be taken away. She explained that little boys cannot be arrested anyway, and that even adults are not sent to jail for losing parts of their bicycles. In response, he told his mother how he had really believed what the policeman had told him. I then asked him to enter the scene as his present adult self and to tell the young Tariq that it was not appropriate for his parents to induce fear in this way as a means of changing his behaviour. Their job was to create a safe world in which he could grow up feeling secure and cared for. By telling him stories like this they were doing something that did harm that would last for a very long time. Next, I invited him to tell his mother the same thing. Tariq explained to her that these methods

of discipline were counterproductive and that the fear she was laying down would trouble Tariq for years to come. Finally, he told the young Tariq that he did not have to be afraid any more because he (the adult Tariq) would look after him.

Session 14 began with his reporting that the imagery work of the previous session had "created a major insight" and a great deal had "clicked into place." He saw with a new clarity how much fear induction there had been from his parents and recalled many situations in which "fear was pressed in" while he was growing up and even as a late adolescent. It had been so strong that he had felt that the responsibility of having children was too onerous and he had not wanted to have children himself. He saw too how his parents' over-protectiveness had compounded the problem. This was a major shift. The demon had been disarmed, the resistance gone. There was also a much greater self-acceptance. He could look at himself compassionately in those early memories, without having to dismiss himself as weak and unworthy of his powerful father. He was also beginning to re-evaluate his parents' behaviour. He could see how they had reinforced the boy's normal fearfulness and caused him to feel demoralized and alone.

Finally, he recalled that telling his parents in the imagery that they should not have induced fear in the way they did had felt like defiance. He was scared to be defiant. He had been "hotheaded" and had a terrible temper, which he had learned to control. Janita had been the defiant one, and her behaviour had become outrageous and eventually she had wound up in a psychiatric hospital. Up until now, it had seemed safer to avoid behaving like her, in case he eventually went insane too. However, because I had allied myself with the healthy child and acknowledged his feelings, he realized there was no further need for defiance, which had been rooted in the desperation of not being heard.

Tariq was keen to finish with further imagery work. Session 12 had focused on the first step of inner child work, activating the child and letting it be seen. Session 13 had focused on the steps two to four, allowing the child to express his real feelings, acknowledging them empathically and explicitly naming the parental attitudes and behaviours that were harmful. A small beginning had been made towards step five, building an appropriate inner parent, in that the adult Tariq had told the boy that he would take care of him. After the relaxation, he connected with a scene at about age 7 in which his father had left him alone in the car while he went into the office. He felt alone, sad his father had not taken him along, frightened he might be kidnapped and never see his parents again, and disappointed his father had no insight into his true feelings. When his

father returned, I had Tariq tell him of all these feelings in detail. Tariq replied, "I'm only 7 years old and many things frighten me. I need you to acknowledge these different feelings that I have and let me tell you about them". His father was able to recognize the boy's legitimate fear and need for parental support and undertook to be empathic and supportive instead of mocking and indifferent. He also acknowledged that ignoring and mocking Tariq's feelings and deliberately inducing fear were harmful and caused him much suffering. We closed by returning to the tricycle scene and worked to create an image of his mother as a "good parent" too. I thought that was the end of the therapy, and wondered if I had helped him enough to make a difference to his panic attacks.

Phase 3: Sessions 15-22

18 months later Tariq returned for a further 8 sessions. Overseas he had had further panic attacks, some anxiety management counselling and taken a benzodiazepine. He had been back for a few months and had recently had another panic attack. Discouraged, he concluded he was "back to square one." However, the situation was moving. He had visited the family and Janita ran to him at the airport, crying. Now he learned from a relative that she had been sexually molested at school. Here was a family plagued by trauma but it was too early for him to take in what this meant. He was ruminating again about whether he was also heading for a breakdown, and whether he might end up being responsible for her in the long term. This was an intolerable thought. He was angry about her teenage affair which she had flaunted in a way that humiliated their parents, and her repeated angry outbursts and demands that took all his parents' attention to the extent that to this day his mother could not come to visit him. He wanted to be as far from her as possible.

At last, however, he was receiving validation for his anger. First, I asked him to express it in a letter to Janita and bring the letter. He also expressed his anger at his mother for tolerating Janita's behaviour. Then on a family visit, he was surprised to find that Janita was well. He met with her psychiatrist who gave him insights into the impact of the sexual trauma and the enmeshed relationship between Janita and her mother. She encouraged him to express his anger to Janita, which he did. Previously he had believed this was not appropriate because of the hardship she had been through. Then he dreamed his father was dying, and, looking closer, saw he was already dead. In a later session, he would indicate that he now recognized that he did not have to behave towards Janita as their parents had done. He could confront her from his own feelings and did not have to take responsibility for her.

Other important changes were also taking place. He acknowledged his intolerance of being alone and began to work with the intolerance. He had also recognized how he had fought for control, being intolerant of others who saw things differently, and demanding certainty. This of course had been apparent at the beginning when he insisted on eliminating the anxiety rather learning to tolerate it. Previously accepting unwanted feelings or accepting others who thought and behaved differently was experienced as being submissive, defeated. He had now reframed it.

Phase 4: Sessions 23-30

Seven months later, he came for a final 8 sessions. He had had no more panic attacks. He worked on incidents where his father has been dismissive or angry. Tariq had once made a White friend and his father had threatened to throw him out of the house, saying "Pack your bags and go and live with them!" He realized that he had believed, "Your parents are right – what they decide is law. You don't have a right to question that." He wrote a letter to his father expressing how he felt. A few weeks later, he dreamed he said to his father, "Let's level with one another," and told his father he had been wrong about the way he did things. This was not in anger, instead he was accepting that this was how it was and feeling the sadness of his own chronic loneliness and deprivation, "a loss I've never acknowledged before", and something exacerbated by his own emotional withdrawal from others. He also realized he had been behaving in a dictatorial manner himself as a way of keeping a connection with his father and was letting go of that now. At the end, he described how he was learning new ways of being in everyday situations and had a strong sense of moving forward.

Interpretive discussion

There is considerable evidence that Tariq was helped by the therapy. He had no further panic attacks after the middle of phase 3. He became accepting of and congruent with his own emotional responses and important relationships in the family had been significantly reconfigured. How this happened is discussed in four steps as described above under method.

Step 1: Initial case formulation in terms of panic disorder

At the outset, Tariq clearly met criteria for panic disorder in terms of the DSM-IV (American Psychiatric Association, 1994). His persistent concern about having future attacks, his worry that the attacks were a sign of impending mental illness, his anticipatory anxiety at the thought of visiting his

sister or playing a game of squash, as well as sometimes avoiding playing altogether in case he had an attack and it ruined his game, are all consistent with a diagnosis of panic disorder. A fear of going insane, like the fear of having a heart attack, has long been recognized as common in panic disorder and helps to escalate the panic attack (Beck & Emery, 1985). There was also evidence that panic could be relieved quite rapidly by helping clients enter situations that triggered panic and training them to rationally evaluate irrational fears and concerns (Clark, 1986), particularly with reference to misattribution of anxiety symptoms to having a progressive mental disorder or impending heart attack.

Step 2: Revised schema-focused case formulation

When the panic did not respond to a cognitive therapy approach in phase 1 and neither the first part of phase 2, the imagery work led to a developmental reconceptualisation of Tariq's anxiety. In terms of Young's (1990) theory of schema development, Tariq had developed fear-driven early maladaptive schemas (EMSs) about the world ("it is a dangerous place in which terrible things can easily happen") and about himself ("I am not safe"). As Young (1990, p. 53) pointed out, maladaptive schemas in the area of autonomy "often arise when parents overprotect their children, for example by continually warning them of exaggerated dangers and risks" and when parental behaviours "make it difficult for children to have the secure sense that they can express their own needs and feelings without fear of reprisal".

In addition, in response to his parents' punitiveness and invalidation of his fears, there was defectiveness/shame ("my feelings are not acceptable ... I'm not good enough"), social undesirability ("I am undesirable because I am weak and timid") and subjugation ("What I feel and need is not important. What my parents need is important"). Tariq had coped by schema compensation, the development of a self-identity that is the opposite of the core maladaptive schemas. Tariq's adult persona, with its strength and resourcefulness, was a compensatory structure that enabled him to cope effectively with challenging situations, including the demands of national level sporting competition.

The news of Janita's breakdown had bypassed this compensation and triggered the underlying maladaptive schemas. His request to the therapist was, in effect, for help in restoring the compensation and preventing further triggering of these schemas. It was clear that this was no longer viable. His insistence on the complete elimination of the anxiety so that he could feel completely in control and the force of the schema-driven distortion that his anxiety

was a prelude to insanity could only be addressed by addressing the EMSs themselves. The inner child conceptualization undercut the resistance. Until session 13, attempts to restructure the thought "I am going insane" had evoked powerful and persuasive counter-arguments. These started to shift in response to contacting and accepting the frightened child.

Although I did not articulate my formulation consciously, my implicit understanding at the beginning of session 13 was that the taped instruction "there is nothing to be afraid of" was a direct attack on the reality represented by the childhood schemas, and these schemas were fighting back. It was as if the demon were saying: "Don't tell me that I don't feel afraid. My father and mother were always telling me that. But I *am* afraid. And no one will acknowledge that and listen to me." The anti-anxiety self-instructions, rather than helping the frightened inner child, were experienced as further invalidation and awakened a defiant response from a deeper part of him that wanted meaningful healing.

The work of session 13 resulted in a great deal of spontaneous insight and cognitive restructuring after the session. The recognition of the full impact of his parents' over-protectiveness and fear induction while he was growing up enabled him to distance from and disidentify with the part of him that felt frightened in a way that had never happened before. The fact that this took place is evidence for the validity of the conceptualization and the efficacy of the intervention to engage the client's early maladaptive schemas. The response to the guided imagery work provided ongoing assessment of the balance between the client's difficulties and resources. The fact that he was able to spontaneously put into his mother's mouth words telling the young Tariq that the threats used to intimidate him were never real, or into his father's mouth an empathic appreciation of the young Tariq's fear at being left alone in the car, demonstrated that the internal images of his parents contained many strong and positive characteristics and that they could be rehabilitated as caring figures for the inner reparenting process. Tariq's feedback about the last few sessions of phase 2 provides evidence for the schema based formulation. Without solicitation, he described the imagery sessions as the most useful. The anxiety management and rational restructuring work of the previous sessions had been of value, but had left him feeling he was not getting to the root of the problem.

Tariq's experience and the unfolding process in phases 3 and 4 built more detail into this formulation. In schema therapy there are two legs on which promoting change is based. The first is the work of reparenting through inner child imagery and the therapy relationship. The second is supporting the

client in reconfiguring current relationships in ways which replace old dysfunctional patterns with new authentic ones. In phase 3, it became clear how his early schemas were being activated by his interactions with the family. His anger with Janita and his mother and his belief that it was not appropriate to feel anger or use it to confront them maintained his invalidation and left him disempowered and helpless. This was first challenged by the therapist's validation of his experience and taken a step further by the insights given him by the psychiatrist and her encouraging him to confront his sister. The therapy given to Janita and family members following her hospitalization had made it possible for this reconfiguration to begin. The fact that Janita was recovering and rebuilding her life and his realization that he did not have to be subjugated to her tyrannical behaviour relieved him of the fear of being permanently responsible for her.

The two dreams about his father were evidence of the transformation of his internalized parental images. In the first, he dreamed his father was dead. His father had been dead for ten years, but this dream was about the grip on his experience of his internalized father whose word was law. He no longer needed to be subjugated to him. The dream in phase 4 in which he leveled with his father and told him he had been wrong in the way he had parented showed that the shift had been thoroughly integrated. His recognition that his own controlling and dictatorial behaviour had been modelled on his father and had been a way of keeping a connection with him allowed him to give it up and become more flexible and in doing this he allowed himself to feel the loss of the loving father he had never had.

Step 3: Retrospective

Looking back to when Tariq was treated, I clearly understood the basics, but now, my clinical understanding is enhanced by the evolving literature on complex trauma. Tariq did not meet criteria for post-traumatic stress disorder (PTSD) as his anxiety was not obviously associated with flashbacks to particular traumatic events. However, he does have a "complex traumatic stress disorder" as defined by Ford and Courtois (2009, p. 442) in terms of having been exposed to "repetitive, chronic or prolonged" events that "involve harm such as physical, sexual and emotional abuse and/or neglect or abandonment by parents or caregivers" that occur at "developmentally vulnerable times ... especially over the course of childhood, and become embedded in and intertwined with the individual's development and maturation." The results of such "a history of complex psychological trauma and complex reactions" can manifest in a range of clinical or subclinical presentations that may or may not meet criteria for a DSM diagnosis. As Ford and Courtois

(2009, p. 441) observed, this perspective "makes a *substantial* difference in clinical assessment and treatment".

The evolution of schema therapy, which fully shares this perspective, has been part of this broader appreciation. Tariq's story is like that of many clients who do not respond to brief CBT interventions and for whom Young's (1990) schema therapy was developed. I had the good fortune of attending seminars by Young during a post-doctoral fellowship in 1985 and had used similar imagery methods prior to these seminars. A schema based formulation therefore evolved naturally once we began the imagery work. Given Tariq's demand that the problem be sorted out rapidly, and because brief treatments of panic disorder had been developed, I did not look deeper in the first few sessions. Looking back that does not seem inappropriate. A great deal of relevant information was gained and Tariq's self-awareness increased during that phase.

Tariq's panic attacks were not obviously secondary to another disorder such as generalized anxiety, social phobia or PTSD. Yet they were the tip of a big iceberg. I see more clearly now how formulation in schema therapy has much in common with our current understanding of PTSD in that it supposes that intense symptoms are evoked by the activation of a dissociated memory system. In PTSD, a dissociated memory of a traumatic event is experienced as a flashback. In schema therapy, the schema is usually associated with a series of painful childhood memories, although most of them may not qualify as life threatening traumas. When the schema is triggered, emotions associated with the schema memories are experienced, but, as Young et al. (2002, p. 29) observed, "the individual may or may not connect this experience with the original memory ... the memories are at the heart of the schema but they are usually not clearly in awareness, even in the form of images". This may happen with PTSD too so that the traumatic basis of panic attacks or other intense symptoms may not be correctly recognized by clinicians (Raby & Edwards, 2011).

Tariq's experience was embedded in schemas incorporating a range of intensely distressing childhood experiences that included physical punishment that left him covered with bruises, threats of being arrested and imprisoned (at the age of 4), the fear of being kidnapped, and experiences of the house being raided by security police because of his father's political activism. They also included the confusing mixture of punitiveness, overprotectiveness and invalidation of his experiences. There is much we do not know, such as the impact of his mother's breakdown when Tariq was born and the general climate of growing up with a political activist father

amid the escalating violence of the later apartheid years. Other childhood memories contributed to his fear of insanity. We do not know whether his mother's breakdown played a role here, but there was a contribution from the fears evoked by his relatives with Downs Syndrome. Some of this was addressed directly in the imagery work which anticipated future developments in the field as this kind work would soon be called "imagery rescripting" and become a standard CBT intervention for a range of clinical problems (Arntz, 2011; Holmes, Arntz, & Smucker, 2007).

Increasingly theories of psychotherapy engage with the multiplicity of voices or parts of self and see psychotherapy as a process in which clients learn to help conflicting parts work together in new ways (Rowan & Cooper, 1999; Stiles, 2011). Although at the time I was aware of how dysfunctional coping had locked Tariq into his anxiety, today I would explicitly formulate them in terms of schema modes, which have become a central feature in contemporary formulation (Lobbestael, van Vreeswijk, & Arntz, 2007; van Genderen, Rijkeboer, & Arntz, 2012; Young et al., 2002). Here I italicize the terms for these modes, some from the literature, others adapted by me. Access to Tariq's *vulnerable child* was blocked by a range of modes: 1) parent modes, internalized from his childhood, the *punitive parent* that criticized and invalidated, and the *demanding parent* that required him to perform; 2) avoidant modes, the *detached protector* that cut off his emotions, and the *avoidant protector* where he avoided threatening situations; and 3) compensatory modes included an adult mode that enabled him to function effectively, but was not a fully *healthy adult* since it was cut off from the child and engaged in rationalization and denial (*rationalizing overcontroller*), there was also a *scolding overcontroller* that imposed control on others, while one mode in which he felt anxiety was not the vulnerable child but a *worrying overcontroller* that ruminated ineffectively in the hope of eliminating uncertainty.

The question is whether these insights would have made a difference to the course of therapy back then. In a similar case today I would probably spell all this out, but even without my having been that explicit, we can see from the narrative that Tariq increasingly allowed the coping modes to weaken. He experimented with more authentic behaviour as the healing in his *vulnerable child* allowed a connection between the emotions in the child and the rationality and strength of the adult which allowed for the building of a flexible and sensitive *healthy adult*. If I were treating him now I would have given him Young and Klosko's (1994) *Reinventing your life* and/or Helen Kennerley's (2000) *Overcoming childhood trauma* to read during phase 2. They were not

available to me then. These might have expedited the pace at which he got to grips with the schema based sources of his problems, but given his frequent relocations these might not have made much difference. Looking back we can see that Tariq's therapy unfolded organically, with the work of each phase providing a foundation for the work of the next as his own innate capacity for healing (Bohart & Tallman, 2010) was supported and strengthened.

Concluding reflection

Phenomenological psychology must do justice to the range of human experiences. This includes the experiences of people that unfold in psychotherapy. The process of psychotherapy is of particular relevance to the phenomenological project because it is a prolonged process of evoking and explicating meanings - which is at the heart of phenomenological psychology. The concept of the lifeworld focuses on the way in which an individual's life and experiences are embedded in life and action in the world. It is a way of stating that experience cannot be separated from the process of living and acting in the world, both physical and social. However, there is a trap here. In practice, much of human experience in the lifeworld is inauthentic, circumscribed by roles, self-protective coping, and meeting other's expectations. It does not have an openness at all. As Kruger (1988, p. 37) observed, individuals can "keep certain aspects of [their] experience in the dark and can in fact hide [themselves] behind a mask".

A focus on the lifeworld deals with consensual reality as widely shared, but leaves mysterious individual experiences which diverge from those of others. Although, Kruger (1988, p. 87) argued that each individual's "life structure remains in principle open", this openness calls for a capacity for reflection which is best done in dialogue with someone who can create "optimal conditions" for them to explicate their experience. This involves empathy and attunement on the part of the therapist that can set in motion what is essentially a creative process that allows the deeper meanings to emerge. For Kruger (1988) these primarily emerge in words, but they can, as powerfully, emerge as images. Kruger (1988) also sees this as a process that is not just of interest to armchair philosophers. It is a process that can give rise to transformation and healing, and the finding of a new way of being-in-the-world.

As Kruger (1988, p. 79) pointed out, anxiety arises in response to threat and that "what looks like something harmless to others can reveal itself to the perceiving person as something quite threatening". The phenomenological stance can therefore not dismiss anxiety that appears irrational or ill founded. However, acknowledging the experienced sense of

threat is only the beginning. The kind of psychotherapy described here helped Tariq explicate the initial distressing experience and layers of deeper meanings that were colouring and exacerbating his experience with threat. The recognition of individual differences in how the same situation is experienced is central to phenomenology and is understood in terms of historicity: each individual's experience in the present is shaped by his or her unique course through life. How this happens, how the past shapes the experience of the present, is of central importance to psychotherapy because problematic experiences are so often rooted in meaning systems that were shaped by adverse situations in the past.

This study provides a detailed investigation of how this developed in Tariq's life. Returning to the quote from Herman (1992, p. 123), in the first paragraph of this article, "the connection between the presenting problem and the history of chronic trauma" is something that therapists need to help their clients uncover as an important step in bringing about a change in their experience. Case studies like this one are particularly significant for the science and practice of psychotherapy as they show how such problematic meanings can indeed be uncovered and changed.

Acknowledgements

The author thanks 'Tariq' for giving permission for this material to be used for research and publication.

This research was supported by grants from the National Research Foundation and the Research Committee of Rhodes University.

Referencing Format

Edwards, D. (2013). From panic disorder to complex traumatic stress disorder: Retrospective reflections on the case of Tariq. *Indo-Pacific Journal of Phenomenology*, 13(2), 14 pp. doi: 10.2989/IPJP.2013.13.2.6.1180

About the Author



David Edwards has been a Clinical Psychologist and practising therapist for over thirty years. He is a founding fellow of the Academy of Cognitive Therapy, having trained at Beck's Centre for Cognitive Therapy in Philadelphia in 1984/5 where he attended seminars with Jeffrey Young, the developer of schema therapy. Professor Edwards has a longstanding interest in psychotherapy integration and has done experiential training in a variety of humanistic and transpersonal approaches. He is certified as a schema therapist and schema therapy trainer with the International Society of Schema Therapy (ISST). He is a Professor at Rhodes University, where, until his recent retirement, he provided professional training and supervision in cognitive therapy for two decades.

Over a long career, he has published some 70 academic articles and book chapters, covering areas as diverse as the use of imagery methods in psychotherapy, the history of imagery methods, case studies of the treatment of simple and complex PTSD, guidelines on the treatment of trauma related disorders, case studies of the treatment of other disorders including conduct disorder, ADHD and social phobia, and case study as a research methodology. Additionally, Professor Edwards has co-edited a first year text book, and is the author of 'Conscious and Unconscious', in the series *Core concepts in Psychotherapy* (McGraw Hill). His research for this book led to the publication of two articles in the *IPJP* in 2003 and 2005.

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