UNIVERSITY OF

BIRMINGHAM

SCHEMA THEORY AND PRACTICE:

EXPLORATION AND REVIEW OF ITS USE WITHIN FEMALE FORENSIC MENTAL HEALTH SERVICES

By

SARAH. L. DAWES

2014

A thesis submitted to the

Centre for Forensic and Criminological Psychology,

University of Birmingham

UK

January 2014

For the degree of Doctorate in Forensic Psychology Practice (ForenPsyD)

ABSTRACT

Within the field of psychology there has been growing interest in Schema Focused Therapy and the theoretical underpinning on which it is based. The overall aim of this thesis was to explore the current application of this model and consider how appropriate and effective it is, with a particular emphasis being drawn to the female forensic population. In order to investigate this three key aspects were explored. Firstly, the Young Schema Questionnaire (Young & Brown, 1990) was reviewed. Good psychometric properties were indicated, however, it is suggested the latest version would benefit from further examination. In the following chapter details of a systematic review are provided. This demonstrated the expanding use of Schema Focused Therapy across general psychiatric inpatients and outpatients with a range of difficulties, and initial use within forensic services. Information on the effectiveness is provided. From the literature reviewed however, there appears to be no substantial evidence base to date for female secure mental health patients. Owing to this an exploratory qualitative analysis was conducted on how the schema model applies to female forensic patients, whereby a template was developed in relation to their experiences of early maladaptive schemas. This enabled links with risk to be made and identified a potential new schema mode. The final chapter summarises the evidence gained throughout the thesis, discusses the implications of the findings and makes recommendations for future research.

ACKNOWLEDGMENTS

Throughout completion of this project various challenges have arisen, creating testing times. However with the support from colleagues, friends and family it has been possible to complete a project which I hope will be of benefit to female forensic services.

First and foremost I would like to send my thanks to the individuals that participated within the research investigation undertaken. From information gathered it has enabled steps to be taken to look at how support may be tailored within services. In order to do this Mr Phil Coombes (Chartered Psychologist) has been consistent in motivating and supporting me through each stage of the process. I would like to say I genuinely appreciate everything that has been done to help me persevere and complete this.

Furthermore, recognition goes to my University supervisor Professor Anthony Beech who has been understanding of circumstances and has given guidance on useful resources, being supportive of the project at hand and completion of the course.

Aside from this, one of the most important factors has been my friends, family and partner who have helped me find a balance in life and keep me smiling whilst helping me see how worthwhile all the hard work can be upon reaching the end goal. This to me has been just as important to help maintain a sense of well-being, thereby enabling me to produce a piece of work to the best of my ability at this time.

So to each and every one of you, thank you! The time, support and reassurance you have given means more to me than you know.

TABLE OF CONTENTS

LIST OF APPENDICES

LIST OF TABLES

LIST OF FIGURES

CHAPTER ONE: INTRODUCTION

Psychological therapy aims to improve depth of understanding, aid insight and support rehabilitation for those experiencing difficulties. This is utilized in a variety of settings but commonly found within mental health and forensic services. Following the initiative for change published by The Department of Health (DOH; 2002) the importance of being responsive to specific populations, ensuring services provided are meaningful and appropriate was highlighted. This indicated that assessment, intervention and service delivery should take into account specific needs and be thoroughly evaluated ensuring it is gender sensitive. Throughout this thesis such aspects are considered, bringing a focus to female forensic mental health patients and schema based therapy. This introductory Chapter initially explores the nature of female offending, followed by gender and mental health issues and provides an overview of schema theory and practice.

Female Offenders

It has been identified that criminal behavior committed by women is thoroughly under researched with a bias in the literature towards male crime (Coombes, 2013). This is thought, in part, to be influenced by the number female offence charges being much lower than that of men therefore it is often deemed to be less significant within society (Smart, 2013). Nevertheless, criminality in any respect is not a trivial matter and can have a profound effect on the perpetrator, victims, families and friends, having a much greater impact on society than would be suggested by prevalence rates (Kratzer & Hodgins, 1999). Therefore, understanding what has led to crimes being committed and the processes behind it is of great

importance to enable preventative measures to be put in place and/ or provide meaningful support and rehabilitation to those involved. Questions are raised however regarding whether female offending can be accounted for using the same understanding of how this occurs for men (Coombes, 2013). It is acknowledged that if not, this could have a major impact upon theory development (Gelsthorpe & Morris, 1994).

On review of the literature, research has identified a number of gender differences within offending and involvement with the criminal justice system. Firstly, participation in criminal acts seems to reduce with age to a greater extent for women than it does for men (Belknap, 2007; Blanchette & Brown, 2006) although the age at first known offence has been reported to peak much younger for men than for women (Block, Blokland, Werff, Os & Nieuwbeerta, 2010; Stattin, 1989). Outcomes of studies regarding the age of onset however have not been consistent in their findings with some investigations reporting no such differences (Tolan & Thomas, 1995; White & Piquero, 2004). Regarding the average frequency of offending, overall this has been demonstrated to be much lower for women than that of men with females engaging in significantly lower levels of violent crime (Bloom, Chesney-Lind, & Owen, 1994). Considering such differences have been identified, the underlying processes that specifically influence female criminality is of importance as it seems we cannot assume the same is happening for women as it is for men in this respect. One potential aspect of significance is that of psychiatric diagnoses. Mental disorders within the female forensic population are known to be highly prevalent. Whilst this could impact upon risk behaviours it could also influence statistical figures for offence rates if not formerly convicted for their crimes due to mental illness

(Dickens, Sugarman & Gannon, 2012). An overview of the mental health diagnostic system is summarised below.

Gender and Mental Health

When it is suspected that an individual is suffering with a mental disorder, one of the current primary tools that informs diagnostic decision making is the Diagnostic and Statistical Manual of Mental Disorders V (DMS-V; American Psychiatric Association, 2013). At the point of writing this thesis the DSM-IV (APA, 1994) was still in place, therefore any reference made to diagnosis are in line with this previous version. It is recognised however that this has since been altered. Within the DSM-IV it provides a wealth of information on psychiatric diagnoses and categorises them amongst five axes according to their main features. Nonetheless, the two principle categories that are most often referred to are Axis I and Axis II. Axis I references clinical disorders; these are the most widely recognised. A small selection of disorders that are represented under this umbrella term are inclusive of mood disorders, schizophrenia, anxiety disorders, eating disorders and somatoform disorders. Such diagnoses have a tendency to be recognised by acute symptoms which may be episodic in nature. Alternatively, Axis II includes personality disorders and mental retardation. Disorders such as these tend to be long standing and chronic over one's lifetime.

Bringing awareness to gender differences, women typically dominate diagnoses such as somatic complaints, anxiety, depression and post-traumatic stress disorder (PTSD) within Axis I and borderline personality disorder (BPD) of Axis II. Alternatively men are shown to have higher rates of antisocial personality disorder. Regarding bipolar disorder and schizophrenia however, no significant differences

have been identified. Overall, it is recognised that amongst clinical population's gender bias is likely to occur, with women being more likely to disclose difficulties with mental health and seek help than men. However females appear to have greater reluctance in disclosing substance misuse problems or vulnerability to violence unless directly asked (World Health Organisation, 2014).

Secure Care

If there is a presence of mental disorder, females who offend may find themselves being detained within a secure facility rather than prison to enable appropriate rehabilitative support. Within secure hospitals however patients may not only be detained regarding risk to others or index offences, but this may also be due to risk to self or challenging behaviour on acute wards which requires increased security (Coid 2000; Rutherford & Duggan, 2007; Stafford, 1999). This differs from men in that a larger proportion of males in secure hospitals tend to have been detained due to their offence histories with much fewer numbers being detained due to risk of harm to self (DOH, 1998). Because of this, the likely presentations on ward can be significantly different between men and women.

With varied risk related behaviours, forensic histories, societal vulnerabilities and mental disorder, women within secure settings are often considered to have complex needs (Robinson, 2013) requiring more specific gender sensitive environments and therapeutic input to help aid recovery. Whilst a number of theories and models exist regarding different psychological phenomena, developments are continuously being made and new lines of thought integrated. For the purpose of this thesis Young's Schema Model (Young, Kloshko & Weishar, 2003) is the focus,

looking at how this is being incorporated within services to achieve an understanding of difficulties and aid change.

Theoretical Model of Schema

Within psychological literature, the terms ‘schema’ or ‘schemata’ are frequently used either on their own or in conjunction with other words. Nevertheless the intended meaning may be unclear due to such extensive use amongst a variety of subject areas (Wagoner, 2013). Due to this it is important to set the frame for the focus of this thesis and appreciate the meaning of the term ‘schema’ in relation to this.

The initial concepts of a schema that are most relevant to current working knowledge were born out of proposals set out by Bartlett (1932). Bartlett (1932) highlighted observations regarding the fluidity of interactions humans have with each other and their environment. It was considered that in order for this to be possible, thinking processes occurring in the brain would need to be engaged and active, utilizing existing knowledge base (memory recall), whilst also having the flexibility to respond to the contextual circumstances. Therefore schemas were used to describe patterns of thinking that develop about people, places, or objects which would enable quick recognition and processing of information, ensuring responses are situationally appropriate, and allowing for learning and adaptation. These patterns are considered to be mental structures that are assimilated using various modalities (i.e. visual, olfactory, auditory, contextual and emotional experiences and memories) which develop to form a framework for making sense of new experiences and integrating information (Bartlett, 1932). This was elaborated on by Piaget (1948) and Beck (1967) who also recognized schemas as templates which could help integrate and aid understanding of ourselves and the world around us; but the long-term stable nature of

these patterns were further highlighted (Beck, Rush, Shaw & Emery, 1979). With this, the tendency for people to become biased in their perception, selecting information that fits with existing knowledge was noted to be likely, providing a sense of familiarity with what they know and understand (Beck, Freeman, Davis & Associates, 2004). Doing this can result in similar thoughts, feelings and memories being provoked within comparable circumstances, allowing for effortless interactions. This ultimately appears to sustain experiences, induce a sense of repetition and makes it increasingly difficult to change.

In acknowledgement of the schema concept, growth and expansion in the use of this term continued. In 1990 Young began to identify specific 'early maladaptive schemas' (EMS) which continued to highlight the role of an enduring theme or template that acts to aid cognitive processing, but brings awareness to those that may be particularly unhelpful. When speaking of EMS these are defined as;

"broad, pervasive themes regarding oneself and one's relationship with others, developed during childhood and elaborated throughout one's lifetime, and dysfunctional to a significant degree" (Young, 1999, p.9)

Of note, this definition starts to bring awareness to the importance of early influences, placing significance on underlying emotional requisites one needs to grow and develop a healthy sense of well-being. This includes the need for a sense of security, consistency and care, with the opportunity to develop independence and become aware of a sense of self as an individual. In addition it is considered to be fundamental that people have the chance to express themselves within supportive, socially acceptable boundaries. It is noted that the experiences people have then interact with

innate temperament, influencing how characteristics are displayed, and how temperament may influence how others interact with them. This interplay between genetics and environment begins to shape personality, providing people with general schemas and ideas of how to manage or respond (Young et al., 2003). If primary needs are not fulfilled however, this is considered to have a detrimental effect, increasing the likelihood of developing EMS (Rafaeli, Bernstein & Young, 2011), which involve the unhelpful beliefs or thinking habits, about oneself, others or the world, thereby influencing behaviour and coping responses (Riso et al., 2006).

Over the past two decades specific EMS have been identified and elaborated on; each highlighting a different pervasive theme of beliefs that one may hold. Whilst each EMS represents a specific belief or expectation, they have been grouped together within five different domains dependent on the general focus or what unmet needs may underpin it from early childhood (Young et al., 2003). These are detailed below;

- The initial domain of ‘disconnection and rejection’, involves the expectation that emotional support and a feeling of safety will not be achieved. This often owes to lack of care from significant others, disruptive relationships or interactions where individuals have felt unsafe.
- The ‘impaired autonomy and performance’ domain is associated with self-identity and perceived capability to function as separate from others. This may result from a strong controlling influence of carers or extreme neglect.

- The domain of ‘impaired limits’, relates to difficulties demonstrating self-control, setting realistic goals and thinking of others. Problems in this area are

thought to stem from having minimal guidance or boundary setting throughout developmental years.

- ‘Other-directedness’ highlights how some may be inclined to put a large amount of effort into focusing on the thoughts and feelings of others at the cost of one’s own needs. Individuals demonstrating EMS in this area are considered to have been required to attend to the needs and wants of others in order to obtain affection or acceptance.

- Finally, ‘over-vigilance and inhibition’, relates to the disproportionate attention paid to preventing emotional expression and meeting standards, placing strict controls on self or others. This may often result from being in an environment where perfectionism and stringent boundaries are considered to be of greater importance than pleasure or enjoyment.

Please see Table 1. detailing the most recent list of EMS identified within their associated domains (Young et al., 2003).

Table 1. Early Maladaptive Schemas (Young et al., 2003)

	Early maladaptive schema (Descriptive pattern of thought)	**Domain**
1	Abandonment/ Instability (*People will move on and leave me*)	Disconnection and Rejection
2	Mistrust/ Abuse (*Others will hurt me in some way, I cannot trust them*)	
3	Emotional Deprivation (*My need for emotional support will not be met by others*)	
4	Defectiveness/ Shame (*I am worthless, unlovable, and defective*)	
5	Social Isolation/ Alienation (*I am different from other people and often feel on the outside of groups*)	
6	Dependence/ Incompetence (*I am not competent with daily living tasks and need a lot of help from others*)	Impaired Autonomy and Performance
7	Vulnerability to harm or illness (*A disaster is likely to occur at any moment*)	
8	Enmeshment/ Undeveloped self (*I am not sure what I want for myself and over-identify/ become over-attached with significant others*)	
9	Failure (*I am going to fail or I have failed. I am not as good as compared to others in terms of achievement*)	
10	Entitlement/ Grandiosity (*I warrant privileges above others*)	Impaired Limits
11	Insufficient Self Control/ Self Discipline (*I cannot contain my urges, impulses or expression of emotion*)	
12	Subjugation (*I feel <u>forced</u> or that I have no other choice but to go along with what other people want*)	Other Directedness
13	Self-sacrifice (*I will v<u>oluntarily</u> do a lot of things for other people*)	
14	Approval Seeking/ Recognition Seeking (*I would like recognition from others*)	
15	Negativity/ Pessimism (*Things are going to go wrong. I have difficulty taking on board the positive aspects of life*)	Over-vigilance and Inhibition
16	Emotional Inhibition (*I feel the need to over-control my actions and try not to express my emotion)*	
17	Unrelenting Standards (*I need to meet high standards*)	
18	Punitiveness (*People/ I should be punished if in the wrong*)	

Whilst EMS have been likened to enduring traits, schema modes have also been acknowledged which are more comparable to transient state-like expressions (Beckley, 2007). Schema modes are defined as;

"…moment-to-moment emotional states and coping responses" (Young et al., 2003, p. 37)

Such shifts occur upon EMS activation which can often be noticed by individuals themselves but also observable by others. For those with mental health problems, intense and rapid alterations may occur generating confusion and an uncertainty in sense of self. Alternatively transient states within individuals without mental disorders tend to be less abrupt and more easily managed. The purpose of labeling such changes in one's presentation enables greater capacity to work with this within therapeutic practice, enhance individuals' awareness, aiding the opportunity for change (Rafaeli et al., 2011). The language used and classification of modes are based on Eric Berne's Transactional theory highlighting three broad characteristics within one's self: the Child, the Parent and the Adult (Berne, 1961; Blenkiron, 2010). Observations and investigations regarding these modes have often been based around outpatients and some general psychiatric inpatient settings (Lobbestal, 2012; Young et al., 2003). However, additional maladaptive coping modes and forensic over-compensatory modes have also been identified primarily from observations within male secure services (Bernstein, Arntz & Vos, 2007). These are outlined in Table 2 below. Please note that within the literature there are discrepancies over what modes exist and what the specific characteristics are. Due to this, the modes highlighted below are the ones that have been acknowledged by Kellogg and Young (2013) and are able to be

assessed using the Schema Mode Inventory developed. In acknowledgement of this thesis drawing a focus on forensic issues however, additional modes identified by Bernstein et al., (2007) are included.

On reflection it is recognized that whilst there is a collective of information from outpatient samples, general psychiatric inpatients and forensic males to guide therapeutic practice, there appears to be an absence of specific evidence for forensic females gathered to date. Therefore this would seemingly be the next logical step within investigatory processes to ensure suitability and appropriateness.

Table 2. Description of Schema Modes (Bernstein et al., 2007; Young et al., 2003)

Mode Type	**Specific Modes (*Mode description*)**
Child	Vulnerable Child (*Sad, frightened, anxious and helpless often wanting the care from others, but may be uncertain how to go about achieving this*)
	Angry Child (*Feels unfairly treated and becomes angry. Expressing this in an inappropriate manner or may appear to make unrealistic demands*)
	Enraged Child *(Feels intense anger demonstrating this in an explosive outward manner)*
	Impulsive Child (*Observed to struggle with immediate gratification, reacts instantaneously to their own wants/ wishes without consideration for others*)
	Undisciplined Child *(Unable to complete mundane/ routine activities. Becomes easily frustrated and reluctant to continue)*
	Contented child *(Experiences a feeling of contentedness and that emotional needs are met. Have the capacity to be flexible to the environment, have a sense of self and optimistic)*
Parent	Punitive Parent (*Becomes critical and punishing which could be towards self or others*)
	Demanding Parent (*Holds high standards and places a high degree of responsibility in the person in question. Could be others or themselves*)
Surrender and Avoidant	Compliant Surrenderer (*Obedient of others, giving in and accommodating their wishes. Can sometimes lead to reliance on what others want*)
	Detached Protector (*Becomes disconnected from others. Withdraws, isolates and avoids*)
	Detached Self Soother (*Repeatedly engages in activities that help settle, comfort or stimulate them, in effort to remove themselves or avoid uncomfortable affect*)

Over-compensating	Self-Aggrandizer (*Tries to demonstrate their superiority and looks down at others. Sees presentation with great importance rather than emotional connections*) Bully-Attack (*Uses hostility, intimidation and threats to achieve dominance, gaining satisfaction from this*) *Conning and Manipulative (*Misconstrues or provides false information to mislead others. Lies used are purposeful to belittle those around them or avoid being reprimanded themselves*) *Predator (*Becomes scheming and manipulative, responding in a callous manner to eradicate a perceived threat*) *Over-Controller (*Becomes extremely controlling, preoccupied and focused, to protect themselves from perceived threat. May be either obsessive or paranoid in nature*)
Healthy Adult	(*Acknowledges difficulties experienced, allows suitable self-expression and utilizes management strategies remaining aware of appropriate boundaries*)

(* represent additional modes identified within a forensic population by Bernstein et al., 2007)

Schema Theory and Associations with Mental Disorders

Upon the development of coping strategies to manage arising schemas; social, relational and general management problems may be observed and difficulties experienced. As these problems can often be observed within those suffering with a mental health diagnoses a focus has been drawn to this, particularly personality disorders, whereby a number of risk issues are often highlighted (Young et al., 2003).

Nordahl, Holthe and Haugum (2005), reviewed an outpatient sample of both males and females for differences between Axis I and II disorders. Twelve EMS were found to be closely associated with personality pathology (Nordahl et al., 2005). Petrocelli, Glaser, Calhoun and Campbell, (2001) reported comparable outcomes. Looking more directly at three specific personality disorders was Jovev and Jackson (2004), who refined their research to investigate borderline, avoidant and obsessive-compulsive personality disorders. With this they demonstrated that participants with

borderline personality disorder provided responses which equated to them experiencing a higher degree of defectiveness, dependence and abandonment, whilst those with avoidant personality disorder identified stronger associations with emotional inhibition. Lastly those with obsessive compulsive personality disorder presented with a higher degree of unrelenting standards (Jovev & Jackson, 2004). Explorations in this field support the notion of persistent dysfunctional patterns present in those with personality disorders, which is coherent with criteria for Axis II disorders (American Psychiatric Association (APA), 2013; Thomas, 2008).

Regarding Axis I disorders, fewer investigations have taken place which would encompass the whole range of mental illnesses. This may be owing to the fact that there is a vast range of symptoms and presenting features which differ quite considerably between diagnoses. What has been observed to date however are links between vulnerability and dependency with agoraphobia and panic disorder (Hedley, Hoffart & Sexton, 2001), and a significant endorsement of vulnerability, negativity and social isolation with obsessive-compulsive disorder (Atalay, Atalay, Karahan & Çaliskan, 2008). In relation to depression however inconsistent results have been obtained whereby Halverson et al., (2009) identified vulnerability as the main correlating factor for those who were presenting with or had a risk of depression. Nevertheless investigations on a clinical sample observed significantly higher levels of insufficient self–control and abandonment EMS (Welburn, Coristine, Dagg, Pontefract, & Jordon, 2002). Whilst some evidence is beginning to emerge regarding EMS and mental illness, this is still in its infancy. The most notable EMS that appears to keep recurring is that of vulnerability to harm, however even in the small range of research that has been conducted, inconsistencies are still present, suggesting further knowledge is required. Interestingly little has been obtained regarding EMS

associations with diagnoses that involve psychotic features. Upon review of literature, no larger scale studies have been conducted in this field with case studies being the main source of information. Owing to this further investigations would need to be conducted in order to develop a greater understanding of EMS in relation to Axis I disorders as a whole. In addition, it is acknowledged that within the above studies reviewed, research was undertaken with participants from outpatient services so caution would be required if applying to inpatients or those within forensic services. This needs to be considered due to the increasing complexity of cases with greater attention needed with regards to risk, as EMS could be influential in the development or presentation of such problems that require differing levels of service input. Associations between EMS and risk have started to be explored and is highlighted in more detail below.

Schema Theory and Links with Risk

To date, there is a small pool of research that has been undertaken with a focus drawn to EMS identification and risk. This appears far from exhaustive, but starts to highlight potential modulating factors.

Risk to Self. Harm to self is a particular concern within mental health and forensic services (Singleton, Meltzer, Gatward, Coid & Deasy, 1998) with clinical teams and care staff trying to ensure a sense of safety. Despite this the underlying cognitive constructs may not always be fully appreciated, with greater focus being drawn to behaviour (Castille, Prout, Marczyk, Shmidheiser, Yoder & Howlett, 2007). Investigations using both male and female samples have begun to demonstrate that identified EMS are able to differentiate between suicidal and non-suicidal individuals within clinical populations (Dale, Power, Kane, Stewart & Murray, 2010). Similar

differential capabilities were noted between those who self-harm and those who do not; with the four influential EMS being those of emotional deprivation, mistrust/ abuse, insufficient self-control and social isolation. Social isolation was also found to become more highly endorsed in correlation to a greater frequency of self-harming incidents (Castille et al., 2007).

Risk to Others. With regard to those who display aggression and hostile behaviours, heightened responses for defectiveness, abandonment and mistrust were discovered by Messman-Moore and Coates (2008), however Tremblay and Dozois, (2009) found schemas of entitlement, mistrust, and insufficient self-control to be the greatest distinguishing factors. Whilst in both studies the construct of mistrust was acknowledged, no other common factors are noted.

Research has also begun to look at associations between sexual offending and EMS that are present. Heightened responses on social isolation, mistrust and emotional inhibition were observed within the offending group. Nuances were also identified in schemas endorsed between those who particularly offended against young children (below the age of 10), against adolescents of a similar age or female adults (Richardson, 2005). Further exploration regarding this would be of benefit however as sexual offending behaviour can be extremely diverse and likely to vary enormously.

Summary of EMS and Links with Risk. Within the research conducted so far, there are initial conclusions drawn within individual research studies regarding links with risk, however a substantiative evidence base for any risk related behaviour is not yet established and variations in outcomes are apparent. In addition it is noted that both risk to self and others are highlighting similar EMS frameworks as distinguishing factors which indicates the added complexity of whether the same EMS function

differently at the times they are triggered. Taking this into account it would be necessary to have a greater understanding regarding this if considering EMS or modes are potential aspects in which to work with when considering risk of harm.

One further aspect regarding risk that requires attention is that of gender differences in relation to patterns of presentation and type of incidents documented. It is recognized that there appears to be a greater tendency for self-harm (Bird & Faulkner, 2000) fire setting or to indirectly express their anger or upset in a passive-aggressive manner (Coida, Kahtanb, Gaultc & Jarmand, 2000) amongst women than there is for men. Therefore distinguishing between different types of risk related behaviour and the underlying processes would be of importance within clinical practice to inform treatment targets. With this variability in mind it would also indicate the necessity to ensure theoretical understanding is applicable for presenting problems and not just based on a generic understanding of risk.

Integration of Theories

Upon considering risk related behaviours and how this may be influenced by EMS (as noted above), a number of other theoretical models seem to be implicated. From a biological perspective it appears that the mere presence of EMS would be associated with uncomfortable emotions which is likely to stimulate the amygdala within the brain and trigger the threat system. When under threat or stress, cognitive processes can become hindered and default responses such as fight, flight or freeze can often be used to help maintain safety (Lee & James, 2012). For example, if the EMS of mistrust becomes overwhelming a behavioural response of fight could implicate violent offending. In order to work effectively with patients the importance of the therapeutic relationship seems key to help develop an environment where they

feel comfortable and safe. Aspects such as choice of clinician can be relevant to help develop a non-threatening environment as the mere presence of a male or female could trigger a sense of uneasiness; however this would depend upon the patient's life experiences. If the therapeutic environment enables the threat system to become less active, the hippocampus and pre-frontal cortex will have the opportunity to become more engaged and enable a greater chance to enhance emotion regulation and adaptive cognitive functioning (LeDoux, 1996).

Considering the threat system and the stressors that people face, Strain Theory also indicates how this can have a profound effect on people's emotional responses. It is thought that if an increasing amount of anger builds then this can be a significant factor in leading to criminal behaviour (Agnew & Passes, 1997). When looking at gender differences within criminal statistics much lower levels of offending are documented for females. Therefore if this theory was correct it would be expected that females experience much lower levels of strain. Contrary to this, women potentially have a greater amount of social stress placed upon them, with expectations of taking on caring roles within families and relationships, being vulnerable toward exploitation and abuse and the need to conform. This raises questions regarding whether the type of strain, underlying cognitions about them and the emotional responses act as a preventative measure for female crime or impact on other risk related behaviours (i.e. self-harm) (Broidy & Agnew,1997). Having more information on EMS, the associated links with certain stressors and related behaviours could provide insight regarding female related risk.

One further theory of interest is attachment theory. This is important considering that EMS can often impact upon relationships and interactions with others. The main aim of schema based therapies is to develop healthy adult responses.

This would seem to correspond with secure attachment styles whereby the individual is able to form and maintain relationships. If a person is able to develop secure attachments and respond in a healthy adult manner, difficulties or separations that occur would be acknowledged, although they would demonstrate an ability to adapt and respond in an understanding manner, assured that they will return. When in the presence of the significant other person a feeling of safety and security would be experienced, maintaining a degree of proximity although they would have the ability to remain independent (Ainsworth and Bell, 1970; Bowlby, 1969; Young et al., 2003). Such characteristics of secure attachments and healthy adult responses can be considered as treatment goals within therapeutic practice. Other schema modes that have been identified may also correspond with different attachment styles (i.e. avoidant and ambivalent), however, further exploration of EMS and schema modes in relation to female offenders or female forensic mental health patients would be of benefit to be able to expand on this. To help gain an understanding of how such aspects may be explored within clinical practice, an overview of schema assessment and therapy is provided.

Schema Assessment and Therapy

The theoretical model that underpins schema therapy has been established over the last two decades. This was born out of recognizing strengths in existing therapies yet identifying common shortfalls in patient engagement with the process itself or difficulties in reaching desired goals (Young et al., 2003). Due to this the schema therapy is an amalgamation of existing concepts drawn from other therapeutic models with additional frames of reference i.e. EMS and schema modes, to make sense of people's experiences.

Assessment. In order to determine maladaptive life patterns an assortment of techniques are available which help aid formulation. This may include gathering a patient's life history. Historical information can help identify important development influences and provide an indication of social attachments. The use of experiential techniques such as imagery and observations made within therapeutic interactions are also used as a way to gather further information. A more structured approach entails the use of questionnaires (Young et al., 2003). Whilst there are a number of assessments' available (for EMS, modes, coping responses and parental schemas) in order to support in the gathering of information, the most commonly used helps identify EMS themselves (Young & Brown, 2003). Different variations of this questionnaire that have begun to be used within research literature are discussed in detail in Chapter Two.

Therapeutic Practice. Due to the integration of several theoretical concepts within the development of this model, session structure and practice may also be observed to have an eclectic mix of methodologies. This varies from enhancing knowledge base and understanding via intellectual methods (i.e., data logs, historical review, and flashcards) to more experiential practices (i.e. historical role plays, image restructuring, and chair techniques) which are considered to evoke more emotionally meaningful responses and changes within the individual (Young et al., 2003). For any one patient it is accepted that a focus may be drawn to the notion of EMS or modes. Alternatively an integration of the two can be considered to be of benefit depending on the complexity of the case and the individual's/ patient's ability to grasp the concepts. Therapy can be delivered on a one to one or group basis. In either instance the therapeutic relationship is key, recognising the importance of being able to challenge maladaptive thought processes and reinforcing behaviours in an empathic

manner, allowing the patient to learn appropriate boundaries through limited re-parenting (Beckley, 2007). For this reason, the need for a feeling of safety and reduced threat is necessary to allow patients' the opportunity to work with such re-parenting techniques rather than becoming immediately defensive, creating barriers to effective change. A systematic review in Chapter Three provides an overall evaluation of therapeutic practice and methods of delivery. In summary however, it is recognized that difficulties may arise when using the schema model within treatment due to the complexity of the processes and language used. For patients with intellectual difficulties this could be overwhelming. Nevertheless, due to the differing methods and ways in which schema based therapies can be implemented (i.e. one-to-one or groups, focus on EMS or modes), this makes schema therapy a potentially flexible model to work with.

Aim of Thesis

Owing to the relatively new existence of the schema model as compared to other psychological theories, this thesis sets out to explore current application and practice, whilst identifying the benefits of its utility. As it is being increasingly used within forensic as well as clinical settings the overall aim was to help improve upon the depth of understanding available when it comes to relevance within female forensic services; thus being able to inform practice, and ensure suitability. Difficulty would ensue however with current theory primarily being developed on general psychiatric populations, with an emphasis being drawn to females with borderline personality disorder, or forensic males. Therefore further exploration is necessary following the Department of Health's (2002) guidance indicating psychological practice should be tailored and evidence based for the population it is being applied to, rather than

assumptions being made about its generalizability. It is acknowledged that differing populations (i.e. based on gender, mental disorder or risk) may have different needs or implicate alternative confounding factors that require particular attention.

Regarding this initial introductory chapter an overview of the theoretical concepts of schema theory has been provided alongside an outline of how developments have been made to get to today's understanding of EMS and modes. This historical context, awareness of current use and application of these constructs are necessary to keep in mind throughout as it will provide the basic framework for the following chapters. In summary the terms of reference are as follows:

- *Schema*- Patterns of thinking that develop about people, places, or objects.
- *Early Maladaptive Schema (EMS*)- Broad, pervasive thinking patterns regarding oneself and one's relationship with others, which are dysfunctional in nature.
- *Schema Modes*- Moment-to-moment emotional states and coping responses.
- *Schema Therapy*- The process of treatment provided for patients which brings a focus to EMS and/or schema modes to help facilitate change and encourage the development of healthy adult responses.

Chapter Two evaluates the psychometric properties of the Young Schema Questionnaire (Young & Brown, 1990); being one of the primary assessment tools used in determining the presence of maladaptive patterns of thought as determined by Young. As such the original assessment is looked at in detail to review its strengths and limitations, whilst recognizing adaptations that have been made thereafter. This is considered of importance taking into account it is often used to help gather

information within research or clinical practice, whereby it would need to be ensured that outcomes are reliable and valid.

Chapter Three brings a focus to the therapeutic side of Young's schema model. Within this a systematic review captures the different populations schema therapy has been used with to-date and highlights what the focus of treatment has been. A review of its effectiveness is also addressed helping identify supportive evidence for areas of strength whilst indicating circumstances where it may not have been so fruitful in effecting change, thereby requiring caution.

Chapter Four gives rise to a qualitative research piece that centres on how EMS function within females detained in secure services. This was considered necessary due to the lack of literature within this area. The purpose was to gain a greater understanding as to how schema theory may be applied to this population thereby helping inform practice and ensure its suitability.

Finally, the concluding chapter provides an overview of the key points raised throughout this investigation and a review of the literature offering practical recommendations for clinical practice.

CHAPTER TWO:

CRITIQUE AND USE OF PSYCHOMETRIC ASSESSMENTS:

THE YOUNG SCHEMA QUESTIONNAIRE

Introduction

As discussed in chapter one it is observed that recurrent themes within thoughts, feelings and beliefs occur regarding self, surroundings and interactions with others. Perceptions that develop are often brought about by an interplay between genetic predispositions and life experiences in order to help make sense of the world (Young, 1994). In 1990 Young began to identify a number of recurrent cognitions that appeared to create difficulties for those that held them (please see Appendix A for details). On identifying these they were termed early maladaptive schemas (EMS) and attempts were made to develop a standardised measure which would identify these underlying concepts. Owing to this the Young Schema Questionnaire (YSQ; Young & Brown, 1990) was developed. Considering the increasing use of the assessment this chapter will focus on its psychometric properties in order to explore its potential value and limitations to practice and academia.

Overview of the Tool

The original YSQ (Young & Brown, 1990) is a 205 item self-report measure that posed questions to elicit the presence of EMS held. Clinical practice formed the basis of its development whereby it was proposed 16 EMS existed within 6 higher order domains (Welburn, Coristine, Dagg, Pontefract & Jordan, 2002; Young, 1994). For each EMS a number of questions regarding particular thoughts, feelings and beliefs are asked which are considered to represent the EMS of interest. Undertaking the

measure individuals are required to state to what degree each statement represents them using a Likert scale from 1 to 6 where 1 represents 'completely untrue of me' and 6 represents 'describes me perfectly' (Young & Brown 1990).

Regarding interpretation it is suggested that only items scored at higher levels should be taken into account (i.e., 5's or 6's) as this would indicate statements of greater significance to the person completing it. The numbers gathered can then be summed to provide an overall score for each EMS. Due to EMS being represented by a varying number of items, yielding a percentage provides a more representative picture of the EMS endorsed and which ones are of greater significance to the individual. Whilst no manual has been published for the YSQ (Young & Brown, 1990), guidance on scoring is provided within related publications such as Young's 1990 'Cognitive therapy for personality disorders: A schema-focused approach' and scoring grids are available to help interpretation.

Since the questionnaire's initial development revisions have been made (e.g., YSQ-L 2nd ed; Young & Brown, 1994 & YSQ-L3a; Young & Brown, 2003). Alterations have involved additional questions to represent two extra EMS (please see Appendix B for EMS alterations), slight modifications to wording and for interpretation to include items response scores at 4, 5 and 6 (Young et al., 2003). Whilst the premise of the questionnaires' are the same they have been altered in response to reviews of the original measure, however, little exploration of psychometric properties has taken place following revisions made, particularly with YSQ-L3a (Young & Brown, 2003). Although it could be assumed that the assessment measure has been improved, further investigations would be required in order to evidence this, ensuring its reliability and validity.

Aside from revisions made to the YSQ (Young & Brown, 1990), alternative inventories have been developed to identify the presence of EMS. Such measures include the Young Schema Questionnaire- Short Form (YSQ-S; Young & Brown, 1999) which is a shortened version of the original YSQ (Young & Brown, 1990) and the Early Maladaptive Schema Questionnaire-Research Version (EMSQ-R; Ball & Young, 1999). The research version was established in an effort to facilitate ease of use for individuals with lower intellectual functioning by rewording questions and altering the rating scale. Both measures noted are 75 items in length enabling quicker completion than the YSQ. Despite alternatives available this review is focused on the long form due to its greater use within clinical practice and research.

Application of the Tool

The YSQ (Young & Brown, 1990; Young & Brown, 1994; Young & Brown, 2003) is a measure that has started to gain increasing interest within research. Whilst it has primarily been used to look at clinical populations and mental health issues it has also been utilised to look at EMS influence on career choices (Bamber & McMahon, 2008), war veterans (Cockram, Drummond & Lee, 2010), physical health (Saariaho, Saariaho, Karila & Joukamaa, 2011), and substance misuse (Ball, 1998). To gather such information, administration has taken place with students at university or within inpatient and outpatient settings at clinics, community support bases and hospitals. Due to growing evidence regarding links between mental health and EMS endorsement and the acknowledgment of clinical diagnoses amongst forensic populations (Nauth, 1995; National Institute for Mental Health in England, 2003) a small number of studies have taken place within secure units and prisons (i.e., Loper,

2003). On review it would appear that this is starting to gather greater interest at present (Bernstein et al., 2007).

Owing to its increasing popularity the questionnaire was translated from English to Dutch, Finnish, Korean, French, Turkish and Spanish. This enabled increasing use on an international basis, allowing for cross referencing and appropriate norms to be gathered, ultimately facilitating interpretation in other cultural settings (Fairbanks, 2004).

Aside from research, application has also started to increase amongst clinicians as it begins to identify specific targets for treatment. The benefits of applying this is that it allows for belief systems more specific to the individual to be recognised rather than purely going from a generic diagnosis (Oei & Baranoff, 2007). Additionally it can ensure parallel behaviours associated with risk can remain within focus throughout all stages of intervention (Beckley & Gordon, 2010). Support for understanding schema focused therapy (SFT), schema assessment and ideas for change thereafter can be sought within at least 10 books or book chapters (i.e., Arntz, Genderen & Drost 2011; Young, 1999; Young et al., 2003) and numerous journal articles.

Psychometric Properties

To identify whether a psychological measure is useful, appropriate and ultimately a beneficial assessment Kline (1986) suggests it is necessary for the level of measurement to be at least interval scale, meaning that outcomes can be ordered in a meaningful way, and that the differences between each outcome are measurable. Furthermore the questionnaire should be reliable, valid, discriminating; and have appropriate norms. Each of these aspects will be considered in turn to facilitate

evaluation of the YSQ (Young & Brown, 1990; Young & Brown, 1994; Young & Brown, 2003).

Levels of Measurement. Using a Likert scale the YSQ allows for structural ordering of answers along a continuum. Although a degree of ambiguity is involved in the distances between each scaled point considering the abstract nature of the construct, overall the scores provide a representation of equal distances (Hogan, 2003). Despite this there is no true zero therefore the level of measurement used is at interval level. Due to this, it enables the use of parametric testing if data collected also complies with additional parametric assumptions. Such assumptions include sample data being homogenous between groups and that they are normally distributed with independent observations having been made. The benefit of this is the accuracy of outcomes gained despite small violations in data allowing for a high degree of precision within interpretation (Clarke-Carter, 2010). It is considered that with the YSQ using a scale of 1 to 6 this also allows for precision in interpretation, provides a greater range of responses and could aid discrimination between differing populations, although a scale of 1 to 3 may have been sufficient.

Reliability. To allow comparisons to be made between different points in time or different people, a level of stability and consistency is required enabling clinicians or researchers to rely on the outcomes gained. Exploration of this is undertaken through looking at levels of internal consistency and test-retest reliability (Hogan, 2003) as indicated below.

Internal Consistency. Upon investigation of the questionnaire through varying samples it appears an adequate to high level of internal consistency is demonstrated. This is assessed by correlating individual items within a measure to the whole measure to gain a numeric score called Cronbach's alpha coefficient and indicates

whether the same constructs are being assessed. Outcomes closer to +1 indicate greater levels of internal consistency (Dornyei &Taguchi, 2010), with a minimum level of .70 being suggested to indicate its adequacy. Whilst alpha levels above this demonstrate stability in the way factors are being assessed within the measure, additional information is necessary to indicate what the concepts being measured are (Hogan, 2003).

In Schmidt, Joiner, Young and Telch's (1995) original study an average alpha coefficient of .90 was gained across a student sample. Of interest, this level was supported through use of the questionnaire within a Dutch sample whereby the level of minimum consistency (.70; Nunnanlly & Bernstein, 1994) was surpassed across all dimensions, within both clinical and non-clinical samples. It is acknowledged however that overall the greatest level of internal reliability was demonstrated within clinical samples (Rijkeboer & Bergh, 2006). ***Test-Retest Reliability.*** A further method of ensuring good psychometric properties of a measure involves its constancy across time. Whilst this measure accounts for stability between different raters' by having an objective structure to scoring and interpretation, test-retest reliability for participants providing responses required further consideration. This can be explored by participants completing the measure on different occasions ensuring the same outcomes are elicited considering no life changes or intervention have occurred in between (Miller, McIntyre & Lovler, 2011).

From investigations by Schmidt et al., (1995) test-retest reliability coefficients between .50–.82 were generated with an average coefficient of .76. If taking into account the average coefficient, the test would be considered to have satisfactory stability going by a minimum value of .70. Guilford (1956) postulates this as a requirement due to its overall impact on standard error rate. With the range of values

obtained however the variation may be of concern as it greatly reduces the potential to be certain of outcomes acquired. Of note this analysis was undertaken with only 12 factors of the YSQ (Young & Brown, 1990) with a student sample. Therefore greater replication would be required to ensure test-retest reliability applies to other populations (Schmidt et al., 1995). Despite this, no further studies regarding test-retest reliability have been identified thereafter.

Validity. When utilising a psychometric questionnaire for any specific reason it is necessary to ensure it assesses the constructs it reports to measure if it is to be worthwhile. This concept represents the validity of a measure and contributes to the accuracy within interpretations made thereafter (Hogan, 2003). To fully understand the extent of validity a number of aspects need to be taken into consideration and are explored below.

Face Validity. Upon review of the assessment the questions asked appear to make theoretical sense in relation to the EMS definitions provided. Nevertheless, the questions are particularly transparent, therefore creating greater opportunity for participants to project skewed or biased responses (Lee et al., 1999). Despite this there is little reported to indicate whether items have been assessed by varying expert panels or systematically reviewed to gather information on whether others consider that the test looks sound, taking into account what it is trying to measure. What has been undertaken however are a number of empirical studies which enable further aspects of validity to be explored.

Content Validity. In order to ensure the validity of item content, it is necessary to take into account all possible questions that could be asked for each construct and the array of responses that each item could yield. This would ensure that what is being asked is representative of the subject in question (Hogan, 2003). Due to the nature of

EMS being an abstract concept this has the potential to create difficulty in ensuring all content is there. Similarly to face validity analyses, experts in the field could help indicate what items to include and whether they are relevant using a numerical approach for judging questionnaire items. Whilst it is reported that the development of the YSQ was undertaken by Young (1990), and a number of other experts (i.e., Schmidt et al., 1995) little information is provided on the specifics of this. Despite statistical analyses that have taken place thereafter, no further additional items are recommended to be included in the questionnaire. Nevertheless, no other studies are reported whereby the specific content of items have been assessed, which could be problematic if key question items are missed.

Criterion Validity. For criterion validity to be demonstrated a close relationship between questionnaire outcomes and a known criterion would be evidenced. This can be assessed in two ways. First, to gain an understanding of whether the YSQ is assessing the constructs intended at the present time it would be beneficial to compare outcomes against a test measuring the same concepts (concurrent validity) (Hogan, 2003). To date however there does not appear to be an equivalent measure whereby this can be analysed. The only other measure of note is the short form version which was developed at a later date by Young and Brown (1999). Investigations into this have started to demonstrate similar psychometric properties (Fairbanks, 2004), however this is to be expected considering the basis for its development was the original YSQ (Young & Brown, 1990).

Secondly, we can assess the relationship between outcomes on the assessment now and some future criterion (predictive validity) (Kline, 1986). In order to ascertain predictive validity Rijkeboer, Bergh and Bout (2005) purport that equivalent split halves of the questionnaire have the capacity to highlight whether someone has

mental health issues or not therefore could potentially be used as a predictive tool. Additionally a review of investigations (Halverson, 2009; Hedley et al., 2001; Nordahl et al., 2005; Welburn et al., 2002) carried out on the YSQ (Young & Brown, 1990) reflected how particular EMS have the potential to predict specific diagnoses. An example given indicates how depression appears highly related to 'defectiveness', 'insufficient self-control', 'social isolation' and 'failure' EMS (Oei & Baranoff, 2007). Considering the definition for predictive validity however it would seem that this has not been thoroughly investigated and that reports on the questionnaire's predictive power relate more to its ability to discriminate. To investigate the questionnaire's ability to predict future outcomes there would be scope to follow up samples of university students assessed taking into account the presence of psychopathology.

Construct Validity. Construct validity refers to whether an assessment measures what it is intended to measure. To evaluate this it is necessary to take into account whether items gauging the same construct are connected (convergent validity) and that those assessing differing constructs are unrelated or show low levels of association (discriminant validity) (Hogan, 2003).

As previously noted the foundations for assessment were initially based on observations and information gathered through clinical experience, whereby 16 distinct factors (EMS) were highlighted amongst 5 broad domains. Taking this into account it has been necessary for investigations to take place ensuring questions devised to measure EMS were eliciting the same thing and determine the relationships between items. In 1995 statistical reviews regarding factor structure were undertaken for the first time by Schmidt et al., (1995) with clinical and non-clinical samples in the USA. For those with mental health difficulties outcomes reflected 15 of the initial

EMS, whilst only 12 were replicated within the non-clinical sample. Considering higher order domains the 5 factors noted were condensed into 3 pertaining to 'disconnection', 'over-connection' and 'exaggerated standards' (Schmidt et al., 1995). Limitations to this study include the number of participants and the alterations made to the questionnaire prior to assessing it whereby twelve questions were extracted. Due to this further investigation was required.

In a study conducted in Australia with mental health patients (both inpatient and outpatient) 14 factors of the original 16 emerged. Overall it was demonstrated that each question was highly associated with one particular factor with a mean item loading of .60 (range from .53 to .77) (Lee et al., 1999). Please note that factors tend to be rated from 0 to 1, with values closer to 1 representing a closer relationship (Hogan, 2003). Regarding the 14 EMS identified, it is recognised that these match those acknowledged through Schmidt et al's., (1995) investigation with the clinical sample. On reflection of both studies the 'social undesirability' EMS failed to be identified as a distinct factor however a large proportion of the items were not redundant as they appeared to represent the 'failure' schema. From the latter study conducted by Lee at al., (1999) two new related, yet distinct, EMS were indicated that were drawn from the original 'emotional inhibition' factor. Such EMS were termed 'emotional constriction' and 'fear of loss of control'. Regarding the broader domains, three were highlighted (impaired autonomy, disconnection and impaired limits) comparable to Schmidt et al's, (1995) demonstrating close relations with more well defined theories of mental health (Lee et al., 1999).

Considering the level of consistency across two studies in different countries not only provides support for construct validity but also provides further evidence towards internal consistency (Lee et al., 1999). Nevertheless, both investigations

undertaken utilised exploratory factor analyses, restricting the certainty with which outcomes could be assumed limiting the depth of investigation (Hoffart, Sexton & Hendley, 2006).

Upon translation of the assessment, a factor analysis was undertaken within a Dutch population between clinical and student samples. This investigation provided evidence towards all 16 EMS being present as distinct factors within both samples using confirmatory methods (Rijkeboer & Bergh, 2006) which checks to see whether data fits with existing theory (Kline, 2010). It is considered that improved outcomes from this study, as compared to others, may be due to differing analyses used and the randomisation of items throughout the questionnaire (McFarland, Ryan & Ellis, 2002).

Within the Dutch population item bias was also explored. This is an evaluation of whether questions generate the same or different responses from individuals within the same representative group. If a questionnaire is to be considered to have high construct validity a consistency should be demonstrated within identified samples. On review there appeared to be consistent response patterns across all items for gender. This was similar for educational levels with the exception of one item. Additionally, item bias was only detected amongst ten questions throughout the measure for those with or without mental health diagnoses. Of note was that any one factor only had up to two item biases. The outcomes of this provide support for the questionnaire's construct validity and indicates that the wording of questions does not require alteration for those with poorer educational backgrounds (Rijkeboer et al., 2011).

Whilst the factor structure of the YSQ (Young & Brown, 1990; Young & Brown, 1994) appears to be supported, minimal research has been conducted on the psychometric properties for the YSQ-L3a (Young & Brown, 2003). Within this,

schemas of ‘punitiveness’ and ‘approval seeking’ have been added and slight alterations have been made within the descriptions of higher order domains. Due to this, such factors have not been fully explored and require further investigation.

Discriminatory Power. Discriminatory power is the potential for a measure to distinguish between varying degrees of wellbeing and is a principal factor required to demonstrate good psychometric properties (Janssen, Birnie, & Bonsel, 2007).

Schmidt et al’s., (1995) study evidenced that EMS contribute to a large percentage of psychological impairment with constructs of ‘dependence’ and ‘defectiveness’ being highly associated with depression, and ‘vulnerability to harm’ often indicating symptoms of anxiety. To increase confidence levels of such outcomes the confidence interval was altered to .0014 in line with Bonferroni correction instead of the typical p value of .05 (Schmidt et al., 1995). On reflection, the tendency for depression to be identified with higher levels of ‘dependency’ and ‘defectiveness’ correspond with more well established theoretical models of depression (Abramson, Metalsky & Alloy, 1989; Arieti & Bemporad, 1980; Beck, 1983), while feelings of ‘vulnerability’ appear congruent with additional models of anxiety (Beck & Emery, 1985).

When considering the discriminatory power for Axis II disorders Jovev and Jackson (2004) identified significantly higher ratings on ‘unrelenting standards’ for those with obsessive compulsive personality disorder. In an alternative study a cluster of EMS such as ‘mistrust’, ‘emotional inhibition’ and ‘vulnerability to harm’ were identified amongst antisocial personality disorder patients (Ball & Cecero, 2001). Considering diagnostic criterion within the Diagnostic and Statistical Manual fourth edition (DSM-IV; American Psychiatric Association (APA), 1994) it seems surprising that insufficient self-control or entitlement were not highlighted. Whilst limited

studies have been conducted for the aforementioned personality disorders, greater interest has been demonstrated in relation to avoidant and borderline personality disorders. For individuals with avoidant personality disorder, 'emotional inhibition' (Jovev & Jackson, 2004) or 'subjugation' (Ball & Cecero, 2001) EMS have been significant distinguishing factors. Alternatively the 'abandonment' EMS has been highlighted in two studies for borderline personality disorder (Jovev & Jackson, 2004; Ball & Cecero, 2001) however there is then a discrepancy between 'mistrust', 'dependence' and 'defectiveness' as each of these have been identified but have not been consistent in their representation.

Upon broader review of symptomology, Lee et al., (1999) discovered significantly larger average scores on the majority of EMS for Axis-II disorders as compared to Axis-I diagnoses (APA, 1994). Rijkeboer and Bergh, (2006) also evidenced a significant difference between clinical and non-clinical samples within a Dutch population for all EMS, this being based upon corrected p values taking into account Bonferroni correction of $p<.003$. Findings seem to indicate good discriminative power of the YSQ (Young & Brown, 1990) between psychiatric disorders and non-clinical comparison groups, with Axis II diagnoses in particular having the highest rated averages. Although these results are promising, more research is desirable to provide greater clarity and a more robust evidence base.

Overall, the outcomes of analysis suggest a continuum between clinical and non-clinical samples (Schmidt et al., 1995) and evidences the capacity of YSQ (Young & Brown, 1990) to discriminate amongst differing disorders. Nevertheless some discrepancies are evident and additional investigations are required to determine more precise patterns for psychopathology.

Normative Data. From an individual's raw score alone it can be difficult to determine what it represents and how this compares to others. With data norms it would allow an individual's responses to be put into context in relation to the relevant population (Hogan, 2003).

From research conducted it has been highlighted that a level of discrimination regarding mean scores has been observed between clinical and non-clinical samples (e.g., Lee et al., 1999; Schmidt et al., 1995). Despite the collection of data and the initial discriminative power, comprehensive normative data for differing populations has not been published. Information pertaining to British residents is restricted to statistics gathered from small sample numbers with a heavy reliance on females with eating disorders (Stopa, Thorne, Waters & Preston, 2001; Waller, Leung & Thomas, 1999; Waller, Ohanian, Meyer & Osman, 2000; Waller, Meyer, & Ohanian, 2001). Consequently larger scale studies are required to help generate such data regarding varying nationalities, gender, clinical, non-clinical and offender populations.

Additional Critique. Owing to the psychometric requiring self-report by the individual being assessed it raises concerns about the openness and honesty of responses gained. This is highlighted considering the nature of questions having the potential to be highly emotive and being explicit in what they are asking. Due to this it could moderate outcomes if wishing to avoid such thought processes or if there is a lack of insight into problems faced (Lee et al., 1999). Alternatively there may be individuals who wish to portray higher levels of distress than they actually are actually experiencing if considering this would serve a particular purpose (i.e., gain further support) (Fairbanks, 2004). In order to minimise the risk of self-report biases queries have been raised regarding the potential to utilise information processing methods to gain a more accurate representation of EMS present. Preliminary

investigations started to address this via Stroop tasks whereby participants were asked to recall the colour that a word was presented in (target word) followed by stating a prime word that had also been shown. Naming of the colour was significantly influenced by whether the words (both prime and target words) were personally meaningful or not and began to provide evidence for investigations to utilise this method (Segal & Vella, 1990). Such methods may also help to reduce the complexity of questions diminishing any limitations there may be for individuals with lower intellectual functioning.

Regarding item placement it is noted that all items for each EMS are clustered together almost representing differing categories. This may have the potential to frustrate participants if considering they are being repeatedly asked the same or similar questions and limit motivation to continue (Stone, Stone & Gueutal, 1990). Additionally it would appear the measure both starts and ends with particularly emotive questions. This could prevent individuals from wanting to complete the questionnaire once they have started or leave the participant within a high state of arousal. Whilst a large proportion of items are likely to be sensitive, some items may be less stimulating than others. Rijkeboer and Bergh (2006) and McFarland, Ryan and Ellis (2002) recognise the potential benefits of item placement being randomised in order to help with this and improve psychometric properties.

All revisions of the YSQ (Young & Brown, 1990; Young & Brown, 1994; Young & Brown, 2003) use a classical response approach assuming all items indicate the same level of significance (Hogan, 2003). Taking into account which questions might be more difficult or meaningful in terms of the construct measured, may enable an item response approach to be undertaken whereby factor loadings of items may

help provide a more graded response. This may be beneficial to counteract any central tendency bias or social desirability efforts.

With the YSQ having 205 items, the time it takes to undertake can be lengthy. No administration time guidance is provided, although this is frequently in excess of 30 minutes. Whilst this makes efforts to increase the likelihood of capturing subtle nuances, it could hinder motivation to complete it (Fairbanks, 2004). From the high level of internal consistency demonstrated (i.e., Schmidt et al., 1995) and through exploration of the factor structure through Rijkeboer and Bergh's (2006) study there appears to be potential for the measure to be parted into two identical halves regarding psychometric properties. What this would enable is a questionnaire much shorter in length, whilst also providing a secondary questionnaire that could be administered at a later date to assess change. As the questions would not be replicated, yet still measure the same factors, this could reduce bias and learning effects (Rijkeboer & Bergh, 2006). Despite participant responses and methods of application, the YSQ is standardised ensuring it is objective regarding interpretations made and allows for ease of communication between professionals.

Conclusions

In summary it would appear the assessment in question has adequate psychometric properties according to Kline's (1986) criteria. Of particular interest has been the evaluation of validity considering the abstract nature of the concepts highlighted. Whilst some ambiguities still remain and further evaluation of revised versions are required, a degree of support has been gained internationally for its construction and ability to discriminate between differing psychopathologies, thereby indicating its potential use. Considering the responsiveness of the assessment it appears to be

consistent with its intended field of application whereby theoretical constructs are supported (Beck 1983; Beck & Emery, 1985). What still remains to be discovered is the capacity for the YSQ to be utilised for prediction enabling early intervention to take place within clinical practice.

Additional psychometric investigations have also yielded support for adequate psychometric properties regarding levels of test-retest reliability and internal consistency (Schmidt et al., 1995; Lee et al., 1999), thereby allowing for clinicians and researchers to be confident of results obtained. Despite this, practical issues persist taking into account the large number of items included (Fairbanks, 2004).

Recommendations

On review of information gathered it has highlighted that the YSQ is a measure that has the foundations to be useful both within research fields and clinical practice. From data gathered however, it appears that there is potential to develop and use the YSQ to enhance its effectiveness and reduce bias. This may include randomising the placement of items so that it is not asking about the same concept several times in a row. Split halves of the questionnaire have also been shown to demonstrate the same psychometric properties throughout therefore using each one as a pre and post measure could ensure that the same questions are not asked at each stage, which would reduce the opportunity for learning effects and make the questionnaire completion time shorter to limit fatigue. Additionally, there have been suggestions about altering the YSQ format to a stroop task to make the questionnaire less complex and minimise self-report biases.

Aside from adaptations that could be made, reviews are required to ensure psychometric properties are adequate within the most recent revised version (YSQ-

L3a; Young & Brown, 2003) ensuring new constructs are valid. A particular area for additional research would be with regards to larger scale studies to gather appropriate normative data for differing populations. This would be of great interest with offender populations considering the increasing use of SFT and assessment within rehabilitative secure settings (Fairbanks, 2004).

CHAPTER THREE: SYSTEMATIC LITERATURE REVIEW

EVALUATION OF SCHEMA THERAPY: APPLICATION AND EFFECTIVENESS

Abstract

Aim. The current systematic review aimed to evaluate the effectiveness of schema focused therapy (SFT) on clinical populations. No particular diagnoses or psychopathologies were specified.

Method. A scoping exercise was undertaken to evaluate the need for the current review. Due to the limited quality of existing review literature a systematic approach to obtaining information was employed. To facilitate this, Inclusion/Exclusion criteria and quality assessment methods were applied, the content of which were defined following reflection of the scoping exercise whereby existing reviews and methods were assessed. Data extracted was then synthesised in a qualitative format guided by the varying nature of outcome measures and statistical analyses applied.

Results. Seventeen studies were included in the review. Preliminary support was gained for the effectiveness of SFT targeting personality disorder, post-traumatic stress disorder, substance misuse, eating disorders and agoraphobia. One study evidenced no change during the schema focused phase of therapy when targeting conviction in delusional beliefs.

Conclusions. Findings suggest that SFT may be applied focusing on early maladaptive schema or utilising schema modes. Additionally, there currently seems no discrepancy regarding therapeutic setting or mode of delivery. The effectiveness of therapy appears more dependent on patient population with potential limitations with

psychosis. The complex nature of research and methodological implications are discussed alongside suggestions for future research.

Keywords: Schema-focused therapy; Schema-mode therapy; Clinical population; Psychopathology; Adults.

Introduction

Current clinical practice supports that there exists a range of psychotherapies available for psychological symptom complaints. Whilst methods vary in terms of the focus of treatment and the way in which they address the problem at hand, the main purpose is to alleviate or enhance the management of symptoms (Meichenbaum, 1997). Although reviews have evidenced the effectiveness of therapy on numerous disorders (Seligman, 1995), greater difficulties are apparent when targeting pervasive psychopathologies sometimes creating the impression that symptoms are treatment resistant (Young et al., 2003).

Limitations to Therapeutic Interventions. Within the United Kingdom (UK), the National Institute for Health and Clinical Excellence (2008) highlights cognitive behavioural therapy (CBT) as the recommended treatment for a variety of mental health issues and psychological symptom complaints. As it is often considered the treatment of choice, CBT appears to be widely used amongst clinical populations. A number of problem areas have been demonstrated however, regarding the assumptions needed for it to be effective. For example; it requires individuals to already be contemplative about the wish to change. However, people are often ambivalent in their motivations, feel they do not wish to change or perceive themselves to be incapable of change. Additionally, CBT considers that clients

involved will be capable of identifying thoughts and feelings they are experiencing, being able to detail them and apply changes. This may often cause discomfort within the client however and could act as a source for avoidance. Regarding interpersonal relationships, CBT does not appear to effectively consider the implications in developing therapeutic rapport, assuming this will be achieved and collaborative working will be possible within a limited amount of sessions (Young et al., 2003). This is particularly important for those involved with brief therapy interventions. Taking into account the background histories of abuse and neglect that many patients suffering with psychological disorders experience (Jumper, 1995), this may be difficult. Regardless of this some individuals hold a feeling of mistrust towards others or find it difficult to openly discuss their inner feelings. Due to the above assumptions made CBT is predominantly used for DSM-IV (APA, 1994) Axis I disorders and often ineffective with disorders within the range of Axis II (Young et al., 2003).

Because of the limitations within CBT, Young (1990) set out to develop a therapy which would expand on basic methods but account for the difficulties experienced. In the process, SFT was developed, accounting for both distal and proximal factors without diminishing the importance of either one. By accounting for this it enables therapist and client to work with enduring symptom patterns that on the surface appear to have uncertain predisposing factors (Young et al., 2003).

Transition to Schema Focused Therapy. As detailed in Chapter One, individuals develop ways of coping with the environment in which they find themselves, from childhood and throughout. Interactions between personality and surroundings then shape thoughts and feelings about the self, other people and the surrounding world (Beck, 1967), with recurrent encounters throughout life often reinforcing ways of thinking and management of the situations. Although initial

methods of coping may have been adaptive at first onset, continuation of the same strategies may become maladaptive later in life and begin to cause difficulties for the individual and those around them (Young, 1999). Owing to this the core psychological themes of EMS were identified (please see Appendix A) with the premise that they provide guidance for one's actions, feelings experienced and occurring cognitions (Young & Behary, 1998). Upon combining elements from existing psychotherapeutic methods and theories from attachment and CBT perspectives, and concepts from Object Relations, Gestalt, Constructivist and Psychoanalytic approaches it begins to provide a holistic treatment challenging cycles of maladaptive behaviour by addressing the longstanding frameworks of thinking and feeling (EMS) (Young et al., 2003). For this reason it is argued to be particularly appropriate for individuals with enduring psychological difficulties that have been problematic for a long period of time. Whilst it is considered suitable for many Axis I and II disorders; it is not thought to be effective for acute symptoms such as psychosis (Young et al., 2003). This would require investigation however in order to provide a robust rationale for or against the use of SFT with such clinical problems.

Within SFT there is careful consideration of interpersonal relationships and therapeutic rapport as this is regarded to be of great importance. Nevertheless this is balanced by the therapist's ability to sensitively challenge the patients' resistance and therapy interfering behaviours complementing this with a rationale for change. In order to effectively combat maladaptive schemas, the therapist assists the client in implementing cognitive, behavioural, relational and affective approaches (Young et al., 2003). In doing this the therapist attempts to create an equilibrium between limited re-parenting and collaborative working (Nysaeter & Nordhal, 2008). This approach can help to provide a supportive and safe environment for change, which many of the

individuals within therapy may have been denied throughout childhood (Young et al., 2003). The efficiency in being able to create this environment is questioned however, as the patient may not have a frame of reference regarding what 'safe' feels like and therefore it may take a prolonged period of time for this to be generated. Therapist-patient dynamics could also be influential. For example, the mere presence of a male or female could trigger difficult/ uncomfortable experiences depending on the patient's life experiences. Therefore this would need to be taken into consideration.

Although Young (1999) identified 18 individual EMS which clinical practice is often based around, some people may demonstrate active combinations of EMS and coping strategies working simultaneously. These clusters are the schema modes as described in Chapter One (please see Table 2) representing the shifts in presentation and emotional state that may occur. Whilst ability to identify core psychological cognitions may be straightforward if the individual is observed to be surrendering to the processes at play, this may be hindered if the method of coping involves attempts to overcompensate, or avoid such feelings (Young et al., 2003). It is suggested that support with this can be sought within the focus of treatment by basing it around modal work whereby the therapy aims to gain a collaborative understanding of the function for their observable behaviour. This can be particularly beneficial for both therapist and client with it being based on something more concrete and able to be witnessed. For this reason, schema mode work is often recommended for individuals who experience quick alterations in affect and demonstrate more complex difficulties (Beckley, 2007). Nevertheless, the basic concept of modes can be confusing for some patients, and with the number of modes identified, this can also become too much for them to keep in mind or be able to recall. On the whole however, due to varying complexity and individual differences in how patients work best, SFT can range from

a short to a long term intervention, from individual work to group delivery and bring a focus to EMS, modes or integrate the two.

The Issue. Because SFT appears to amalgamate effective concepts from a range of therapeutic models (Young et al., 2003) it is capturing the interest of psychology and therapeutic staff alike. Implementation is beginning to increase, particularly within the UK, United States (U.S) and the Netherlands, as it is designed to tackle longstanding and chronic psychological symptoms, often considered untreatable by alternative psychotherapies. Although there have begun to be a number of research studies and meta-analyses on aspects of schema therapy, its application and its effectiveness, there is currently a scarcity of thorough systematic reviews which consolidate all of this information.

The Current Review. Considering the theory behind SFT, its growing usage and the shortfalls of alternative treatments, the current review attempts to clarify SFT's effectiveness and current usage with various psychopathologies. Through evaluating these aspects it helps provide direction within clinical practice regarding its application, clarifies whether it is suitable to implement and facilitates future research.

Due to schema theory and SFT being a recent development within the psychology field over the past two decades there are only limited amounts of data and research conducted so far, disallowing a solid systematic review to be performed on any one population or specific area at present. Due to this, the criteria for studies to be included allows for a broad scope of literature to be assessed. Notably it would have been beneficial to review the current literature on schema therapy specific to male or female forensic populations; however there is minimal research on this at present preventing such a narrowed focus. Due to this, the breadth of the review was widened to target individuals, forensic or not, undertaking SFT for psychological difficulties or

mental health problems. In an effort to reliably interpret findings and draw valid conclusions, quality assessments were conducted on each study identified.

Existing Review Assessment

Exploration for prior systematic literature reviews and meta-analyses were carried out using the search terms ‘schema* and “schema adj5 (intervention* or treatment* or therap* or work)” to ensure the scoping exercise was relevant but as broad as possible. Data was extracted by limiting searches to ‘reviews’ from the following databases and search engines;

- Centre for Reviews and Dissemination
- Cochrane Database of Systematic Reviews
- PsychINFO
- MEDLINE
- EMBASE CLASSIC + EMBASE
- Web of Science
- PsychARTICLES Full Text
- Google

In 2009, a clinical review was conducted by Zanarini regarding psychotherapy for borderline personality disorder (BPD). The research question was clearly stated whereby four treatment methods were assessed, one of which was SFT. Whilst the selection of material maintained good quality research by restricting criteria to include only relevant randomised control trials (RCT), this provided a very limited review. For the evaluation of SFT in particular there was only one RCT in which this method was compared with transference–focused psychotherapy (TFP) (Geisen-Bloo et al.,

2006). Conclusions drawn from the assessment indicate that DBT, SFT, TFP and psychodynamic based treatments are effective in reducing severity of symptoms associated with BPD. However SFT was the only one to highlight its effectiveness with a broad range of symptoms experienced by BPD patients. Within the journal article there are no indications of searches conducted and therefore it is not possible to comment on literature that was excluded during the initial search process. Additionally, although Zanarini (2009) acknowledges DBT is the psychotherapeutic method with the greatest amount of literature behind it, the potential limitations to understanding and assessment are not detailed with regards to the other forms of treatment.

To assess the quality of existing reviews a quality assessment form was compiled (see Appendix C) based on the foundation of Critical Appraisal Skills Programme (CASP) checklist for reviews (http://www.phru.nhs.uk/casp/rcts.htm). Upon completing this, the review under assessment achieved a score of 15 out of a possible 38, demonstrating the poor methodological approach used and documentation provided.

In a similar nature to that of Zanarini (2009) was a further review specific for BPD and psychological treatments by Stoffers, Völlm, Rücker, Timmer, Huband and Lieb (2012); including RCT's only. Using the assessment within Appendix C the quality of this review was somewhat improved gaining a quality score of 19 out of 38 owing to a thorough breakdown of comparisons made within the review and 2 assessors individually selecting and reviewing studies for incorporation. However with numerous treatment modalities being identified throughout, SFT was not the main focus and minimal information was therefore available. The most significant finding for them was with regards to the enhanced outcomes of this therapeutic

intervention over TFP with direct comparison being made (Geisen-Bloo et al., 2006). Whilst this review was carried out three years later than that of Zanorni, concerns continued to be raised about the amount and quality of research being undertaken, suggesting the need for this to be improved upon.

An additional review was located conducted by Kienast and Foerster (2008). The focus of this was to evaluate existing literature on psychotherapy available for individuals with personality disorder and substance dependence. Evidence base for DBT and dual-focused schema therapy (DFST) was included however only two RCT's were able to be incorporated for DBT whilst only one RCT existed for SFT. With the minimal amount of data available, their assessment of the RCT considering schema is negligible, providing little detail of what was included and lack of comprehensive details for outcomes. The reason for the overall minimal data reviewed was noted by the authors to be due to lack of RCT's especially for those with dual diagnosis. The search strategies utilised and studies that were omitted from the evaluation were not detailed thus making it difficult to evaluate and highlight potential alterations that could be made to gain a wider scope of information. Overall, the findings were promising, yet additional research is required to incorporate a wider range of populations (i.e. male clients). Due to this limitation the results may generate bias and alternative findings may be indicated when larger samples of quality studies are obtained. The quality of the review evaluated by the checklist in Appendix C highlights a minimal score of 13 out of 38. Although the current review does not focus specifically on dual diagnosis it will incorporate additional findings in relation to this as it captures the effectiveness of schema therapy within clinical samples. The inclusion criteria identified will also enable a wider range of study designs and as

mentioned previously, a systematic approach will be employed explicitly detailing methodology.

Within more recent years, and with a growing research base a more direct systematic review for SFT was conducted by Masley, Gillanders, Simpson and Taylor (2011); identifying 12 studies for inclusion. Whilst they acknowledged limitations noted by Young (1994) for SFT and wished to evaluate his true intentions for this therapeutic treatment, all studies available were included due to the minimal number existing. Upon evaluation of this review it reached a representative score of 25 of 38 owing to the clarity of the write up, explanation of review question and the search strategies implemented. As noted, due to minimal investigations having been carried out, the quality of the review was restricted and unable to review only RCT's. To ensure credence was given to the actual impact of treatment however only interventions that surpassed 10 sessions were counted and were required to have more than 5 participants. Outcomes demonstrated significant changes within clinical practice although they acknowledged the ongoing limitations with minimal RCT's. Due to this there are recommendations for ongoing exploration and investigations to ensure there is an evidence base for the increasing interest it has so clearly gained within the therapeutic arena.

The latest review most specific to schema therapy for personality disorder has been conducted in the form of a meta-analysis (Jacob & Arntz, 2013). This incorporated 5 investigative projects, one of which was a pilot; with all providing promising changes from pre-treatment to post-treatment. Of note, the length of treatment appears to have impacted on effectiveness with more improved outcomes occurring for those who maintained therapeutic input for over 18 months. On review of drop-out rates an average rate of 10.1% was demonstrated within this collective

which is encouraging next to figures of 23% for DBT (Kliem, Kroger & Kosfelder, 2010), and 34.9% for TFP (Clarkin, Levy, Lenzenweger & Kernberg, 2007). Further indications from this meta-analysis begin to provide initial support for therapeutic groups using SFT taking into account potential benefits of group dynamics and social learning for active participants and cost effectiveness within practice (Jacon & Arntz, 2013).

Observing results gained from preliminary scoping exercises and taking into account the lack of literature available for a range of populations, it is suggestive that a wider sample is required for evaluation. At present there seems to be only Masley et al's., (2011) review on the generic effectiveness of SFT in relation to a clinical sample, although interest has continued to grow in the time lapse since this review was completed. It would therefore seem beneficial to conduct a full review to highlight the impact this form of therapy has. If clarity is gained regarding the evidence base, this may influence choice of treatment for differing populations and aid future research.

Aims

This systematic review aims to evaluate the effectiveness of schema therapy on clinical populations.

Objectives

The systematic review objectives incorporate the following:

1. Determine the evidence base regarding the practical use of schema therapy with different types of psychopathology.

2. Determine effectiveness of schema therapy depending on mode of delivery (i.e. schema focused, mode focused, group or one to one).
3. Determine the practical use of schema therapy within alternative settings (i.e., community, outpatient, inpatient and forensic).

Inclusion Criteria

Considering the preliminary evaluation of existing reviews and scoping exercises conducted, boundaries for the following inclusion/ exclusion criteria were established:

- *Population:* Adults (18+), clinical population including inpatient and outpatient settings, diagnosed psychological symptom complaints.
- *Intervention:* Schema-focused therapy, schema modal work or dual focused schema therapy.
- *Comparator*: Alternative psychotherapies, medication, treatment as usual, or no intervention control group. Pure comparison of pre and post measures will also be included.
- *Outcome:* Existence and severity of symptom complaints as measured by validated assessment tools and diagnostic criteria.
- *Study Design:* Randomised Control Trials (RCT's), quasi-experimental, cohort studies, or observation without control studies.

Exclusions: Adolescent patient groups, physical ailments, opinion papers, book chapters, commentaries, editorials, non-English papers, and cross-sectional designs. A copy of the of the inclusion/ exclusion criteria form is provided within appendix C.

Methodology

Sources of Literature. In order to identify potential literature to be included within the current review, searches were conducted on the following:

Electronic databases;

- PsychINFO (1987 to December week 1 2013, search completed on the 8th December 2013)
- EMBASE CLASSIC + EMBASE (1947 to 2013, search completed on 8th December 2013)
- MEDLINE ® (1950 to November week 3 2013, search completed on the 8th December 2013)
- Web of Science (1900 to current, search completed on the 8th December 2013)
- PsychARTICLES Full Text (search completed on the 8th December 2013)

Gateways/ resource lists: Cochrane CENTRAL was employed to search for existing reviews and journal articles (1801-2013, completed 8th December 2013).

Use of reference lists: Reviews identified within the original scoping exercise were searched to identify any studies that may be of relevance. In addition references from books and book chapters were explored.

Contact with experts. A meeting was held with two experts (one who specialises in SFT, CBT and EMDR, the other being a Forensic Psychologist) whilst email contact was made with three others (one of whom is dual qualified as a Clinical and Forensic Psychologist the other who is a Clinical Psychologist and Schema therapist who is qualified to offer training to those delivering SFT training). Although no journal articles were explicitly provided by the initial experts spoken to, the

discussion held highlighted additional resources and experts in the field who could be contacted. Following email contact with these practising clinicians and researchers I gained responses from two. The information they provided was of practical use whereby 24 articles relating to SFT were provided for review.

Grey literature. A search was conducted using additional resources such as the internet search engine 'Google'.

Search Strategy. Initial scoping exercises performed to obtain existing reviews and an overall understanding of potential literature aided the final search strategies employed. Different sources were utilised to gain a greater range of information and eliminate a degree of publication bias that may occur in systematic reviews that endeavour to obtain only works from electronic databases. Whilst searches for unpublished data obtained no further literature, this begins to demonstrate the minimal research that has currently been conducted within this field. Despite this, bias may arise due to the dismissal of any research presented in a language other than English. This restriction formed part of the exclusion criteria due to time constraints in obtaining translations.

In order to facilitate information gathering from electronic databases, search terms were developed considering a range of potential adjectives and spelling differences across cultures. Identified search terms then remained as consistent as possible. Due to differing exploratory strategies enabled by the databases however, the search terms required slight modifications to gain the most relevant information from any one source (see Appendix D for syntax). To reduce the potential for relevant data to be omitted, terms were mapped to title, heading, abstract or keywords rather than subject headings. Whilst this method helps enhance the number of recommendations provided it also makes it more likely that articles will be repeated.

In conducting the current systematic review all searches were carried out by the author. It is acknowledged that a greater scope of information may have been covered if multiple assessors were employed utilising a structured protocol for information gathering. Due to limited resources however, this was not feasible.

Search Terms.

1. (compar*) OR (effective*) OR (evaluat*) OR (cost benefit*) OR (efficac*) OR (assess*) OR (differen*)

AND

2. (psychotherap*) OR (talking therap*) OR (cognitive behaviour* therap*) OR (cognitive behavior* therap*)

AND

3. (schema*) OR (schema therap*) OR (schema intervention*) OR (schema treatment*) OR (young schema questionnaire*) OR (schema interview*) OR (schema questionnaire*) OR (schema psychometric*) OR (early maladaptive schema*) OR (schema mod*)

AND

4. (patient*) OR (client*) OR (service user*) OR (outpatient*) OR (communit*) OR (inpatient*) OR (detain*) OR (prison*) OR (convict*) OR (clinical population*) OR (section*) OR (secure hospital*) OR (secure facilit*) OR (secure unit*) OR (forensic) OR (offender*) OR (psychiatry) OR (psychiatric population*) OR (psychiatric sample*) OR (psychiatric setting*) OR (mental health) OR (mental illness) OR (personality disorder) OR (PD) OR (psychological symptom*) OR (psychological difficult*) OR (psychological dysfunction*) OR (rehabilitation) OR (relapse*)

Study Selection. Data obtained from the exploratory phase of the review were assessed by title and abstract to determine their potential relevance. With this, the

expanse of literature initially identified was reduced. Abstracts that did not provide enough detail for rejection or inclusion were evaluated utilising information from the full article. All research considered to be of potential relevance were then obtained in full before strict inclusion criteria were applied (see Appendix E). Data rejected according to the Inclusion/Exclusion criteria, are detailed within Appendix I including reasons for exclusion. Due to the limited number of studies identified a quality assessment score was not defined for cut-off. Alternatively all relevant studies were attained and the quality score noted within the concluding comments.

Quality Assessment. Selected material for inclusion required a thorough review of quality in order to determine data of significant value to the question at hand and gain awareness of potential weightings that should be placed on outcomes obtained. In order to conduct this assessment, standardised quality assessment forms were developed (see Appendix G and H). To facilitate their development, the Critical Appraisal Skills Programme (CASP) checklist (http://www.phru.nhs.uk/casp/rcts.htm) was used as the foundation, with assessment forms being tailored to the current review question. Experimental, cohort and observational studies were assessed using separate criteria in order to accurately evaluate the validity of each study. Checklists from CASP were chosen as the basis for quality assessment due to the developers' expertise in appraising research validity and experience in evaluating methodological issues and evidence based practice. Criteria thought to be of particular value when evaluating epidemiological principles include the following: aims of study; study design; sample selection; group allocation; data collection procedures; attrition rates; statistical analysis; clarity of outcomes; and appraisal of limitations or bias. For quality scoring purposes each item is assessed using a three point grading system. Items may be quantified as follows;

- Yes = 2 points

  (The issue in question has been met in full)

- Partly = 1 point

  (The issue has been addressed in part but there is room for further consideration)

- No = 0 points

  (The issue has not been addressed)

There is also an option to highlight the outcome of questions as unclear. If there are any aspects of a study which remain uncertain the most definitive way to achieve clarity would be to contact the author. Gaining additional facts may increase one's understanding of the nature and quality of resources. However, time constraints limited the potential to gather such information.

Upon gaining all relevant information and attributing scores a total may be achieved by summing each item. A range of 0 - 54 may be obtained for experimental studies, whilst observational studies may score from 0-44. Although assessment forms with scales are not overly recommended due to lack of indication regarding the direction of bias (Greenland, 1994), the quantitative measure helps provide a simplified summary for the reader in determining overall study quality. In addition, in order to overcome the limitation of the scoring system, bias will also be discussed in greater depth within the descriptive synthesis and discussion.

Data Extraction. In order to extract the relevant data from each study and ensure that there was a high degree of consistency, a template for extraction was

compiled (see Appendix F). Both general information and specific details were included to ensure data for evaluation and assessment was available. The extraction form included the following;

- Aims and objectives
- Population characteristics
- Study design
- Conditions (including: number, type, delivery and facilitator details)
- Outcome measures and their validity
- Length of follow up
- Attrition within each condition
- Statistical analysis employed
- Confounding variables
- Results

To make comparisons of included studies possible, Table 3 presents a summary of research content. This indicates the application of SFT regarding population, sample size, comparators, mode of delivery, length of treatment and therapeutic setting. Outcomes are also identified and detailed.

Extracted data also requires an understanding of its strengths and weaknesses therefore the quality of research conducted is highlighted within Table 4.

Results

Description of Studies.

Figure 1. Flow Diagram Summarising Study Selection and Exclusion

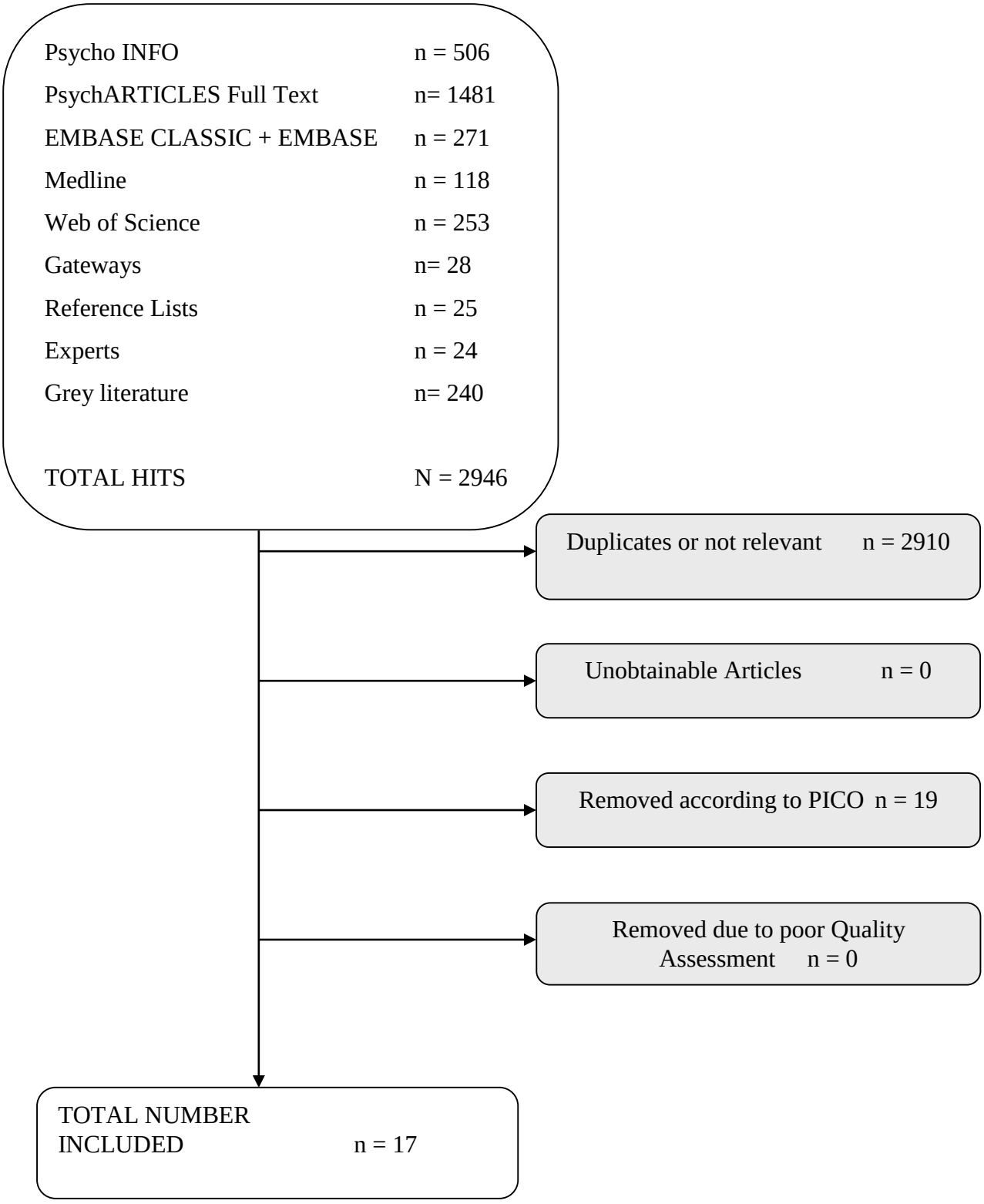


Table 3: Characteristics of Included Studies

Authors/ Year	Sample size	Type of participant	Intervention type & length	Comparison Group	Setting	Outcomes
1. Ball (2007)	Pre= 30 Post= 30 Follow up= N/A	Mixed gender (50% male: 50% female) Adult Opioid dependant Personality disordered On stable dose of methadone	6 months Dual focused schema therapy (DFST) (1:1)	6 months 12 step facilitation therapy (12FT) (1:1)	Outpatient	A decrease in substance misuse was noted to be more rapid in DFST compared with 12FT. Psychosocial impairment, psychiatric symptoms and negative affect showed clinically significant reductions ($p < .05$) in both conditions, however there was no statistical significant difference between the groups.
2. Ball, Cobb-Richardson, Connolly, Bujosa and Neall (2005)	Pre= 52 Post = 12 3 month follow up= 12	Mixed gender (94% male, 6% female) Homeless adults (18 +) Literate Substance use within past 30 days Personality disordered	24 week Dual focused schema therapy (DFST) (1:1)	24 week Substance abuse counselling (SAC) (Group)	Outpatient	Overall there was greater engagement with DFST; however clients with a higher degree of personality pathology demonstrated better engagement with SAC. A thorough analysis of symptom outcomes following treatment were compromised however due to low retention rates.
3. Ball, Maccarelli,	Pre= 105 Post= 44	Mixed gender (79% male, 21% female)	6 months Dual focused schema	Drug counselling	Residential	Similar reduction in symptoms of personality disorder within both treatments was

LaPaglia and Ostrowski (2011)	Follow up= N/A	Adult Substance dependant Personality disordered	therapy (1:1)			demonstrated within the first 3 months of therapy (p <.001). Nevertheless, drug counselling generated a more consistent reduction in personality disorder symptoms than DFST over the last 3 months. No significant difference in the amount of sessions attended throughout the 6 month period was noted.
4. Ball and Young (2000)	Pre=3 Post=3 Follow up= N/A	Mixed gender (1 male: 2 female) Adult Opioid dependence Stable dose of methadone for at least 1 month No current engagement with alternative psychotherapy aside from drug counselling at the methadone clinic	24 week Dual focused schema therapy (DFST) (1:1)	N/A	Outpatient	Reduced substance misuse was noted for both cluster A and C patients. Whilst psychiatric symptoms and negative affect also decreased, dysphoria then increased almost to baseline levels within cluster C patient at point of termination. No changes to baseline measures were noted for the patient with cluster B symptoms.
5. Bamber (2004)	Pre=1 Post= 1	Male Adult	33 sessions of Schema Mode therapy (SMT)	N/A	Outpatient	Significant clinical reductions on most of EMS scores although some modest (but not

	Follow up= N/A	Chronic Agoraphobia	(1:1)			statistically significant) increases in 'enmeshment' and 'self-sacrifice' schemas.
6.Carter, McIntosh, Jordan, Porter, Frampton and Joyce (2013)	Pre= 100 Post= 55 Follow up= N/A	Mixed gender (31% male, 69% female) Adult Depression	Weekly SFT sessions for 6 months (1:1). Followed by 6 monthly sessions of SFT (1:1).	Weekly sessions for 6 months of CBT (1:1). Followed by monthly sessions for 6 months CBT (1:1).	Outpatient	Outcomes demonstrated reduced scores on the Beck's Depression Inventory–II (Beck, Steer & Brown, 1996) over the course of therapy. These results were similar to the outcomes from CBT with no statistical significance demonstrated between the groups suggesting that SFT is a comparable therapy to CBT in treating depression.
7. Cockram, Drummond and Lee (2010)	Pre= 181 Post= 181 3 month follow up= 177	Mixed gender (4% female, 96% male) Adult War veterans PTSD	190 hours Schema-focused therapy (SFT) (Group + 1:1)	190 hours Traditional Cognitive Behavioural Therapy (TCBT) (Group+ 1:1)	Inpatient + outpatient	PTSD and anxiety improved within both conditions ($p < .001$), however change within the SFT group was more significant. Scores maintained the same level from termination to follow-up within the SFT group. Alternatively depressive symptoms decreased to a similar extent within both SFT and TCBT. Upon measuring levels of EMS's in the SFT group a statistically significant reduction ($p < .05$) was discovered in 17 EMS's from pre-treatment to post treatment.

8. Farrell, Shaw and Webber (2009)	Pre= 32 Post= 28 6 month follow up = 26	Female Adult (18-65 years) Borderline personality disorder (BPD) In 1:1 psychotherapy for at least 6 months	8 month Schema-focused therapy (SFT) + Treatment as usual- Individual psychotherapy (TAU) (Group + 1:1)	Treatment as usual- Individual psychotherapy (TAU) (1:1)	Outpatient	Statistically significant reductions in BPD symptoms and global severity of psychiatric symptoms were observed in addition to improved global functioning with large treatment effects sizes in the SFT-TAU group. At the end of treatment, 94% of SFT-TAU compared to 16% TAU no longer met BPD criteria ($p < .001$).
9. Geisen-Bloo et al., (2006)	Pre= 88 Post= 86 Follow up= N/A	Mixed genders (90% female; 10% male) BPD diagnosis 18-60 years Dutch literacy	3 years Schema-focused therapy (SFT) (1:1)	3 year Transference focused psychotherapy (TFP) (1:1)	Outpatient	Statistically significant improvements ($p < .001$) were found in both treatments on all measures after 1, 2, and 3 year analyses. After 3 years however SFT patients evidenced a higher degree of recovery and reliable clinical improvement in BPD symptoms. SFT patients also improved more in general psychopathological dysfunction and personality concepts. Additionally, a greater improvement in quality of life was demonstrated in SFT as compared with TFP.
10.Gude and Hoffart (2008)	Pre= 42 Post= 42 1 year follow	Mixed gender (31 % male, 69% female) Agoraphobia	11 weeks SFT (5 week cognitive therapy 6 week SFT)	12 weeks TAU (psychodynamic therapy) (1:1 +	Inpatient	Interpersonal skills and phobic anxiety were significantly more improved for individuals that undertook SFT as compared to TAU (p

	up= 37	Panic disorder Cluster C Personality Disorder Traits	(1:1 + group)	group)		<.01), with the greatest changes made during follow up.
11. Gude, Monsen and Hoffart (2001)	Pre= 47 Post= 45 Up to 15 month follow up= 44	Mixed gender (25.5% male, 74.5% female) Age between 22-60 Cluster C Personality Disorders Diagnosis of agoraphobia with or without panic disorder	Phases of treatment: 5 week cognitive therapy group for agoraphobia/ panic disorder Followed by 6 weeks of SFT group to address personality disorder	N/A	Inpatient	Outcomes looked at awareness and ability to endure emotional states (affect consciousness) with improvements being made within the SFT phase rather than at the time of the cognitive therapy group ($p < .001$). Nevertheless alterations in affect consciousness through therapy showed no significant relationship with changes in Cluster C personality disorder symptoms aside from avoidant personality disorder.
12. Jakes and Rhodes (2003)	Pre= 5 Post= 5 1 year Follow up= 5	Mixed gender (4 female: 1 male) Adults Chronic psychosis Chronic delusions Adequate trial of antipsychotic with no plans to change	Phases of treatment: Solution focused Schema focused Cognitive- delusion focused (Phases of treatment variable between participants) (1:1)	N/A	Unclear	No clients evidenced a clinical or statistical reduction in belief of delusion during schema focused phase. However two patients evidenced a decrease in delusional beliefs during solution focused phase, and one client did so during cognitive phase. Of note, one patient also evidenced an improvement during the baseline period. At 1 year follow up, all clients demonstrated reduction in

						preoccupation, conviction and distress regarding delusional beliefs.
13. Nadort et al., (2009)	Pre= 62 Post= 61 Follow up= N/A	Mixed gender (97% female: 3% male) Adults (18-60 years) BPD Dutch literacy	1.5 years Schema-focused therapy with therapist telephone availability (1:1)	1.5 years Schema-focused therapy without therapist telephone Availability (1:1)	Outpatient	Considering the group as a whole, 42% of patients did not meet criteria for BPD diagnoses following treatment. There appeared to be no added value of therapist telephone availability however, with the statistical p value being over .05.
14.Nordahl, Holthe and Haugum (2005)	Pre=82 Post=82 Follow up= N/A	Mixed gender (44% male: 56% female) Adults Axis I disorders Axis II disorders	Schema focused therapy (1: 1) (length of therapy unclear)	N/A	Outpatient	Reductions within EMSs appeared to predict a decrease in general symptomatic distress to a significant degree ($p < .003$). This excluded EMS of 'entitlement', 'emotional deprivation' and 'enmeshment'.
15.Nordahl and Nysaeter (2005)	Pre= 6 Post= 6 1 year follow up= 6	Female Adults BPD	18- 36 months Schema-mode therapy (1:1)	N/A	Outpatient	3 of 6 patients did not fulfil criteria for DSM-IV BPD any longer. Remaining 3 fulfilled criteria but to a lesser extent. 5 participants also demonstrated high levels of improvement on general symptomatic and interpersonal distress 12-16 months following treatment.

16. Simpson, Morrow, Vreeswijk and Reid (2010)	Pre= 8 Post= 6 6 months follow up= 6	Gender mix unspecified Adults Chronic eating disorders	20 adapted group schema therapy sessions	N/A	Outpatient	Patients demonstrated a decrease in severity of EMS by 49% at the end of group. At the time of the final follow-up 5 of 6 participants reduced by at least 60% being statistically significant with a p value of .02. The remaining individual's overall EMS scoring had gone up, although had begun to reduce on the initial highest rated EMS. This was consistent with change with regards to eating disorder symptoms also at follow up with the majority showing a reliable improvement in symptoms ($p < .02$).
17. Tarrier et al., (2010)	Pre= 63 Post= 49 Follow up= N/A	Male Adults Detained in high secure facility Psychopathy Anti-social PD BPD	18-36 months Schema modal therapy + treatment as usual (SMT + TAU) (group+ 1:1 or group)	Continuation of Treatment as usual (TAU) (1:1 or group)	Inpatient	SMT + TAU and TAU interventions demonstrated clinically significant reductions in aggression and EMS scores by the end of therapy. However SMT + TAU did not demonstrate statistically significant improvement in scores on dynamic measures of risk, schemata, personality and interpersonal style, when compared to the TAU group.

Table 4. Quality of Included Studies

Authors/ Year	Study Design	Recruitment Procedure	Group Allocation Acceptable	Follow Up Period	Attrition Rate	Treatment change	Strengths/ Weaknesses	Quality Score	Applicable to UK
1. Ball (2007)	RCT	Clinical referral or voluntary	Yes	N/A	100% completed	Yes	Strengths: Randomisation; compensation for assessment completion but not treatment; measurement of therapist adherence and competence; use of urine analyses Weaknesses: Limited sample size; lack of follow up period; self-report	46/ 54	Yes
2. Ball et al., (2005)	RCT	Invitation	Yes	3 months	23.07% completed	Unreported	Strengths: Randomisation; use of urine analyses Weaknesses: Attrition rate; difference in treatment and comparator modality; self-report	29/54	Yes
3.Ball et al., (2011)	RCT	Voluntary	Yes	N/A	42% completed	Yes	Strengths: Randomisation of treatment, use of statistical analyses, treatment integrity supervised, and use of	45/54	Yes

							experienced therapists. Weaknesses: No objective measure of reduction in substance use due to restriction placed upon participants within their residential setting. Self-report measures used, high drop out for both interventions, lack of follow up period.		
4. Ball and Young (2000)	Observation without control	Clinical referral	N/A	N/A	100% completed	Cluster; A. Yes B. No C. Partly	Strengths: Separation of PD clusters Weaknesses: Lack of statistics reported; no control; study design; no follow up period; self-report measures	25/44	Yes
5. Bamber (2004)	Observation without control	Clinical referral	Yes	N/A	100% completed	Yes	Strengths: Graphical representation of change Weaknesses: No control; single case series; self-reports; lack of clarity regarding statistics	25/44	Yes
6. Carter et al., (2013)	RCT	Clinical referral/	Yes	N/A	50% completed	Yes	Strengths: RCT, comparator group utilised, therapy adherence monitored	50/ 54	Yes

		telephone interview			SFT 60% completed CBT		via supervision, statistical analysis presented and data provided on graphs. Weakness: Numerous therapists delivering therapy, self-report measures used, lack of follow up after therapy completion, attrition rate.		
7. Cockram et al., (2010)	Quasi-experimental	Clinical referral	Yes	3 months	97.7% completed	Yes	Strengths: Comparator utilised; statistical analyses documented Weaknesses: Sample size for each population unequal; SFT within group variation between older and younger generation; self-reports	39/54	Yes
8. Farrell et al., (2009)	RCT	Clinical referral	Yes	6 months	81.25% completed	Yes	Strengths: Statistical analyses provided; randomisation. Weaknesses: Lack of standardisation in treatment as usual; self-reports	50/54	Yes
9. Geisen-Bloo et al.,	RCT	Clinical referral	Yes	N/A	97.27% completed	Yes	Strengths: Length of therapy provided; randomisation; use of independent	51/54	Yes

(2006)							researchers and assessors; multicentre; treatment integrity checked; statistical analyses stated. Weaknesses: Lack of follow up; self-report measures; medication; just short of sample size required for accurate analysis as indicated by power analyses.		
10. Gude and Hoffart (2008)	Quasi-experimental	Clinical referral	Adequate	12 months	100% completed SFT 72% completed TAU	Yes	Strengths: Compared to control condition, follow up period, Weaknesses: Unclear if treatment integrity maintained, no measurement of change in EMS, samples acquired from different time periods.	32/54	Yes

11. Gude et al., (2001)	Observation with no control	Clinical referral	Yes	12-15 months	93.6% completed	Yes	Strengths: Clarity on sample characteristics, use of various assessment measures, use of statistics. Weaknesses: No control condition, treatment integrity unreported, no measurement of change in EMS, research question not clearly defined.	25/44	Yes
12. Jakes and Rhodes (2003)	Observation with no control	Clinical referral	Yes	1 year	100% completed	No	Strengths: Measures taken to reduce impact of potential medication changes; outcomes gained through each phase of treatment. Weaknesses: No opportunity for follow up; limited sample size; medication as confounding variable.	25/44	Yes
13. Nadort et al., (2009)	RCT	Clinical referral	Yes	N/A	98.38% completed	Yes	Strengths: Multicentre; treatment integrity monitored; statistical representation Weaknesses: Self report; differing competence level of therapists; overly	50/54	Yes

							formal and structured; lack of follow up (results of 1.5 year follow up to be released 2010)		
14.Nordahl et al., (2005)	Observation with no control	Clinical referral	Yes	N/A	100% completed	Yes	Strengths: Demonstrates relationship between EMS and distress; Sample size. Weaknesses: Lack of clarity regarding length of intervention and statistical outcomes; self-report measures.	28/44	Yes
15.Nordahl and Nysaeter (2005)	Observation with no control	Clinical referral	Yes	1 year	100% completed	Yes	Strengths: Individualised number of sessions; same therapist treated all; statistics provided. Weaknesses: Self report; differing amount of sessions; no control; one therapist; lack of independent assessor	39/44	Yes
16. Simpson et al., (2010)	Observation with no control	Clinical referral	Yes	6 months	75% completed / available for follow	Yes	Strengths: Use of various assessment measures; statistics provided; graphical output of change	33/44	Yes

					up		Weaknesses: Small sample size, no control group, gender mix unspecified, self-report measures		
17. Tarrier et al., (2010)	RCT	Clinical referral	Yes	36 months	77% completed / available for follow up	Yes	Strengths: Independent randomisation; statistical analyses provided Weaknesses: Effectiveness of SFT not conclusive due to level of TAU TAU was not standardised; Attrition rate; self-report; treatment integrity	38/54	Yes

Descriptive Data Synthesis

Due to the heterogeneity of the studies included and outcome measures utilised, a meta-analyses was not conducted. Egger, Schneider & Smith, (1998), support the dismissal of this method when literature is diverse noting the significant potential for data to be misinterpreted, particularly if utilised when observational information is present. Whilst some research has utilised statistical analyses, the expanse of outcome measures and analyses used would make it difficult to implement a single standardised approach. Data synthesis has also been conducted in a qualitative manner detailing methods and overall outcomes obtained. Vote counting exercises were conducted to facilitate this.

Study Populations. The localities of investigations included within this study appear primarily based within the United States and Europe. It is noted that five studies were carried out within the U.S; four in Norway; three in the U.K; two in the Netherlands whilst the three remaining were conducted in Australia or New Zealand.

Therapeutic settings also varied in nature between inpatient and outpatient settings. The limited number of inpatient research however appears to be due to the early development of SFT and its apparent preliminary use with outpatients. Despite this, expansion of SFT and it application is currently being explored. At present there are studies being undertaken examining effectiveness of SFT within inpatient forensic settings as recommended by Bernstein et al., (2007) with Tarrier et al., (2010) being one of the first.

Regarding the target population a high proportion of studies explicitly recruited participants with personality disorders. Of particular interest were the studies targeting BPD which claimed treatment change in psychopathology, symptom distress and functioning. Symptom improvements ranged from 94% of patients no longer meeting BPD criteria ($p<.001$) (Farrell et al., 2009) to 42% recovery from BPD (Nadort et al., 2009). There was just one study that reported no changes to baseline measures (Ball & Young, 2000). The

quality of this study was limited however, using a case series design whereby the application of SFT involved just one individual with cluster B (BPD) personality traits.

Considering alternative personality disorders and Axis I diagnoses, there continued to be support for the implementation of SFT. Nordahl et al., (2005) indicated degree of distress was reduced after engaging in SFT targeting EMSs in individuals with and without personality disorders. Of noteworthy clinical and practical value is the identification of SFTs contribution to change in symptomatic distress that a reduction in specific EMSs bring about, ranging from 5% in emotional deprivation ($p < .007$) to 23% for vulnerability to harm ($p<.001$) (Nordahl et al., 2005). The primary use with personality disordered populations was expected as SFT was developed in order to target the complexity of chronic, habitual life patterns often associated with symptoms of personality disorder (Young et al., 2003). Nevertheless, four identified studies examined the dual impact upon substance dependence. Within Ball's (2007) study, the effectiveness of SFT in reducing substance misuse appears more compelling than comparator programmes specific for this area of difficulty. Results indicated a more immediate reduction in use than alternative treatment ($z=-1.83$, $p= .068$). However in an observational study without control Dual Focused Schema Therapy (DFST) only appeared to have an impact upon cluster A (odd/ eccentric) and B (dramatic/ erratic) patients (Ball & Young, 2000) whereas Ball et al., (2011) demonstrated only comparable outcomes with no significant difference to that of drug counselling.

Further psychological difficulties targeted were post-traumatic stress disorder (PTSD), delusions, eating disorders and agoraphobia. PTSD appeared to respond well to treatment showing a reduction in PTSD, anxiety and depressive symptoms ($p<.001$) from intake to follow up (Cockram et al., 2010). In addition there was a significant reduction in seventeen EMSs. It is reported that on intake EMSs varied from an average of a raw score of 63 (SD= 34) to 9 (SD= 19), whilst follow up rates ranged between a mean score of 46

(SD=35) to 8 (SD=15) (Cockram et al., 2010). Similar responses were demonstrated in the single case study targeting agoraphobic symptoms, indicating significant clinical reduction in most EMS ratings. Nevertheless, slight increases were documented for EMS of enmeshment and self-sacrifice. Reports suggest that this was due to the activation of such EMSs following a period of dormancy (Bamber, 2004). Whilst it is noted that a cut–off point of 3 was utilised to determine treatment change as suggested by Young and Brown (2001), unfortunately no specific statistics were reported to demonstrate the degree of change reported. In Norwegian studies regarding agoraphobia (Gude & Hoffart, 2008; Gude et al., 2011) a reduction in symptoms were demonstrated although changes in EMS were not measured. Due to this it is unclear as to whether alterations in EMS would be impacting on such changes or whether it is other aspects within therapeutic practice that are influential. In an alternative investigation regarding eating disorders however, EMS were measured before and after treatment with an average 60% reduction being demonstrated upon follow-up with a marked reduction in disorder symptoms also (Simon et al., 2011); this highlighting the potential relationship between the two.

Taking into account the general positive outcomes of the above investigations, one study yielded no positive changes. The target symptoms included chronic delusions and symptoms of psychosis which were maintained after delivery of the schema focused phase (Jakes & Rhodes, 2003). Whilst it is noted that SFT is not usually recommended for symptoms of psychosis, the quality of study may also have impacted on the research findings. The investigation focused on the process of treatment looking at alternative psychotherapies one after another, in which each patient participated, and providing no opportunity for follow-up. At the time follow-up could have been made, patients were then engaging with therapy focusing on conviction of delusional beliefs which could create an additional confounding variable

Whilst there appears to be some indication of the populations in which SFT is effective, there may be potential for the modality of treatment delivery to have had an impact on outcome. Due to this further exploration is required.

Modality of Schema Intervention. There are two significant methods of therapy that focus on the adaptation of EMSs. The first is schema focused therapy (SFT), whilst the second is schema mode therapy (SMT). As noted within the initial stages of this report the two modalities are not separate and distinct, however SMT is considered to be an extension of SFT suggesting that it provides a simplified approach to more complex cases (Young et al, 2003). Within the studies included it is noted that there were three that highlighted the use of SMT (Bamber, 2004; Nordahl & Nysaeter, 2005; Tarrier et al., 2010). Clinically significant improvements were reported within all studies; however in Tarrier et al's, (2010) RCT, it was noted that the improvements were not statistically significant and SMT did not produce significantly greater improvements as compared with TAU. Bamber (2004) and Nordahl & Nysaeter (2005) did not provide comparators with which to substantiate their claims and reporting of statistics was minimal. The remaining research investigations implemented SFT. Please see study populations above and Tables 3 and 4 for details.

A further distinction in mode of intervention may be considered in terms of group therapy or individual intervention. Again, Tarrier et al's., (2010) study within a high secure environment utilising SMT was delivered within a group setting. As previously documented, the results showed preliminary support however greater statistical improvements are required for it to be recognised as clinically beneficial within a high secure facility. Conversely there was a high degree of statistical reduction ($p<.001$) in symptoms in the study involving group SFT conducted by Farrell et al., (2009) and additional support within the SFT group created specifically for PTSD patients ($p<.001$) (Cockram et al., 2010).

Nadort et al., (2009), appears to have conducted the first research project investigating the effectiveness of individual outpatient therapy with or without access to therapeutic telephone support. Whilst an overall significant effect was demonstrated for the use of SFT on a one-to-one basis (ES= 1.55), there was no evidence to suggest that therapist telephone availability was beneficial.

The remaining studies conducted implemented schema based therapy on an individual basis. This appeared to have a positive impact upon symptoms of personality disorder (Geisen-Bloo et al., 2006; Nadort et al., 2009; Nordahl, et al., 2005; Nordahl & Nysaeter, 2005), inconsistent result with substance dependence (Ball, 2007; Ball et al., 2005; Ball & Young, 2000) and no significance in addressing conviction in delusions (Jakes & Rhodes, 2003).

Follow-up of Participants. A number of the studies presented failed to demonstrate a design whereby participants were followed up for a period of time after the termination of the relevant intervention. Whilst there were studies that did assess patients after treatment, length of follow-up varied greatly. Follow-up periods ranged from 3 months (Ball et al, 2005; Cockram et al., 2010) to 36 months (Tarrier et al, 2010). Whilst Ball et al., (2005) were unable to conduct analyses on symptom alterations, Tarrier et al., (2010) as well as Nordahl and Nysaeter, (2005) demonstrated maintenance in treatment effects from post treatment to follow-up. Conversely Cockram et al., (2010), demonstrated continued reduction in five EMSs (range of significance levels, $p<.0013$ to $p<0.045$) during the 3 months follow-up considered whilst other factors maintained their reduced status from therapy termination. Farrell et al., (2009) also contributed to the positive reflection on follow-up periods evidencing that the impact of intervention continued have an effect during this time demonstrating further reduced outcomes on some measures. This is given additional credit considering that there improvements were not maintained within the assigned control group.

Outcome Measures. Due to the variant nature of research focus there was a range of outcome measures utilised dependant on the clinical issue of interest. Despite the overall concern being on the effectiveness of schema it is noted that the series of Young Schema Questionnaires (YSQ) (Young & Brown, 1990, 1991, 2003) were not readily utilised in all investigations. The potential reluctance to use this may be due to lack of a global score available for an overall outcome. With the YSQ it is necessary to highlight individual EMS's or schema domains. What seemed to be of greater interest in the studies reviewed however was the amount of distress and psychosocial functioning participants experienced. The most common forms of measurement included; Brief Symptom Inventory (BSI) (Derogatis, 1992), Structured Clinical Interview for DSM-IV Axis I (SCID-I; First, Spitzer, Gibbon & Williams, 1995), and Axis II (SCID-II; First, Spitzer, Gibbon, William & Benjamin, 1994), Symptom Checklist-90 (SCL-90) (Derogatis, 1994), Borderline Personality Disorder Severity Index, fourth version (BPDSI-IV) (Arntz et al., 2003), EuroQol thermometer (EuroQol Group, 1990), and the World Health Organization quality of life assessment (WHOQOL) (WHOQOL Group,1998).

Alternative measures used to assess psychopathology and distress included Borderline Syndrome Index (Conte et al, 1980), Personality Diagnostic Questionnaire-Fourth Edition Revised (PDQ-4R) , Hospital Anxiety and Depression Scale (HADS; Snaith & Zigmond, 1994), Multiple Affect Adjective Checklist-Revised (MAACL-R; Zuckerman & Lubin, 1985), Millon Clinical Multiaxial Inventory-II (MCMI-II; Millon, 1994), and Diagnostic Interview for Borderline Personality Disorders-Revised (DIB-R; Zanarini et al, 1990). Additional measures focusing on the patients functioning incorporated the Global Assessment of Functioning Scale (GAFS; Endicott, Sptizer, Fleiss, & Cohen, 1976), and Inventory of Interpersonal Problems-Circumplex (IIP-CX; Horowitz, Rosenberg, Baer, Ureno &

Villasenor, 1988). These measures were utilised within included studies but were not repeated across the board.

More specific measures included the use of the PTSD Checklist Military (PCL-M; Forbes, Creamer & Biddle, 2001), whereas substance dependence studies appeared to utilise the Addiction Severity Index (ASI; McLellan, 1992), and Substance Use Timeline Calendar (Miller & DelBoca, 1994). The psychometrics outlined above highlight the majority of inventories utilised however this list is not exhaustive.

Despite the array of psychopathologies in which schema therapy was applied, self-report measures appear fundamental in gaining information regarding change. The only clear objective measures utilised within the review was urine analyses to confirm self-reports on substance misuse (Ball et al., 2007). Due to the expanse of outcome measures employed, the statistics applied were also varied and made it difficult to gain a standardised measure of assessment.

Outcome of Interventions. To clarify, there are 12 studies indicating an impact of SFT on treatment change, three studies that highlight this intervention did not make a difference or were comparable to other therapeutic methods and one that appeared ambivalent in its outcomes. Unfortunately, the remaining study conducted by Ball et al., (2005) was able to provide outcomes based on the retention and engagement with therapy; however measures for the overall effectiveness of interventions were unable to be carried out due to attrition rate creating a very limited sample.

Out of the 17 studies identified, 8 managed to implement a RCT study design, 2 utilised a quasi-experimental design and the remaining 7 would be considered observational studies without controls. Considering RCT's are the gold standard for investigatory research and that reliability and validity diminishes down the hierarchy of study designs (Centre for Reviews and Dissemination, 2009), the outcomes within this review may require further

consideration in terms of quality and weightings applied to findings. This may be done by placing greater importance or weighting to investigations of higher quality.

Discussion

Main Findings. This review had three aims:

1. To determine whether there is an evidence base supporting the practical use of schema therapy with different types of psychopathology.

Despite SFT being a relatively recent development there appears to be an overall positive impact on various clinical difficulties. Research has demonstrated that the implementation of schema based therapy has been particularly effective with Axis II disorders (Farrell et al., 2009; Geisen-Bloo, 2006; Nadort et al., 2009; Tarrier et al., 2010). As the use of schema has expanded, research is also indicating the potential use with a significant impact of therapy upon PTSD (Cockram et al., 2010). The application of this to trauma seems suitable as the success within personality disorders demonstrates its likely use with individuals who have suffered Type II trauma (Van der Kolk, Perry & Herman, (1991). As there is currently only one study applying this to a PTSD population, further investigation is required.

SFT has also demonstrated preliminary effectiveness regarding substance dependence, approaching this in a way that identifies and manipulates underlying cognitions that drive the behaviour rather than maintaining a basic low level therapeutic approach (Ball, 2003). Despite this, there appears to be slight inconsistencies between studies and therefore its implementation requires additional evaluation.

Considering Young et al's, (2003) expressed doubt in the application of schema therapy to acute psychosis and delusional beliefs, one study provided evidence of symptom

severity remaining the same within the schema focused phase. Whilst this supports the initial limitations highlighted, the study evaluating this utilised a restricted case series design. Due to this the supporting evidence may not be fully representative of how schema therapy may be applied and its potential effectiveness.

2. Determine effectiveness of schema therapy depending on mode of delivery (i.e. schema focused, mode focused, group or 1:1).

Support regarding method of delivery seems inconclusive at present. Within the current review only 3 out of the 17 studies employed SMT with 14 utilising SFT. Similarly only 5 studies delivered schema therapy within a group setting rather than on an individual basis. Farrell et al., (2009) and Tarrier et al., (2010) in particular examined group settings implementing RCT designs. Both of these provided supportive evidence for symptom reduction. Despite this, Farrell et al., (2009) obtained much greater effects than Tarrier et al., (2010). Considering the differences it is worth bearing in mind attrition rate, limited treatment integrity and high rates of paralleling therapy provided within Tarrier et al's study. Regarding SMT both Bamber (2004) and Nordahl and Nystear (2005), provide an evidence base for its effectiveness in reducing severity of symptoms. Both of these studies are observation based with no controls thus caution is taken when considering their findings. The evidence base for group work and the use of schema modes is increasing but this highlights the need for further research.

Individual SFT seems to be the treatment of choice in this area at present with marked improvements of symptoms being demonstrated within the majority of studies. Restrictions in its application appear more dependent upon the psychological symptom complaints experienced. As the use of schema therapy expands, greater use of group work and SMT may

be evidenced if employed within inpatient settings. The rationale may include potential time saving and cost effectiveness of group delivery. In addition, those individuals who are residing as inpatients are likely to be experiencing greater complexity and severity of symptom, therefore mode work would potentially ease both therapist and patients understanding of occurring schema (Young et al, 2003).

3. Determine the practical use of schema-focused therapy within alternative settings (i.e. community, outpatient, inpatient or forensic).

Outpatient settings have been predominantly used for delivery of treatment within this review. Whilst the current evidence seems supportive of inpatient and outpatient settings to date, the effectiveness of schema therapy appears more dependent upon population samples. What is noted however is the lack of significant difference between outpatients who have access to therapist telephone availability and those who do not (Nadort et al., 2009).

Strengths and Weaknesses of Review.

Methodological Considerations. Considering the method and approaches used to conduct a review is of significance to highlight potential biases that may have implicated the findings obtained. Determining this would facilitate the reader's conviction held within reported outcomes and aid future research in conducting methodologically sound investigations.

Considering some of the previous reviews conducted and their lack of structure (Kienast & Foerster, 2008; Zanarini, 2009), this review attempted to apply a standardised strategy to allow a thorough and systematic search and evaluation process to take place. As each step has been explicitly stated this allows for the course of action to be fully understood and evaluated.

In order to extract data, search terms were required to be entered and applied to numerous sources. The variety of sources utilised within this review seems appropriate as exploration was futile within the last few searches, providing duplicates and little additional literature relevant to the review. Despite this, further searches could have been made to ensure a complete and accurate sample had been acquired. Due to time constraints however the author was unable to contact principle investigators of studies identified to gain full awareness of any unpublished data there may be. With the increasing interest in schema therapy there is potential for unpublished research to be available, and such contact would therefore have been beneficial to undertake. Without it there is potential for publication bias to have implicated findings. Although the author has awareness of certain studies currently being undertaken (Bernstein et al., 2007; Dickhaut & Arntz, 2010), results have not yet been published and were therefore unavailable. In addition, both financial and time constraints prohibited the extraction of data from the British Library and translation of research when articles were unobtainable in the specified format online. Regarding the search terms entered, a list was made to create an exhaustive account of potential language variations that may be applied to relevant literature. Whilst this generated a large number of hits, it also provided the opportunity for all relevant studies to be identified.

Inclusion criteria applied to the review enabled robust evaluation of the effectiveness of schema therapy in relation to the adult population with various psychopathologies. The wide criterion applied was required due to the limited research conducted to date. Applying this however began to allow for an understanding of the evidence gained so far and will enable a narrowing of criteria when a greater literature base has been established.

To enable the evaluation of the methodological quality of studies identified, assessment forms were compiled and utilised for each relevant hit. Based on CASP (http://www.phru.nhs.uk/casp/rcts.htm), separate forms were developed taking into account

study design. Significant considerations included sample selection, size and allocation. In addition; attrition rate, statistical methods and confounding variables were taken into account. As noted in the initial stages of this review, assessment forms with scales are not overly recommended due to lack of indication regarding the direction of bias (Greenland, 1994). Nevertheless the quantitative measure helps provide a simplified summary for the reader in determining overall study quality. To improve upon the quality assessment process, two or more individuals could be utilised to determine inter-rater reliability. This may be deemed of significant importance if utilising cut-off points when determining inclusion of data. Whilst quality assessment forms enabled a thorough evaluation, the quality was not considered as a foundation for inclusion/ exclusion within the current review. If this was applied, the number of studies would have been limited further. As all were included however it means that no data has been lost within this phase. Nevertheless there is the potential for bias and reliability of weaker studies to impact on the outcomes discussed (Centre for Reviews and Dissemination, 2009).

One of the greatest limitations to this study is the heterogeneity of outcome measures and statistical analyses used. Whilst evaluation attempts were made by reviewing statistical literature and contacting authors, the expanse of analyses meant that no valid measures could be applied to calculate effect size or provide a standardised quantitative analysis for all. Additionally, numerous journals had limited clarity within results sections and omitted data required to make such analyses. For some, access to raw data could only have been gained via contact with the authors. If time permitted this may have been an option to consider.

Literature Considerations. As previously noted studies were included regardless of quality, however potential biases were taken into consideration when reporting findings. For example; whilst RCT's are considered the gold standard from which to conduct an investigation (Centre for Reviews and Dissemination, 2009), study designs included a range

of RCT's, quasi-experimental and observational studies without controls. Clarification of design and methodological quality is provided within Table 4.

The overall recruitment of participants for sampling appears in line with clinical practice as most were clinically referred. It does not appear that this would have had a detrimental effect on review findings. The only study employing methods that would appear out of the norm within clinical practice is Ball et al's., (2005) study providing compensatory money to the homeless if they complete the relevant assessments at set intervals. Providing compensation may have had an impact upon engagement; however motivation to change is likely to have remained the same with this being more dependent on how much they were invested in the therapy. Despite this approach the studies attrition rate was high and ultimately created selection bias regarding individuals that remained.

Sample sizes of included studies ranged from a single case of 1 to 181. Whilst single observational cases appear to have been used as preliminary studies investigating the effectiveness of SFT in its early application, reliability and validity requires consideration as confounding variables may have greater impact. It is understood that studies with larger sample sizes provide more accurate reflection of outcomes and enable greater generalisation to the population of interest. Although the RCT's employed larger numbers of participants, attrition rate was noted to be of significant value. One of the smallest rates of completion was 23.07% (Ball et al., 2005), which hindered the investigatory process to a point where effectiveness of schema therapy on psychopathology and distress was unable to be accurately completed. It is worth noting however, that in comparison to alternative treatment conditions schema therapy maintained greater retention and utilisation.

The study populations included within identified research appear reflective of to the populations experienced within clinical practice. Of particular interest is the DFST for those with personality disorders and substance dependence. A relationship is often shown between

the two disorders (Rounsaville et al., 1998) highlighting the need and applicability to the dual aspect of functioning rather than working on issues independently.

When participants engage with specific interventions, pre and post measures are important to demonstrate and evaluate any changes in symptom patterns as a result of therapy. Just as important, but often forgotten, are follow-up measures to determine reflective function and increased application of skills as patients become more familiar with their usage. Levy (2008) noted the critical function of this process as continued improvement may lead to more sustainable change. Upon gaining outcomes either at termination of treatment or follow-up, statistical analyses often provides the basis for evaluation. Whilst statistical analyses appeared appropriate for the individual studies conducted, outcome measures and analyses were not standardised across the research included, therefore creating greater difficulty in its evaluation. Aside from this there were a number of studies that noted outcome measures used and provided baseline assessments but post assessments were lacking statistical evidence. As a result findings discussed may not appear as cohesive as desired, therefore limiting the ease of understanding.

Finally, regarding ecological validity and whether the studies are reflective of everyday practice, limitations may be noted in that only 2 studies out of 17 were conducted within the UK. Due to this some caution may be necessary when considering their generalizability. However the referral procedures, clinical settings and method of delivery were taken into account. Studies conducted internationally demonstrated similar proceedings to that of the UK and were therefore considered appropriate.

Interpretation of Findings. Support has been shown for the implementation of schema therapy to psychological difficulties including personality disorder, substance misuse, eating disorders, PTSD and agoraphobia, with conviction in delusional beliefs being an exception. Greater time and effort is required however to determine clarity in clinically

significant effects and statistical significance. This may be achieved by calculating effect sizes on those studies that provide some of the statistical information to work this out. Additionally contacting authors of studies for raw data and further research would be beneficial to collate a greater amount of evidence.

Whilst RCT's demonstrate the most thorough methods in which investigations are conducted, only half of the studies included employed this design. Nevertheless it is understood that the ethical nature of conducting an RCT is somewhat questionable particularly when applied to psychological interventions as the needs of the patient should inform the treatment provided rather than this being randomised (Centre for Reviews and Dissemination, 2009). Outcomes from RCT's demonstrated overall support for schema therapy highlighting greater improvements as compared with comparator groups. Whilst Tarrier et al., (2010) did not gain significant statistical support for SMT within an inpatient setting the validity of the study is highly questionable as schema was able to be accompanied by non-specific alternative therapies considered within TAU. The group receiving TAU also engaged in numerous non-specific therapies and retrospective reflection identified that the TAU group received more input than the schema group. Because of these implications caution should be taken when interpreting this study..

In light of the difficulty in applying RCT's and the relatively new developments in schema theory and practice it is not surprising that alternative methods of investigation were employed. Nonetheless systematic bias, validity and reliability must be considered.

This review also found that schema based therapy can be applied effectively within outpatient and inpatient settings. Whilst it may be considered that inpatient settings would have greater control over confounding variables such as medication, involvement with alternative therapies and treatment, this did not appear to be the case. Rate of attrition was not protected in inpatient environments either. The reasoning behind this may be due to greater

severity of symptoms within inpatient settings whereas outpatients are more likely to have a level of stability to be living within the community. A patient's stage of change is also considered relevant as there is likely to be greater motivation if outpatients are willing to return to clinics to attend for regular appointments; nevertheless inpatients have an added benefit of discharge or lower level of security and/ or restrictions if they are seen to be engaging. Alternatively inpatients may experience lower levels of motivation if acutely suffering with particular psychopathologies, and there is the potential for self-defeating behaviour and using disengagement as a functional behaviour to remain in their current setting.

Conclusions on group therapy are ambivalent due to contrasting results provided. Nevertheless individual therapy seems beneficial overall. A larger number of studies have been conducted using one-to-one methods however, indicating a gap in knowledge base regarding the understanding of group effectiveness. Due to this no conclusive statements can be drawn at present.

Conclusions and Recommendations.

Implications of Findings and Limitations on Practice. Noting the diversity of psychopathologies to which schema therapy has been applied it would indicate its growing acceptance in clinical practice. This is despite its divergence from what is currently recommended for 'best practice' within national guidelines (National Institute for Health and Clinical Excellence, 2009). With the continuation of research however, the evidence base behind it will provide greater clarity for clinicians when considering its usage. Regarding the facilitation of therapy, it appears to be occurring internationally and in a variety of settings, often delivered by psychologists or specially trained psychotherapists. Due to the nature of schema therapy it is often delivered as a manualised programme requiring the therapist to undertake specialist training and utilise regular supervision to help maintain treatment

integrity. Because of this, schema therapy may be readily applied across different cultures and in different countries whilst maintaining a high degree of consistency. The benefits of this include applicability of research findings regardless of country of origin.

Through gaining an overall account of the current literature available it is encouraging to see the positive impact that this innovative therapy is having. Through evaluation of its use within clinical practice schema based therapy is also noted to be evolving to capture variations in the patient population characteristics and degree of complexity. This implicates the introduction of schema modes to work with severely personality disordered individuals (Young et al., 2003). A current limitation to research however is the lack of application or research within forensic populations, with a particular scarcity amongst female forensic mental health. Considering the high degree of Axis II within inpatient populations and level of substance dependence demonstrated (Mason, Birmingham & Grubin, 1997; Tarrier et al., 2010) it would seem feasible to introduce this method of interaction. Due to forensic services often applying the 'what works approach' (Howells, Day, Thomas-Peter, 2004) narrowing therapeutic input to focus on risk, needs and responsivity, the lack of current evidence base is likely to restrict its usage.

Future Recommendations. Due to the minimal amount of research currently conducted within this area and the limited number of RCT's available it is suggested that a greater number of studies with good quality designs would be the future goal. As it is still unclear regarding the potential extent to which schema based therapies could be used this may be applied to a variety of diagnoses. In particular it may useful to determine any differences between its effect with specific personality disorders. Whilst there are a number of investigations conducted on the application with BPD, alternative diagnoses and clusters are minimal. If an RCT was to be carried out, recommendations would include the following;

- Provide clarity on diagnoses and symptom traits targeted

- Clarify recruitment procedure and treatment setting
- Utilise an alternative psychotherapy for comparison where possible to determine not only if schema therapy is effective overall, but if it provides greater improvements in target symptoms of the mental disorder being treated than other therapies.
- Employ a power calculation to determine number of participants needed for statistical analyses to be work out the size of the treatment effect.
- Consider potential attrition rates and how to counteract this
- Clarify outcome measures
- Utilise independent raters to assess treatment integrity
- Detail when assessment periods will take place
- Consider an adequate follow-up period to evaluate reflective functions
- Ensure treatment and assessments are standardised as far as possible
- Take into account confounding variables such as medication and additional input and control as far as possible.
- If therapies are being investigated by practitioners who have developed the programme or been heavily involved in its development, ensure research assistants independent of programme are employed to reduce bias.

Taking the above into account, greater reliability, validity and potential for review would be achieved.

CHAPTER FOUR:

A QUALITATIVE STUDY OF SCHEMA FUNCTIONING AMONGST FEMALE FORENSIC MENTAL HEALTH PATIENTS

Abstract

Aim. Young's (1990) schema focused therapy is becoming increasingly popular within the world of psychology (Giesen-Bloo et al., 2006). Although initially utilised with community populations, it is beginning to gain more attention within forensic settings (Bernstein et al., 2007). The aim of this investigation was to explore how early maladaptive schemas function specifically for female forensic patients as there has been limited research in this area to date. In addition it questions whether schemas function differently depending on how they are processed which could make risk to self or others more likely. The primary hypothesis posed is that if individuals perceive an internal locus of control then risk to self would be more likely. Secondary to this it was considered that if individuals had a tendency to view others at fault for events occurring, then risk to others would be heightened.

Method. Ten female patients within a low secure setting were interviewed. Interviews were recorded and transcribed maintaining confidentiality and anonymity throughout. Template analysis was used to help inform exploration to pick out significant themes and codes emerging.

Outcomes. For data collected, a template was developed that could be applied to each schema. This appeared to show some resemblance to functional analysis, which identified a hierarchical flow of events, with additional indications of maintenance cycles that kept the same process occurring. Some exit strategies, when schemas are triggered, were also noted. Alongside templates developed, a review of schema modes highlighted how childlike presentations (i.e. appearing vulnerable) seem to be most prevalent whilst few other modes

were identified. Nevertheless the tendency to be eager to please others in order for acceptance was repeatedly illustrated. As this does not appear to be captured within existing schema modes it is proposed that a new 'pleasing child mode' exists within female forensic populations in light of evidence obtained.

Conclusions. Schema therapy and the theory behind it has begun to gain credence within a number of settings. How this applies within a female forensic setting however seems to differ slightly and therefore requires careful consideration with its application. Similarities, differences and limitations are discussed throughout.

Introduction

Secure forensic services are designed to provide safe living environments whilst individuals reduce the likelihood of risk to themselves or others, learn how to effectively manage mental disorders and regain independent living skills (Drennan & Alred, 2012). To enable effective treatment and rehabilitation, a comprehensive understanding of the driving forces that add to risk behaviours is required. This not only provides an indication for specific targets for change, helping clarify treatment pathways, but also aids the individual's awareness allowing for greater opportunities and choices. Following a systematic review within Chapter Three SFT is evidenced to be a treatment approach that has recently gained interest within the clinical field regarding PTSD (Cockram et al., 2010), personality disorder (PD; Giesen–Bloo et al., 2006; Nadort et al., 2009; Nordahl et al., 2005a) substance misuse (Ball, 1998), agoraphobia (Gude & Hoffart, 2008; Gude et al., 2010) and eating disorders (Simon et al., 2011). With this approach, it provides support to help develop a healthy approach to life, but does so by understanding those driving forces that cause problems in the first place (Young, 1990). As effectiveness began to be demonstrated within clinical populations (Giesen–Bloo et al., 2006) it started to be considered within the forensic field also (Bernstein et al., 2007),

owing to the large crossover of issues arising. Although it is acknowledged that many individuals experience similar types of thought patterns upon each schema being triggered, people's presentations, ways of coping and emotional responses may differ. At present it is unknown what it is exactly that may bring these differences about, but it may potentially be linked to the way each person processes the activated schema, or be the result of what behavioural presentation has worked for them in the past. Greater extremes in behaviour become increasingly apparent in forensic systems with a seemingly increased lack of empathy, prevalence of aggression, addiction problems and deceit. Whilst SFT was initially utilised in its original form with EMS and schema modes, adaptations were made within the schema mode model to help capture some of these issues which are more specific to the forensic population. (Bernstein et al., 2007) Please see Chapter One, Table 2, page 11 for the additional forensic concepts.

With the use of SFT both EMS and schema modes may be identified, thus ensuring they are addressed to help manage or change difficulties arising. It is noted however that there is the flexibility within this working model to bring greater focus to one or the other, depending on the particular problems noted or which format the patient works with best. It has been suggested that schema mode work may be of greater benefit when working with forensic populations due to the high level of schemas often identified, thereby making it too complex to work with all of them at any one time (Beckley, 2007; Bernstien et al., 2007). Furthermore, mode work enables therapist and patient to work on observable behaviour. As such this creates greater opportunity for empathic challenging and lessens the chance of intellectualisation (Arntz & Jacob, 2012).

Female Forensic Services. Within recent years there have been a growing number of secure services specific for women within the UK. This has become increasingly common following identified problems with mixed wards, differences in rehabilitation needs,

presentations and variations in reasons for detention between males and females. This was supported by the Department of Health (DOH; 2002) initiative for change.

Pathways to Security. With reference to being detained, pathways to secure hospitals for women come from both prison transfers or result from an increase in risk behaviours whilst on acute wards; thereby requiring secure conditions (Coid 2000; Stafford, 1999). The escalation however may be due to risk to self or others (Rutherford & Duggan, 2007); therefore a number of those detained may not necessarily have offence histories. This seems to differ from males in that a greater number of men in secure hospitals tend to have been detained due to index offences (DOH, 1998). Taking this into account it is worth considering the potential difference in how women may come across as compared to men within secure units and the problems they are likely to face.

Presentations. Within female forensic services a high level of risk taking behaviours can be observed, whether this is directed towards self or others (Jeffcote & Watson, 2004). Vulnerabilities within relationships may also be noted. Overall, maladaptive behaviours may be easily identified and overtly observed; however, more subtle paralleling behaviours also need to be considered whereby continuing risk can be highlighted in a more indirect way (Daffern, Jones & Shine, 2010). For example, if inpatients with substance misuse problems do not have the opportunity to use, these patients may be observed to use excessive amounts of caffeine or prescribed medication in order to try gain the same effect. Being able to take account of a patient's experiences regarding EMS activation may help provide greater insight regarding what drives such behaviours.

Justification for Research. Within the forensic field the female population and female services are currently under researched in comparison to males (Coombes, 2013; Jeffcote & Watson, 2004; Long, Fulton, & Hollin, 2008). Despite growing interest and numerous female units being opened, further exploration is required to make sure services

offered are as effective as possible. This is particularly noted following the DOH Review (2002) indicating the need for support and facilities to be tailored to each population, rather than just transferring services between the two. Such suggestions arose upon recognising underlying difficulties are likely to vary, with women having a greater tendency to be affected by emotional and interpersonal issues. Due to this, the evidence base of existing treatment pathways for men (often using cognitive behavioural methods) was not comparable and subsequently led to an increase in the use of Dialectical Behaviour Therapy (DBT) and SFT in attempt to address relationship, attachment and emotion focused matters (Willmot & Gordon, 2011).

With regards to SFT, it is a relatively recent development compared to more established models such as CBT (Beck, 1997). Whilst SFT integrates an eclectic mix of existing evidenced based concepts (Young et al., 2003), the basic premise behind it of identifying EMS and schema modes requires clarification. Questions may be raised as to whether individuals answering the YSQ-L3a (Young & Brown, 2003) have the same understanding of each concept as originally intended. As such there is potential for differences to occur in the way one processes language and the meaning that is created within their internal world (Langer, 1990). Overall however, EMS and schema modes were compiled through observations of both genders, although forensic modes were based primarily upon presentations of males (Bernstein et al., 2007). Whilst the Young Schema Mode Inventory (SMI) is available (Kellogg & Young, 2013) to support assessment, utilising this could restrict responses given and assume that females respond in the same manner, when to date, this has not been established. Due to this, using the SMI may limit the full range of emotional shifts and behavioural changes that could be identified. Bearing this in mind, use of the SMI would violate the DOH (2002) proposal regarding gender specific services. Aside from this, as SFT is now being applied within forensic services, it would be

of benefit to identify any links between EMS and risk towards self or others. If there are associated links, this could not only help build insight for patients but clarify targets for treatment and be utilised to help formulate and hypothesise likely internal experiences patients are having and highlight potential presentations expected on the ward, thereby supporting staff.

Aims of Research

The aim of the investigation was to determine if women within forensic services experience EMS as described by Young et al., (2003) and if there were any identifiable themes arising in terms of how EMS may function within female forensic mental health patients if they are activated.

Research undertaken by Dawes, Beech and Coombes (2010) indicated no significant differences in schemas between female forensic patients who had an index offence and those who did not. Due to this it is considered whether the same schemas may function differently for certain subgroups regarding emotions they elicit, resulting coping responses or potentially who individuals see as responsible for such experiences. Nevertheless this could not be determined through the sole use of a quantitative investigation; therefore the current study aims to qualitatively explore how schemas function within female forensic patients and whether there are aspects which create a greater likelihood of risk to themselves or others.

In 1990 Young began to develop schema theory and SFT which was used mainly for non-forensic outpatients. Its utility has started to gain evidence for its effectiveness particularly with personality disordered individuals (Giesen–Bloo et al., 2006; Nadort et al., 2009; Nordahl et al., 2005). Considering a large number of individuals within the forensic system display symptoms of or are diagnosed with personality disorder Bernstein et al., (2007), began to take into account the specific challenges of a forensic population and further

develop schema theory in relation to this. In doing so they discovered that taking different EMS into account was helpful, however it was most beneficial to work with the emotional changes and coping styles EMS brought about (Young et al., 2003). On review, the population they tended to have based their recommendations on was males or observations of clinician's observations who work with men in the forensic system. Whilst it may be useful to work in the same way with women we first need to understand the impact EMS have. Basing our understanding on how EMS affect forensic males could potentially be too restrictive when applying this to a different population. In fact this could lead to inappropriate or ineffectual treatment programmes and high levels of under reported and unmet need; this being highlighted by the DOH (2002) review. Due to this a qualitative research project would not only allow for similar themes to be identified, but also enable the opportunity to identify any patterns that may be more specific for a female forensic population.

Research Questions

The project aims to gain evidence towards the following research questions:

1) Do women within forensic services experience EMS as described by Young et al., (2003)
2) How do EMS function for female forensic patients?
3) Is the way in which EMS are processed likely to have an impact on risk related behaviours?

A number of hypotheses that arise from these research questions are as follows:

Hypotheses

1) Upon experiencing any particular EMS, if an internal locus of control is held this would be linked with greater risk to self.

2) An external locus of control would be linked with greater risk to others.

Methodology

Sample. All patients within a female low secure unit (N=46) were initially considered to participate in research which included the following characteristics;

- Female (18- 65 years of age)
- Inpatient setting-low secure conditions
- Detained under section due to mental disorder (mental illness or personality disorder)
- History of offending or challenging behaviour

Taking into account mental wellbeing (i.e. considering if patients had been settled or were currently acutely psychotic) and capacity to consent (i.e. if this was affected by brain injury, psychotic illness or intellectual functioning), appropriate candidates were identified through discussion with clinical teams and contact with commissioners. This resulted in 26 potential participants, all of which were approached and offered the opportunity to participate. 10 individuals decided to partake and undertook the full process, with informed consent gained. Demographic details are provided within the data analysis section.

Materials.

Information Sheet. The information sheet is an A4 page which asks for basic details including: age, ethnic origin and reason for residency. This was compiled to enable demographics to be considered within the investigation.

Semi-Structured Interview. Due to the nature of the investigation being qualitative, a semi-structured interview was developed. Within this it required questions to identify schemas present and experience of them to gain an understanding on the impact they have and how they function. To capture this, careful consideration was required regarding the wording of questions. Lay language was utilised to enable patients of all abilities to relate,

and understand what was being asked and definitions were phrased as questions within each subsection so it may be easier for them to decide whether it was relevant for them or not. If a participant was to state a certain schema was not relevant then this was to be acknowledged and a focus brought to the next schema. Nevertheless if they recognised they had previously experienced the schema then further information would be gathered. Information sought was with regards to occurrences at the time of the schema arising, thought processes, feelings and actions taken.

In addition to language used, the question order was also taken into account. This was in an effort to make the interaction as smooth and comfortable for participants as possible. In order to do this, EMS with greater potential to induce uncomfortable emotional states were identified (i.e. defectiveness/ abandonment). This was done taking into account observations from own clinical experience and case study reports (Bamber, 2004; Jakes & Rhodes, 2003; Nordahl & Nysaeter, 2005). Being aware that some subject areas may be more difficult than others, questions addressing more uncomfortable EMS were interspersed with questions around potentially less threatening EMS. Despite this, individual differences are acknowledged and thereby question order may not have had an impact on the level of an individual's participation or their experience of it. Aside from this, interview items were reviewed and evaluated to ensure questions and schema definitions were valid. This was undertaken by two independent schema therapists, one of whom was a chartered psychologist, and the other a recognised CBT and schema therapist. Following confirmation that interview questions were appropriate, and captured their intended meaning, pilot interviews were conducted with colleagues to further gauge the language used and to determine an approximate time frame for how long the interviews were to last. Please see Appendix K for the full interview schedule and note that a dictaphone was also required to record interviews taking place.

Procedure. Following identification of suitable patients, initial contact was made to inform them there was an opportunity to participate in research. This involved discussions regarding what it was about and what it involved enabling questions to be asked. Issues around confidentiality, and their right to withdraw were also raised, highlighting participation was entirely voluntary and would have no impact upon standard treatment regardless of the decision made. If an interest in participating was expressed, patients were provided with an information sheet and asked to consider the costs and benefits over the following week to help ensure an informed decision was made.

Upon return at a suitable time for the patient, clarity was gained regarding whether the patient would like to participate or not, again, highlighting the voluntary nature of this. If they did not wish to take part this was accepted without question and no further contact was made. Nevertheless if patients were interested consent was gained, the additional information sheet was completed and the structured interview was undertaken. A dictaphone was set to start recording at the first question and stopped upon completion of the last question. All participants were approached in the same manner following the above procedure outlined and interviews took place in a quiet room.

Ethical Considerations. Prior to embarking upon the investigation, various ethical considerations were taken into account to keep in line with standards set by the Ethics Committee of the British Psychological Society (2009), Health and Care Professions Council Code of Conduct (2008), University and NHS Ethics and hospital policy. In line with this, meetings were held with supervisors and the lead psychologist of the unit in question. This confirmed the appropriateness of the research to be undertaken within the setting, considering how it could facilitate understanding, rapport, risk assessment and therapeutic approaches.

Due to the setting being low secure in nature and it involving patients with mental disorders (as classified by the Mental Health Act, 1983, revised 1997), the opportunity to participate

was not able to be openly advertised or involve random selection of participants. Alternatively it was necessary to ensure the individuals approached would not only have the capacity to consent but also have the resilience to undertake the research process if they so wished. To generate an appropriate pool of potential participants, checks with clinical teams and commissioners were undertaken. Whilst this limited the number of individuals ultimately able to be approached regarding research, it minimised the potential for undue stress on those whom it would be inappropriate for (i.e. if someone was acutely psychotic). Upon gaining this, all individuals identified were informed of the chance to become involved in the research, indicating the process and purpose of the investigation, how data would be treated, and confidentiality. It was explicitly stated that this was not part of therapy or assessment on behalf of the hospital and was not required for progression. Within this the voluntary nature of it was highlighted and subjects informed that whether they wished to partake or not would not impact upon the services received. Their right to stop or withdraw at any time was also highlighted. Of note, they were informed that if in discussions a current risk to themselves or others was indicated, it would be necessary to pass this on to relevant staff in keeping with duty of care. Such information was discussed and provided in writing to help them understand what is being offered. This also allowed for them to take the information away to consider over the following few days.

Approximately one week after approaching individuals, they were re-visited to see if they wished to participate, once again highlighting the voluntary nature of the research and that no reason would need to be given if they did not feel it was for them. If an interest was expressed, appropriate timings were considered so as not to interfere with regular therapeutic activities. Upon undertaking the research process, consent was gained in writing and through verbal confirmation and data collected remained anonymous by assigning reference numbers. Information regarding allocation of reference numbers was stored within a protected

document on a password protected computer, required in case information wished to be withdrawn. Additionally it was noted that any personal identifiable information would be removed (i.e. names, dates, wards and placements). Therefore, when sharing the research project with the hospital, university, review committees or publication, information would remain confidential.

Within interview, consideration was given to the sensitive nature of questions and potential for them to evoke emotional responses. Additionally it was acknowledged that the length of the interview could lead to fatigue. With this in mind the participant was intermittently asked to see if there were any issues arising. This allowed for the interview to be broken down into smaller manageable sections if required by offering breaks or to complete the interview at a later date. At the end of each session participants were given the chance to debrief and discuss their experience of it. Furthermore participants had a therapeutic environment to return to and staff were made aware of the nature of questions in case a change in presentation was noticed or support required.

Following the above ensured that each individual was respected, allowed choice, opportunity, and to consensually participate and withdraw at any time in keeping with ethical standards.

Treatment of Data. Upon completion of interviews, recorded data was transcribed under anonymous reference numbers to maintain confidentiality. Exploration of the information gathered was then undertaken utilising the qualitative method of template analysis.

Template Analysis. Template analysis (TA) is used to uncover the true experiences people have within daily occurrences, provide insight into how people view the world and highlight what underlying processes might be influencing them. This is often done by analysing a large mass of information, often from interviews, into themes. To do this,

participants would tend to be asked about a phenomena of interest, their responses recorded and the data transcribed (King, 2004). Initial themes may then be recognised from current models or theories which start to provide structure to the data. In some cases the initial a-priori codes or themes are the key concepts being explored within the investigation (Crabtree & Miller 1999). Whilst TA acknowledges the existence of key concepts prior to surveying data, it remains flexible in allowing further themes to be identified (King 2004). Whilst TA follows similar processes to existing qualitative methods, such as grounded theory and interpretive phenomenological analysis (IPA), some differences exist (Waring & Wainwright, 2008) and thereby required consideration regarding which method was the most suitable for purpose. This is discussed below.

Reasons for Choosing Template Analysis. Overall TA was chosen because the initial themes were pre-defined (schemas) enabling data to be more easily linked with known theory, and therefore not considered appropriate for other methods of qualitative analyses. Whilst a coding process was used to help filter a large amount of data into more manageable and meaningful pieces of information, flexibility was maintained to enable the pre-defined codes to be processed alongside new emerging codes or themes. Regarding outcomes, TA often highlights a hierarchical structure demonstrating each step of the process an individual may go through regarding a particular phenomenon, creating ease of understanding. In addition it was recognised that the process does not have to be linear but can move backwards and forwards to aspects of greater significance, adding depth or alterations to the template. With this it is not considered to follow the traditions of other qualitative approaches (Strauss & Corbin 1990; King 1998). Furthermore, whilst TA could impose greater constraints than other methods by having pre-existing codes, it is not associated with any one philosophical stance, thereby being less restrictive with regards to how data is interpreted (King 1998).

Coding Process. As previously noted TA is a qualitative method of analysis to gather informative details regarding the experiences people have within daily living. When faced with a body of transcribed data, information was viewed sentence by sentence. Text relating to particular subject areas was then brought together to form overarching themes and codes; the content of which would be represented in the code/ theme name. King (2004) supported the notion that codes may be predefined, highlighted after brief investigation or begin with a few predetermined codes but further developed and refined upon exploration. For this study, the latter, half-way position was taken. In order to do this, some initial codes were noted (i.e., the schemas), although information from the text was arranged in groups to represent particular emerging topics; this being transformed into other meaningful codes. Upon generating code names, overarching larger categories became evident which then represented themes with smaller subcategories within them. As there are often a number of themes that emerge from data these can be arranged in a hierarchical format although this is not prescriptive (Brookes & King, 2012). This then forms the template which helps interpret meaning within text. The template was tried and tested amongst each set of data to ensure its authenticity. If differences occurred, the process allowed for revision and alterations to be made until it was considered that legitimate connections were made.

For the purpose of the investigation a subtle realist epistemological position was taken, meaning that great effort was made to ensure interpretation was as objective as possible and grounded in the information provided by the participants themselves (Hammersley, 1992). Nevertheless it was recognised that as with any qualitative research there is likely to be a degree of interpretation bias and results should therefore be taken with caution. This in itself is an exploratory study and acknowledges slight differences may have occurred with a different researcher, although actions were taken to maintain its validity. With this it does not represent a true realist perspective (objective, true account of

experiences) nor a contextual constructivist position (numerous subjective interpretations made from data) (Madill, Jordan & Shirley, 2000), but characterises a mid-point between the two (Hammersley, 1992).

***Quality and Validity*.** Due to taking a subtle realist approach validity and reliability were taken into account. Inter-rater reliability was tested through having two psychologists look at five sets of data who spent time coding independently and then verified the interpretations made. The inter-rater review process continued when generating themes and developing the hierarchical structure. With this, five sets of schema information were processed by the second psychologist. No further corroboration was able to take place due to time constraints of the individual involved.

Data Analysis

Participants. Data analysed was inclusive of 10 completed interviews (Please see Appendix L for an example transcript); with participants ranging from 20 to 49 years old (M= 32 years of age). Within the sample there were eight individuals who were white British, one black Afro-Caribbean and one lady who was Asian in ethnic origin. Out of 10 participants, five identified that they had been detained under section 3 of the Mental Health Act (MHA; 1983) due to posing greatest risk to themselves. The remaining five indicated that they posed a greater risk to others. Two of the remaining five were detained under section 37/41 following offences against people, ordered to reside within hospital by the criminal courts with additional restrictions. A further two were on section 47/ 49 having been transferred from prison with offences against property and/ or persons. The remaining participant was under section 3 of the MHA (1983), despite being detained after carrying an offensive weapon. Nevertheless this had not been processed as a police matter but had triggered a psychiatric assessment. When identifying participants as posing greatest risk to self or others,

this did not indicate that that these were the only risks that such participants presented with, but that this was the main reason for them being detained within secure services. Regarding mental disorders, diagnostic labels identified two participants' with schizoaffective disorder, one with bipolar disorder, one with schizophrenia and six with borderline personality disorder (BPD). Of note, three individuals (one with schizoaffective disorder and two with BPD) also had a secondary diagnosis of post-traumatic stress disorder.

Qualitative Analysis. Upon review of data with the use of template analysis, hierarchical diagrams began to emerge indicating themes and interlinking codes. The template developed took on a structure similar to that of an ABC (antecedents, behaviour and consequences) functional analysis, but with additional subsections identifying methods of cognitive processing, emotional affect and ways of coping. Coping methods did not just identify behavioural responses like the ABC analysis does, alternatively this theme was inclusive of both behaviour and thinking process that one may go through in order to cope. All themes that were identified are detailed below.

Themes.

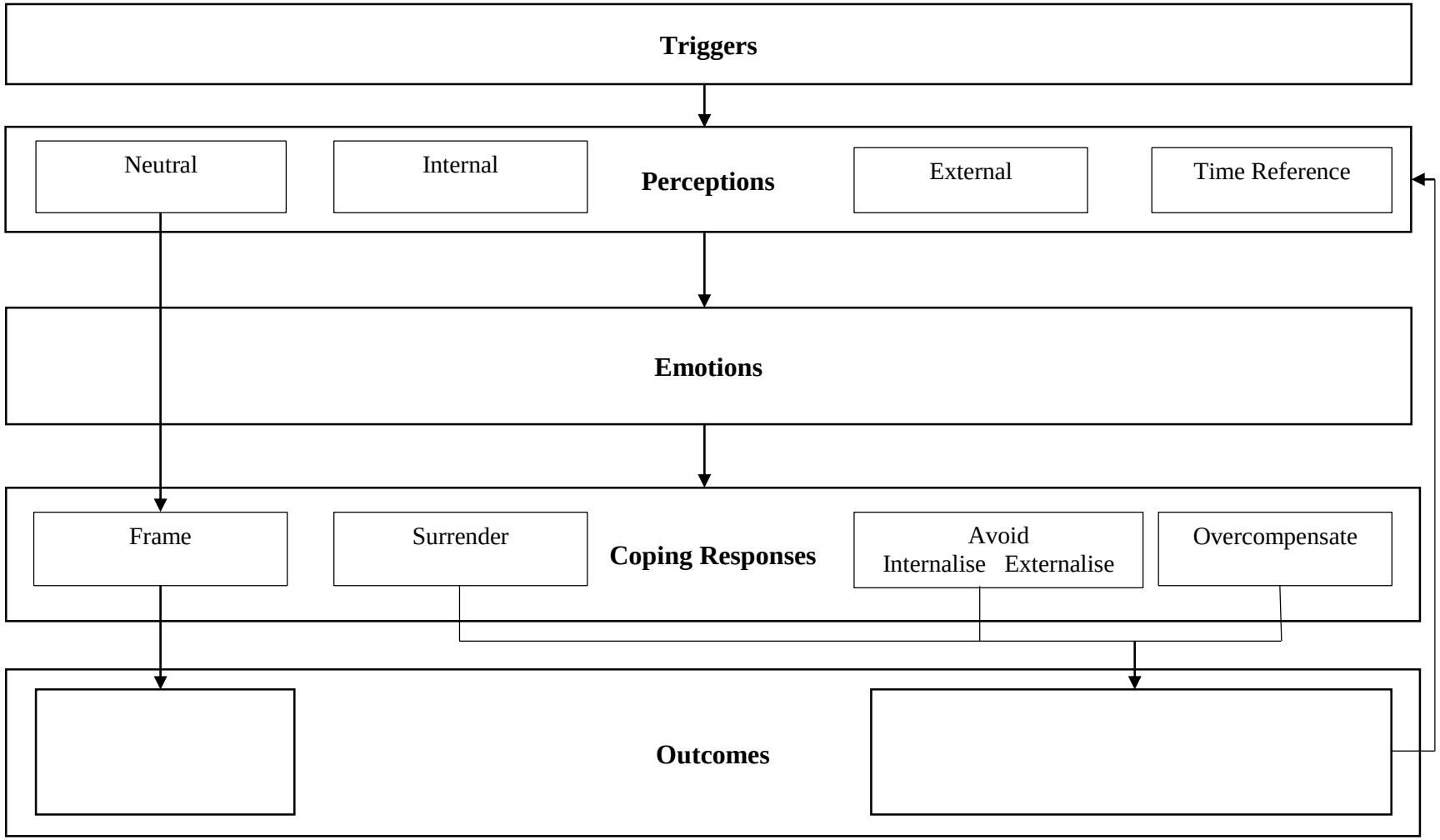
- ***Triggers***: This theme was defined as triggers at it appeared to include circumstances or involvement with others in which the schema was likely to occur.
- ***Perception***: Upon gathering information this theme could have been termed 'thoughts' although the overarching sense was that of one's perceptions of events whether that be towards self, others or a situation. Within this the core of the schema is implicated, however it was recognised that additional cognitions were present that appeared to be just as significant.
- ***Emotions***: Within this theme the feelings arising are highlighted, which seemingly followed after participants had surveyed the circumstances and formed a view on the situation.

- ***Coping Responses***: Defined as strategies used following preceding events and their evaluation of these events. Upon exploration of data, it became apparent that the schema model (Young et al., 2003) was useful in identifying and distinguishing between differing coping methods.
    - *Frame*: Healthy adaptive, responses whereby participant is able to appropriately rationalise events and deal with it effectively. Actions within this seemingly help to diverge from cyclical patterns of thoughts, feelings and behaviours'.
    - *Surrender*: Acceptance of the schema as if it is true and going along with what would be expected from this.
    - *Avoidance*: Attempts to get away from the schema and additional perspectives and associated feelings.
    - *Overcompensation*: Acting as if the schema is untrue or unfounded and making efforts to go against this. This would involve behaviours that would suggest the opposite of the schema being activated.
- ***Outcomes***: This is the final box within the template which highlights consequences of actions taken. Whilst all behaviours serve a function, it appeared evident that actions involved in surrendering, avoidance or overcompensation seemingly feedback into the initial perceptions generated and became reinforcing in nature. Alternatively the framing actions stopped the cycle and offered a healthier, pro-social outlet.

Please see Figure 2. for a diagram of the template developed which includes all of the above themes noted. The arrows between each section provide an indication of which aspects influence each other and the order in which they tend to be experienced. After Figure 2. a qualitative description of the date analysed is provided for each EMS.

Figure 2. Template Overview

Please note that whilst a descriptive overview is provided within the main content, templates can be found in Appendix M.



Unrelenting Standards EMS.

Triggers. Unrelenting standards appeared to be triggered by practical tasks or activities where measurable outcomes were likely to be noticed. The majority of participants highlighted events occurring throughout their lifetime within community settings, for example participant (p) J2. indicated "sports mainly and academic". Although situations arising in hospital conditions were still likely to trigger unrelenting standards with occupational therapy activities and continued learning.

Perception. Here the schema itself was identified, appearing to be achievement focused, as pE1 stated "I've just got to be the best". Of note however, pF1 highlighted that being the best did not necessarily mean in terms of things that would be viewed as positive, but could mean the most extreme. Accompanying perceptions involved were perceived criticism from others and also pressure from self. For pH1 the mere fact that she was diagnosed with a mental disorder was also deemed a reason for not meeting perfectionist standards.

Emotion. Representative feelings participants noted involved being scared, anxious and excited. This is interesting considering the similarities in the physiological responses these would generate; with each stimulating the sympathetic nervous system. This in turn would cause the secretion of noradrenalin and adrenaline, increase heart rate and inhibit saliva production and bladder sensitivity (Kreibig, 2010).

Coping Responses. Discussions with participants highlighted an array of coping responses when unrelenting standards were triggered. Whilst some appeared to surrender to the schema and keep trying really hard to achieve and please not only themselves but others, some would overcompensate and become overly childlike in manner, being more

haphazard in their actions. The majority of responses however seemed to highlight avoidance strategies whereby tasks would be evaded. Within this, risk of self-injury, substance misuse, arson and violence were identified.

When considering schema therapy, the ultimate goal is to help clients achieve a healthy adult stance when faced with difficulties and to be able to reframe the situation and manage appropriately. Emergence of the following concepts were highlighted which appeared to remove the individual from maintaining the maladaptive cycle and cope effectively if triggered: acceptance of good enough; belief in own competence; positive self-talk and the ability to seek support from others.

Outcomes. Following the aforementioned coping response, maladaptive coping strategies of surrender, avoidance and overcompensation appeared to lead to gaining attention from others and gain positive feelings. However, for the most part this would in fact result in criticism from others, feeling singled out and induce further self-criticalness. Such aspects would then feedback in to the original perceptions whereby they consider they are not meeting standards.

Social Isolation EMS.

Triggers. External events triggering social isolation appeared to involve group situations and experiencing sarcasm from others.

Perception. Participant's perceptions of such events included feeling misunderstood, often within a victim frame of mind. Even if no untoward events had occurred it was noted that a wariness was likely to remain, maintain low expectations and a disbelief if at times they feel they are accepted as part of a group. Participant I2 stated

"To say to anyone I feel like an alien is a strange thing to say, and people might not understand that if they fit in to everybody's world. But I feel like an alien, an outcast, some victim and not included". Of note there was a tendency to be dismissive of present tense, highlighting that this was not a current issue, but came up more frequently in the past.

Emotion. Core emotions of being sad, upset and angry were identified, alongside an overwhelming feeling of being disappointed.

Coping Responses. Upon feeling isolated and different from others, some identified a tendency to find comfort in other things as an alternative or try extremely hard to fit in by buying and doing things for others. For example pB1 reported "buying friendships". For the most part however avoidance was evidenced through withdrawal, making efforts to mask true feelings, self-harm and distraction. Avoidance methods on a more externalised level were also highlighted in the form of rebellion against rules and expectations, aggression and playing 'power games' (i.e. exerting underhand control upon others).

Throughout interviews only two adaptive methods were recalled. The first was noting the benefits of reflection, i.e. on psychology sessions or the situation, to see what they can learn from these. The second was regarding efforts to try and think of things from other people's perspective.

Outcome. The main function for behaviours seen upon feeling socially isolated appeared to be to help keep people at a distance and to gain a greater sense of control over the interactions. This not only seems to have been done for safety reasons but to release pent up emotion, pD2 stated "it eased the pain". Nevertheless additional outcomes

were identified in that this expression of emotion would often taint their reputation, provide only superficial and false friendships, and when on own provide greater time to ruminate. One further difficulty noted was then about the process of having to accept responsibility for their actions. All of the above then maintained that experience of feeling different and set apart from others. On the other hand however, framing responses identified enabled some development of a feeling of social inclusion, security and acceptance, slowing thought processes down.

Abandonment EMS.

Triggers. Issues relating to feelings of abandonment were highlighted within relationships and family. This also came up when considering resources may be strained for people to keep in contact or when there were pressures put upon people to separate themselves from others. Participant E1 stated "the professionals say don't mix with people with mental health problems".

Perception. Upon concerns arising that abandonment might be inevitable judgments were noted to become either internalised or externalised. For some a greater sense of entitlement was displayed, considering others to be at fault for separation and not making the effort and would therefore highlight mistrust as they felt this was to be expected. Alternatively, in the search for reasons as to why someone may be unlikely to stay, they considered themselves to be the cause, becoming more self-critical and seeing the self as defective in nature, i.e. pI2 stated "it's more centred around me, somebody who is leave-able, who deserves rejection, who is a failure." This also seemed to have an impact on self-confidence. For one individual it was indicated that due to expectations

that people are going to leave, there may be a sense of relief when it eventually happens. Whilst recognition was given to having the feeling that people may leave and abandon them, dismissal of the present tense was noted with some participants stating that this was not currently relevant.

Emotion. Key emotions mentioned included those of feeling sad, scared, guilty and grieving over the loss of contact, with the tendency for this to build up and for there to be a struggle in tolerating this.

Coping Responses. Strategies of surrendering to such perceptions involved crying, rumination, just allowing it to happen without question and being very uncertain of what else to do. In efforts to avoid however, risks were identified both to self and others in the form of self-harm, arson, and aggression. Participant F1 stated "the tiniest thing would wind me up and that's it, I'd blow!". It appeared that the direction that individuals actions were taken, i.e. either towards self or others, was influenced by whether they held an internal or external locus of control within their initial perceptions of abandonment. The prospect of withdrawing and making efforts to mask emotional content, were also noted. Conversely overcompensation methods were observed within persuading people not to leave and trying to care for and do various things for others.

On a more adaptive level participants identified restructuring their thought processes by learning to accept change and take into account that some people do care, rather than becoming focused on the sole person whom they feel is not available. Applying coping strategies learnt through therapies was also found to be beneficial, i.e.:

> pD2 "Because it's alright having triggers that set you off, its learning how to cope with that trigger. At the same time other people have triggers as well. Now some

> of their coping strategies could help you cope with them as well. But my worst one was not listening and flying off the handle. Now I take things on board and let people speak."

Of note participants talked of learning from their own behaviour and mistakes in order to change. Whilst this could have been held as critical towards self, this was not viewed to be the case considering it involved developing a more rounded view of oneself and making conscious adaptions that were thought to be more helpful. The benefits of learning from others and how they cope with change was also identified.

Outcomes. Behaviours based around surrendering, avoidance or overcompensating for the perceptions held appeared to bring about a sense of relief with regards to the pent up emotion. Such efforts were also identified as attempts to gain a sense of control; however it was acknowledged that this would later make them feel worse. Participant F1 stated "it would help for a bit, but then obviously feel like I want to do it again". On a secondary note, methods of framing were recognised to build on the notion of acceptance, to develop a sense of calm and allow the individuals to move on rather than getting caught up in the vicious cycle.

Mistrust EMS.

Triggers. When questioning about the experience of mistrust, events involving abandonment were highlighted alongside aspects that involved being taken advantage of (i.e. feeling used). Aside from this, mental health appears to play a significant part whereby participants acknowledged a tendency to feel paranoid and wary at times. The expressed expectations and controls/ restrictions from others (in particular mental health

services) were also questioned in terms of their real motive. Of note, minority groups reported that mistrust arises in the presence of different cultural backgrounds, particularly when there is a lack of understanding in either party.

Perception. Whilst the core belief of feeling mistrustful was recognised, this appeared to be accompanied by the consideration that they were also being punished. This was perceived to be either one's own fault considering they were to blame, becoming self-critical in nature and evidencing aspects of defectiveness. Alternatively blame was externalised towards others bringing about a sense of hopelessness and defiance. In either case a sense that no-one could help was indicated, creating a sense of helplessness.

Emotion. Experiences of feeling hurt, angry, and sad were highlighted upon the mistrust schema being triggered, acknowledging the particular difficulties in tolerating such emotions.

Coping Responses. Coping strategies identified for these experiences included surrender strategies of hyper-vigilance and rumination whilst not doing or saying anything about how they were feeling. This could highlight potential vulnerabilities to continuing mistreatment. Alternatively, the risk behaviour of self-harm could occur with a tendency to withdraw and mask the emotion. This seemed to be linked with internalising self-blame and participants considering they were being punished due to not being good enough themselves, for example pH1 stated "I feel like such a horrible person". Risks to others were also identified however, with participants identifying acts of rebellion and defiance. These appeared to be either overtly aggressive or passive aggressive in nature. Participant G2 stated that she was "probably quite defiant and fairly

aggressive in some respects. I have threatened to want to, not to blow up the whole hospital, but to do some damage in the front area of the hospital". No behaviours associated with overcompensating were identified.

Of note various methods of framing were acknowledged to enable emotions to be expressed appropriately. Such actions involved taking into account the situations experienced to reflect and learn from what had occurred and to begin to positively reframe what had happened. With this participants recognised that they still had existing more stable relationships, that some relationships may be re-established under the correct circumstances and that some people are genuine. This averts the need to be mistrustful towards all. Furthermore, it was identified that allowing people to get to know them could take time and could support more positive meaningful interactions instead of pushing people away. If concerns did arise about the potential for another to harm them in some way, the process of reality checking and rationalising the situation supported the ability to make an informed and valid choice.

Outcomes. Methods of coping generally resulted in blocks to people or emotions, providing individuals with a greater sense of power and control. These coping strategies were highlighted as attempts to keep themselves safe: pB1 indicated "I just keep them at arm's length, and not let them in. It's like a little safety barrier." Nevertheless due to the way in which this is dealt with, greater controls would then be placed upon them (i.e. within services), therefore feeding back into the perception that they were being mistreated. With this, the acts chosen also seemed to serve as a way to punish self; which again would be reinforced. Upon utilising some of the framing methods however, this

appeared to provide an exit from the cycle, allowing the individuals to feel safer, secure and reassured.

Emotional Deprivation EMS.

Triggers. When discussing issues around not feeling cared for, family and services were often mentioned following the experience of abandonment/ rejection or when people highlighted their expectations of them. When others were trying to be supportive however and set out potentially positive expectations for how things would be, this also appeared to be a trigger for the thought processes related to this EMS.

Perception. Interestingly issues with dependency were highlighted although accompanied with the perception that no one actually cared, i.e. pI2 stated "nobody actually cares. I don't think anybody has cared for me. And nobody knows how to care for me". Due to this participants often felt that they could not let people in or let their expectations be raised as they are likely to be let down. When looking to understand the perceived notion of emotional deprivation, participants thought processes appeared to split into external or internal blame. In considering if people were to be supportive, fears of being hurt by others were raised along with the fear that they themselves may hurt others.

Emotion. The emotional content highlighted included feelings of desperation, loneliness, confusion, and sad at being let down. With this the need to express emotion was indicated.

Coping Responses. After experiencing such feelings, a number of individuals noted they would tend to surrender to this and deal with things on their own as they had

to learn to do that in previous experiences. Alternatively, avoidance strategies of withdrawal, self-harm and substance use were highlighted to prevent the experience of feeling let down. Behaviours such as arson and aggression demonstrated avoidance also, but in a more externalised manner. Opposing this was the tendency to overcompensate by trying to please others despite not feeling cared for themselves.

With regards to responses considered to help frame the situation and respond in a more adaptive manner, acceptance of emotion was indicated alongside widening one's social perspective taking to understand things from other people's points of view. With this, black and white thinking appeared to be prevented and also helped when starting to consider that even though support may not be available at all times, there are occasions when support is there. Recognition of reciprocal support was also highlighted along with aspects of self-soothing if an individual was struggling with the uncomfortable nature of the feelings at times.

Outcomes. Upon efforts to frame the situation and rationalise the perceptions held, participants reported feeling calmer in nature and were able to gain greater self-acceptance. Alternatively however, the remaining methods of coping acted to serve the function of releasing pent up emotion or help to block it altogether. When looking at surrender and avoidance methods this also kept people at a distance yet on some occasions would bring services closer by requiring detention considering the actions undertaken. Nevertheless, for each action noted it was highlighted as an attempt to keep safe.

Self-Sacrifice EMS.

Triggers. Trigger factors for self-sacrifice appeared to come to the forefront when considering expectations from self and others; this seeming particularly relevant for participants from Asian cultures. Interactions with family and at work were also mentioned alongside participants wanting to do things for animals being indicated. Of note, participants appeared to recognise that when they are having problems themselves or feeling lonely, they may have a tendency to want to help/ be supportive of others in order to avoid their own issues or keep people close; pE1 "I buy things for them and do things for them, trying to make them like me". Recognising that they have received little support in the past also appears to induce a wish to become self-sacrificing.

Perception. Key perceptions noted when questioning about self-sacrifice, involved considering that one would like to support/ help others in differing circumstances, with some questioning if they showed that they cared enough. Whilst recognising that this has been an issue for them, a number of participants disputed that this was currently a problem.

Emotions. Following perceptions arising participants noticed raised levels of loneliness, sadness, depression, anger and worry, with a tendency for there to be a build-up of pressure also.

Coping Responses. Upon experiencing feelings of self-sacrifice many participants identified surrendering to this and putting their efforts into caring for others. If for some reason this was not possible however attempts to try and ensure people were supported by others was reported. Whilst this seemed to be acknowledged as something that may come up for them, it was vocally dismissed that it was a problem: pH1 stated "no matter how tired I am it is always a pleasure to go and do this". Participant F1 also indicated "I go out

of my way but I don't mind it, as I think it's a very important thing for me to do." Alternatively, upon recognising the associated emotions they were avoided by use of self-harm. No other maintaining behaviours were identified. On reflection it would appear participants recognised only actions that would be classed as a risk to themselves and highlighted their vulnerability rather than this being associated with risks to others at all.

In order to cope more effectively with the self-sacrifice EMS, framing methods highlighted recognition of their wish to support others and allowing enough time to prepare this, whilst ensuring a balance is gained by engaging in activities that are soothing for themselves also. The concept of reciprocity was also recognised within acquiring healthy interactions with those around them.

Outcomes. In response to the above actions the outcomes appeared to involve feeling that it made the participants feel good, valued and that they had purpose. Nevertheless, it was accepted that this was often in order to gain acceptance, avoid harm and keep them safe whilst at the same time left them vulnerable to being taken advantage of; pE1 stated "I just want to please other people". Participant B1 also reported "I think it ties into not letting people in with my own emotion, because people won't like me if they know my emotion and everything. So I please them instead so they might like me and they will stay". In addition, the degree of exhaustion and potential debt also increased. Alternatively, avoidance methods of self-harming acted as a release and distraction from such feelings arising.

Upon speaking of more adaptive methods it was acknowledged that the consequences of this lead to feeling valued and secure in their interactions whilst both parties gain meaningful interaction from the exchange of help/ support.

Defectiveness EMS.

Triggers. When asked about experiencing defectiveness this appeared to arise particularly when criticised by others or when in groups. Of note, having experienced past abuse or just the mere presence of having a 'disorder' either mental or intellectual in itself contributed to feeling like one was no good.

Perception. Upon discussing perceptions, the identification of feeling as though there was something fundamentally wrong with them was highlighted, often feeling like an outsider in groups: pG2 indicated "feeling like an outsider in groups would make me feel like there is something wrong with me". This appeared to be substantiated when feeling uncertain of what being 'normal ' was or had the tendency to compare themselves to others and see the other person in a positive light, whilst downplaying their own positive traits. Whilst this could be held without accountability there was again a tendency to either internalise or externalise blame, regarding why they felt this way, and vigilance to criticism was highlighted. Although recognising such difficulties, dismissiveness of present tense was also present, indicating it used to be a problem but it did not concern them now.

Emotions. Overriding emotions of feeling empty, awkward and angry were suggested.

Coping Responses. Upon bringing about change, an acceptance of differences and the ability to soothe the inner child was noted, with the ability to allow it to pass and engaging in meaningful reciprocal interactions.

When experiencing thoughts of being defective it sometimes appeared as though the individual would not know what to do and would therefore just remain with that position, surrendering to the perception. Alternatively strategies of avoidance involved active withdrawal, self-harm and masking of the emotion. Avoidance by externalising their behaviours however involved aggression and thoughts of arson: for example pJ2 stated "and then I wanted to burn the place down because I felt like they were getting on at me like the way they used to when I was a kid".

Risks identified with regards to overcompensation attempts included that of self-sacrifice; therefore potentially leaving them vulnerable to exploitation: pH1 reported "just feeling all the time that you are people pleasing, like a little puppy dog wagging its tail".

Outcomes. Of note there was only one identified outcome of acceptance noted as to why potential framing behaviours are helpful. In instances such as this it could mean that these framing strategies are not resilient or strong enough to recognise the further beneficial impact, and could be more likely to shift back into more maladaptive behaviours. This would indicate an area of need within therapy.

Regarding surrender, avoidance and overcompensation strategies however there was a general sense of release to make individuals feel better. However, a small handful identified that it could indeed make them feel worse. With such ways of coping, methods of avoidance were particularly highlighted, however the resultant feeling of missing people was acknowledged: pE1 stated "so that would make me yearn and miss them". In some cases behavioural outcomes led to observers considering the individual to be inappropriate in nature, for example pG2 stated "they just think I am an idiot". Outcomes such as this therefore increased the void further and supported the maintenance of the

vicious cycle whereby perceptions and emotional content became progressively negative or uncomfortable.

Negativity EMS.

Triggers. Upon experiencing memories of past uncomfortable events (often including family and/ or loss) participants noted retaining a sense that things were always likely to go wrong and not work out. Negativity also appeared to arise when perceiving they were being criticised/ judged by others.

Perceptions. When considering that things were likely to go wrong, a sense of hopelessness and helplessness prevailed and thoughts became solely focused on themselves: pD2 stated "there's no future for me". Alternatively a degree of external blame and criticism was upheld considering that others were responsible for why things would not turn out for the best. As with other schemas, a number of participants identified that this had been a particular pattern for them previously, although dismissed the fact that this was a current concern.

Emotions. Confusion, distress and grief were all indicated to be emotions experienced when becoming negativistic in one's thinking patterns. This being regardless of whether judgements were made either internal or external to themselves.

Coping Responses. In order to help reframe difficulties experienced, participants highlighted the use of positive thinking and reality checking. Despite this, few noted the ability to do this and/ or truly believe the positive statements that they would think of. Alternatively it was reported that there was a tendency to ruminate, remain hopeless and

therefore lack motivation to try and make changes and progress: pE1 stated "I felt like that no matter what I do, it's all going to fall apart anyway so what's the point?"

Although no overcompensation responses were identified, avoidance methods of withdrawal or aggression were highlighted.

Outcomes. Whilst framing responses brought about a sense of relief, reassurance and an increasing feel of security that things will be alright, maladaptive responses seemed to help individuals to detach away from emotions. Nevertheless this appears to leave a residual feeling of hopelessness, feeding back into the cycle of negativity. Although the benefits of framing strategies were highlighted for some, the ruminative nature of negative thought patterns appeared persistent.

Failure EMS.

Triggers. Triggering factors for the perception of failure included that of vocational activities, education, employment and holding other peoples' expectations in mind (i.e. from the family).

Perception. Upon engaging with these activities or experiencing this, the concept of failure was highlighted with a tendency to compare themselves to others, viewing peers as better than themselves. With the sense of failure there was a concern about it holding them back, however with regards to placing responsibility for this coding was split between internal self-blame; for example pB1 stated "I just feel like a failure", or external blame considering there was a lack of support to enable them to succeed; pA2 "the mental health team did not respond quickly enough when I was having trouble".

Whilst these issues were raised, a dismissal of present tense was once again noted, with a number of individuals stating that this was not a current problem.

Emotions. Upon experiencing feelings of failure, emotions of hopelessness, jealousy and despair where indicated. Interestingly however participants noted this also brought up vengeful feelings when linked with the externalised blame component; pA2 "the anger was directed towards my mum and my sister. I wanted revenge".

Coping Responses. Efforts to frame difficulties arising were inclusive of consequential thinking, being able to recognise areas of strength and having the capacity to identify when people had been acknowledging of their efforts. Behaviourally, asking for support when necessary was also considered helpful.

Codes relating to schema surrender implicated not knowing what to do or how to cope and making every effort to try hard to not fail, but this seemingly led to actions that confirmed the aspect of failure. Regarding avoidance strategies however, internalisation appeared to result in withdrawal, masking of feelings; pG2 stated "it's weird; it's like only talking to them at a certain level to try and avoid giving anything away". Alternatively avoidance by externalisation involved arson and carrying offensive weapons; both in themselves potentially considered as passive aggressive acts. No further coping strategies were identified and overcompensation was not noted.

Outcomes. Actions taken when avoiding feelings of failure appeared to serve the function of relief, allowing the individual to detach from the feelings of failure and increase their sense of control: pD2 reported "if I avoid, I feel relieved because otherwise it puts me under so much pressure". When surrendering to the failure EMS by engaging in activities but not performing to the best of their ability, participants also stated that this

was in effort to gain a sense of control. Nevertheless, all of these outcomes then seemingly led back in to the existing cycle. Alternatively, relief, understanding and acceptance of what is realistically achievable were outcomes reported following framing behaviours.

Enmeshment EMS.

Triggers. Upon defining enmeshment few participants noted this as an issue. For those that recognised this however, relationships with family and partners played a major role, whilst one participant indicated the implications of this for new interactions.

Perception. Perceptions arising included feeling enmeshed as though others were over involved in their life and that this was unfair. Despite this it would often yield a fear of rejection/ criticism from those they felt involved with and a desire to be accepted. For new interactions it was considered that quick attachments were formed and participants described they would begin to put on a front in order to develop a relationship in the first place.

Emotions. With the conflict experienced it appeared to induce a state of feeling sad and scared of the rejection: pF1 stated feeling "pretty scared of what they may think". Participants also reported feeling particularly oppressed when considering the circumstances were unfair and the pressure experienced due to this.

Coping Responses. Upon this schema being triggered, surrendering coping responses included that of putting on a good front, trying to do what is expected of them or persuading people not to leave. On the other hand, avoidance strategies described involved delay tactics to postpone interactions with individuals involved for as long as

possible; particularly if the individual was thinking that the other person would not approve of them or their behaviour. Overcompensation techniques involved being abrupt and 'brutally honest' rather than surrendering to the pressures felt within the relationship/ interactions. This only appeared to be if they felt they had or would shortly be questioned about this and that the person was already aware of information.

Regarding more healthy adaptive responses, participants noted the potential for taking the time to consider when such significant others have been accepting of them and respectful of their wishes despite initial anxieties about being open about this. In addition, making efforts to use assertiveness skills to help maintain boundaries and limitations within the relationship were highlighted.

Outcomes. Framing responses managed to achieve a level of acceptance within oneself and help to feel more self-assured, maintaining and developing a sense of self-identity. With other methods of coping however it left a feeling that one had changed or should change for others, which then appeared to perpetuate the cycle: pA2 stated "I change to be accepted but still never feel good enough".

Entitlement EMS.

Triggers. A tendency to experience a sense of entitlement appeared to occur at times when comparing one's self to others and being aware of what other people were being allowed or offered. This seemed particularly the case for situations experienced within services. For example, knowing what peers had managed to gain from ward rounds (i.e. observation levels, tool access, section 17 leaves): pE1 stated "like if I'm

doing really well and somebody else isn't, and that person's got leave, it's like well why haven't I got leave yet? I think to myself and say well surely I deserve leave now!".

Perception. Only two areas stood out within this theme, which included the perception of being entitled whilst holding a degree of external blame (not getting the help).

Emotions. Emotions of anger and jealousy were highlighted with an apparent undercurrent of feeling upset.

Coping Responses. When looking at coping responses it appears that surrendering to this schema was the only reaction identified whereby participants noted vocalising their opinion to contest decisions others had made. Participant E1 indicated that "I just say it's not fair and that I should have my leave. I go on a bit of a whinge really. So I contest and say I should have my leave and tell them they are wrong in not giving it to me". No other behaviours or coping responses were identified.

Outcomes. Following the coping responses noted outcomes highlighted would often be negative reactions from others. For example, participants did not like it if other people brought up how they had behaved in the past and or if others were in disagreement with their requests. At times such as this they indicate the likelihood of feeling their efforts, or they themselves, are unappreciated and devalued: pA1 reported "No-one appreciates me". If on the other hand they are able to achieve the ideal outcome they report being happy, find it encouraging "making progress" and begin to feel more confident and positive.

Insufficient Self-Control EMS.

Triggers. Reported triggering events for difficulty managing oneself included that of symptoms of mental disorders such as hearing voices and flashbacks. Other aspects mentioned were that of external stressors such as interactions with family or professional meetings such as care programme approach reviews (CPA's). Of note, even internal symptoms were externalised to a degree as participants reported that it was due to symptoms of their illness that they respond in the manner they did.

Perception. The sense of being impulsive and the intensity of urges in themselves have the potential to be held in a neutral state of mind. For some participants however there is a greater sense of responsibility, feeling uncertain whether they want to act on their urges or not. The perception that their actions are a last resort was identified when considering they had run out of inner resources to maintain stability and that urges just become too strong: pD2 stated "I tried all the rest of my coping strategies and that was my last one". Perceptions that became externally directed were highlighted however when recognising the feeling of being unsupported. Similar to many other schemas, the dismissal of present tense was also frequently identified.

Emotions. Emotional content expressed was of annoyance, upset, desperation, anger, and worthlessness. With this the intensity of emotion was particularly noted, with expressed difficulty in being able to tolerate this.

Coping Responses. To engender framing responses individuals noted making effort to learn coping strategies, taking the time to reflect, rationalise and consider consequences. With this, aspects of morality and values were also highlighted.

Risk behaviours of suicide and self-harm were identified as techniques of surrender in an internal manner, for example pB1 reported "lots of self-harming and

suicide attempts". Whereas aggression and arson also highlighted a tendency to act on urges but more external to themselves: pJ2 reported "sometimes the fires are impulsive and the stabbing was impulsive". Whilst such behaviours have been identified with avoidance of other schemas, this is represented as surrender for insufficient self-control as it is going along with the expectations and wants of the perceptions generated. Remaining coping responses that did fit with avoidance however were those of isolation and withdrawal in order to try and prevent acting on the self-control difficulties arising.

Outcomes. From framing responses, impulsiveness was reported to be reduced, helping maintain appropriate boundaries and building confidence within one's self that they could manage such experiences. For other responses however, it appeared participants resulted in justifying their actions and minimising incidents that had previously taken place. Acting on urges however, often resulted in transference of pain as a release to help feel better, or became somewhat punishing in nature, seemingly perpetuating the cycle.

Subjugation EMS.

Triggers. Triggering events for feeling as though they had to relinquish their own needs were namely when participants felt put on the spot (i.e. asked there and then to do something) even more so when with family.

Perception. There appeared to be a tendency for negativity to be induced, ruminating on how things would go wrong and feeling forced into going along with others' needs/ wishes. With this, those that internalised the experience noted blaming themselves for this. Alternatively, externalisation involved viewing others as a priority

whilst becoming blaming, critical and judgemental in their own minds about these other people.

Emotions. A lot of anger and a high degree of burnout was noted after experiencing this schema over prolonged periods.

Coping Responses. Framing responses involved the ability to self-soothe and to engage with/ seek positive support from others. Alternatively however, a greater number of responses were coded for surrendering to subjugating ones needs by giving practical support to others, providing gifts and having a tendency to justify their own actions. Some individuals indicated being uncertain about how else to respond in this situation. For others avoidance methods were implemented, highlighting risk of self-isolation and self-harm. Overcompensation however involved the tendency to become rebellious and ensuring things are done their own way.

Outcomes. Upon surrendering and making efforts to avoid such situations, participants noted they were consequentially left feeling that there had been a degree of release from the negative affect although it would often leave them feeling vulnerable. For example, pE1 indicated it as a necessity to attend to what others want "I have to please them so they will like me". Nevertheless overcompensation enabled an alternative outlet to prevent them turning their anger in on themselves. With the ability to utilise framing responses however, a greater level of reassurance was sought, enabling an exit from the cyclic pattern of subjugation.

Vulnerability EMS.

Triggers. Vulnerability was noted to be of greater sensitivity when with family or when memories of the past were to come to the forefront. This may involve flashbacks from past trauma when they have felt under threat.

Perception. Interestingly, only the perception of being vulnerable was noted without placing anyone at fault for this. Nevertheless a sense of hopelessness seemed to prevail. As with other schemas however, the tendency to dismiss this as present currently also arose.

Emotions. Emotional states of panic, fear and anxiety were identified. Such emotions can often be associated with the threat system when considering this from a biological point of view as automatic responses prepare the body for fight or flight.

Coping Responses. With no perceptions of external fault or blame being identified, no overcompensation responses nor external methods of avoidance were indicated. What was apparent however was a propensity to remain with the feeling of being vulnerable and to consider that one just has to cope or make efforts to avoid by using suicide/ self-harm behaviours or have a tendency to withdraw: pB1 reported "I kind of lock myself away and feel scared". Self-sacrifice was also highlighted with the aim of seeking safety and comfort from another. Nevertheless, in order to help frame the situation, participants identified the capacity to check things out, considering evidence for or against their initial perceptions.

Outcomes. Upon discussion, participants identified the function of framing responses as that of safety and reassurance, providing some relief from the anxieties raised. Conversely it was recognised that remaining efforts to manage feelings of vulnerability was reported to receive criticism from others, despite their efforts to please

them at times. Although self-harming/ suicide attempts were also being aimed at seeking a sense of controlled safety for themselves, this ultimately fedback into feeling vulnerable and helpless.

Emotion Inhibition EMS.

Triggers. Authority figures were highlighted as the likely triggering factor for feeling the need to mask emotions experienced; this often being represented throughout services.

Perception. When in the presence of authority figures the schema itself was activated regarding inhibiting emotions. The perceptions held were that of being self-critical, that people will judge them and that there was concern over being rejected or experiencing confrontation. This was amidst holding the perception that other people are likely to have hidden agendas so a degree of mistrust was held. It was noted that with this ambivalence in themselves they were often being torn between wanting to display their affect or hide it.

Emotions. Although feeling the need to hide emotional content, participants reported feeling angry and shy.

Coping Responses. The only coping response styles identified for this schema were that of surrender and avoidance; whereby they would surrender by making conscious efforts to mask underlying emotion or withdraw from the situation so that it would not be displayed: pB1 stated “they find it hard to see the real me which is why I wear the ‘mask’ most of the time”. Further behavioural and risk responses noted were that of self-harm or aggression. Such methods of coping were identified within both the

avoidance and overcompensation subsections although the responses used seemed to be dependent on whether participants saw themselves or others as responsible for the feelings they had. If behaviour is overt they would be demonstrating the extent of their distress or anger and considered to be overcompensating and doing the opposite of the schema experienced. If feeling shy about expressing their emotions however efforts may be more discrete (i.e. when self-harming) or masking the true underlying feeling with risk behaviours demonstrated.

Outcomes. Of note, the only outcome identified for this schema was that of self-blame/ criticism which resulted in reinforcing initial perceptions held: pF1 stated "so I'm kind of letting people down and feel disappointed at myself as they are trying to help me but I'm not giving them the chance to help".

Dependency EMS.

Triggers. Triggers to dependency were advocated when thoughts regarding moving on and being discharged from hospital arose or at times when undertaking practical tasks.

Perception. Perceptions arising involved an internalisation of participants not trusting themselves and being uncertain of how others think of them. With this, the feeling of dependency and placing responsibility in others arose. This may be wanted as support or a quick fix. Nevertheless it allows blame to be placed externally when things do not go right: pG2 stated "but my psychiatrist knew that I felt like doing it (index offence), I had told them several times, and the day I felt like doing it I told him I could not stop myself any longer".

Emotions. Participants reported feeling particularly scared, vulnerable and weak when this EMS arose. Upon identifying this, the tendency for it to build and the need to express it was noted.

Coping Responses. Adaptive methods noted were being able to recognise one's own abilities, the balance of support and own responsibility to enable greater independence. To aid this, the process of future planning and thinking of practical strategies to manage arising problems were used to help.

In surrendering to dependency participants spoke of just experiencing it and playing it out as and when needed, and seeking support for issues to be dealt with for them. Alternatively, avoidance strategies were of withdrawing, inhibiting their emotional states and perceptions by masking, self-harming or absconding in order to physically run away from it: pH1 stated "because if you are not sure that people like you and the potential of people hating you can be so intense that you just feel like pushing people away, my instinct was to hurt myself, my instinct was to not talk to anybody, not to take my medication". Upon coding this it was difficult to ascertain whether these were in fact avoidance techniques or ways in which to ascertain help in an indirect manner. Rather than speculating however, this was coded solely on the reports provided. More externalised ways of avoiding seeking support were those of aggression, arson and displaying a tendency to be/ feel out of control. Lastly the tendency to care for and please others was detailed as a method of overcompensating for the feeling that they cannot do things themselves.

Outcomes. Aspects of surrender, avoidance and overcompensation were recognised as being unhelpful ways of coping: pC1 indicated "I know it's wrong".

However they are reported to utilising such strategies in order to release the uncomfortable emotional states, enable avoidance of the dependency aspect (i.e. push people away), feel safer and more empowered by having some sense of control. No outcomes were highlighted for framing responses.

Punitiveness EMS.

Triggers. Events participants identified as initiating thoughts of punitiveness were with regard to perceived criticism, bullying, maliciousness and witnessing aggression; to either human or animals. Thoughts of past trauma or being mistreated were also recognised as trigger factors.

Perception. The importance of rules and the schema itself were acknowledged, although participants would often distinguish between punishment and consequences. The understanding of this however appeared to differ amongst individuals. With regard to internal perceptions it appeared that for some a degree of entitlement was noted, becoming adamant that they would put up with the situation at hand and justify their thought process around punishment. This was often accompanied with externalising perceptions of feeling that situations were not fair, thinking people had got away with it, and that other people were at fault: pG2 reported that "in places like this if they don't deal with bullies, if they don't take action, then they are going to get people like me who will take it in to their own hands to deal with it". For some however, self-blame and defectiveness arose appearing to turn it on themselves, believing that they deserved punishment for their own mistakes: pA2 stated " I realise I have done a lot of mistakes" " I should have just done what they said". Participant B1 also reported feeing "pissed off

with myself for not knowing different". Finally, dismissal of this schema being present at this time was again highlighted.

Emotions. Upon witnessing things participants did not like sadness was noted to arise, however the greatest overriding emotional response was that of anger which appeared to fuel the coping responses. Guilt responses were in relation to how they perceived their own behaviour however, which would lend itself to being punitive towards self: pA2 stated "I am really guilty and I can never let go of it".

Coping Responses. With reference to more adaptive ways of trying to manage this, participants noted taking the time to think of consequences before becoming involved with situations and trying to learn from their own mistakes if they had dealt with a situation poorly before. Alternatively if they were to be involved with others they would utilise reasoning skills to help resolve issues arising was noted. Considering the tendency for thoughts of past trauma to bring punitiveness up, individuals highlighted the benefit of learning to develop acceptance for past experiences so they were not left with the anger towards people who have harmed them in the past.

Upon speaking of the punitiveness schema it became apparent that aggression was heavily endorsed, alongside passive-aggressive behaviours, and participants indicated that they would inform people within authority of other people's wrongdoing with malicious intent to get them in trouble. Whilst aggression/ passive-aggression were about punishing others, self-harm was used in order to punish one's self when surrendering to this schema. Avoidance was also noted through withdrawal and inhibiting emotion and perceptions. No overcompensation methods were indicated.

Outcomes. Participants identified that methods of coping helped release pent-up emotion whilst aiming to seek justice; this being to make people think things through next time and to protect others. Alternatively trying to mask the thoughts of punitiveness and withdrawing were noted to increase the level of intensity describing how it maintains the emotional state: pB1 reported "it just starts to bubble inside me and I keep it all in". On the other hand framing responses were thought to help engender change through more socially acceptable methods and prevent individuals from becoming involved in punitive acts themselves.

Approval Seeking EMS.

Triggers. Four categories appeared to be highlighted when considering occasions when approval seeking may come into play. The one noted most often was that of thoughts of family. Therefore following therapy sessions where thoughts of the past have been raised, individuals seemed to report missing the attention they had once experienced and this would therefore lead to wanting this attention following sessions: pF1 reported "especially after therapy because I was talking about my past and it brought up memories from when I was younger. Leaves me wanting to be loved by other people, the love I didn't get off my dad". Approval seeking also came about on occasions when feeling rejected by others or isolated in some way. Additionally, upon completion of achievement focused tasks or upon developing an admiration for another, individuals recognised these events as leading to the approval seeking schemas being raised.

Perception. The greatest endorsement within the perceptions theme was given to the generic need to seek approval. Individuals seemed to distinguish between seeking

approval however and attention seeking; some preferring to use either one of the terms to describe it. Upon exploration, internal perceptions would diverge between feeling as though something is wrong with them to being proud of themselves. Additionally pH1 highlighted a tendency to externalise credit rather than acknowledge achievement for herself.

Emotions. Emotional responses noted appeared more reflective of the internal perceptions identified. For those that felt they had done well and wanted recognition for their achievements they appeared to be more excitable. On the other hand however, for those whose internal perception was of being defective in some way, sadness and desperation were indicated.

Coping Responses. With reference to framing responses, reciprocal acknowledgement, contributions to tasks and asking for support when needed were adaptive methods people had found to manage when this schema had arisen. It was acknowledged that a degree of approval seeking was acceptable, although making effort to ensure it was not only focused on self.

Upon approval seeking being triggered, there was a tendency noted by several participants to become quite childlike in nature. This could be represented in a number of ways by being either playful in manner, vulnerable or bad tempered. Methods of self-harming and openly discussing historic events were ways that participants noted additional methods to engage other people within interactions that would meet their need for approval or attention. This differed somewhat to avoidance methods of withdrawal to help keep "under the radar" as noted by pH1, and overcompensation methods of being abrupt and pushing people away that would work against the schema being triggered.

Outcomes. Framing strategies seemed to contribute to improving self-worth and providing mutual appreciation amongst individuals; thus creating a feeling of reassurance also.

With regard to surrendering to the schema, a level of safety and reassurance was sought, as they felt some recognition and care was gained. However it was recognised that this was not done in the most adaptive way. With this, participants reported beginning to feel soothed, and stated that once they received some approval feel they had pleased others and had thereby avoided rejection. With efforts to avoid or overcompensate however, the prevailing outcomes indicated a feeling of punishment upon themselves and a degree of shame. This once again led back into initial perceptions held and maintained the perpetuating cycle.

Summary of Risks Identified

With the vast amount of data gathered from interviews and the qualitative process of analysis, it provides in-depth information verifying the presence of EMS as described by Young et al., (2003) within female forensic mental health patients. It also offers insight regarding how such EMS are experienced when they are triggered. As this thesis is focused on a female forensic service it was necessary to look at the relationship between activated EMS and risks for the participants involved. Table 5. presented below provides an overview of EMS which participants self-report to be associated with either a risk to themselves or others. Whilst individuals may have been admitted into services primarily due to harming self or others, it did not mean that this was their only presenting risk. Taking account of this, the table was constructed based on information participants

provided within interviews, rather than being based on their initial reason for entering secure services. For example, if an individual stated that when the 'defectiveness' EMS was activated that they had harmed themselves in order to cope, then this would be documented as a related risk for that particular EMS. Please note that the table identifies that an association had been made if one or more participants have made reference to such risks.

Table 5. Table Summary of EMS and Related Risk

EMS	Number of participants endorsing EMS	Self-reported risk to self (i.e. Self- harm, substances, vulnerable to others)	Self-reported risk to others (i.e. Aggression, Arson, weapon use)
Unrelenting Standards	8	Y	Y
Social Isolation	9	Y	Y
Abandonment	8	Y	Y
Mistrust	8	Y	Y
Emotional Deprivation	10	Y	Y
Self-Sacrifice	10	Y	N
Defectiveness	9	Y	Y
Negativity	5	N	Y
Failure	8	N	Y
Enmeshment	3	Y	N
Entitlement	5	N	N
Insufficient Self-Control	9	Y	Y
Subjugation	8	Y	N
Vulnerability	6	Y	N
Emotion Inhibition	3	Y	Y
Dependency	4	Y	Y
Punitiveness	8	Y	Y
Approval seeking	9	Y	N

Key: Y= Yes, N=No

Exploring risks associated with different schemas, it is highlighted within Table 5 that self-sacrifice, enmeshment, subjugation, vulnerability and approval seeking are solely associated with risk to self. In contrast, negativity and failure demonstrated links only with risk to others. The remaining schemas demonstrated connections with risk in all areas aside from entitlement which participants reported had links with none. Considering reasons why this may occur is addressed within the discussion section.

Notes on the Coding Process. Within the templates developed, it is acknowledged that some coding had the potential to be interpreted differently. One particular area was that of arson and whether this would be deemed as risk to others at times when no person may have been present. This was ultimately included as risk to others, however incidents noted by participants would often be attributed to section 1(2) of the criminal damage act (1971) which identifies the potential threat to life whether a person is present or not due to potential for fire to spread, or the impact this could have with it being a person's property.

Aggression is another code observed throughout. When considering the term for this there was the potential to use the word 'violence' however this has a greater tendency to be considered to be more physical in nature. Using the term aggression however enables us to encompass both physical and verbal acts which could be deemed as threatening in nature.

Inter-Rater Reliability. Through the interpretative process, coding was undertaken by two raters for five schemas picked at random in order to ascertain a level of reliability. This was done by each rater taking all 10 interview transcripts, focusing on

questions relating to the particular EMS identified, and reviewing them independently. The process required the transcript to be broken down sentence by sentence and each one placed into categories with other sentences that were considered to represent the same concept. When all of the data available for a particular EMS was collated, the categories that had been identified were then named to represent a code. Upon completion, the raters compared and counted the number of codes that they had generated for that EMS and a percentage agreement was calculated. Resultant agreement scores range between 0.00 (no concordance) to 1.00 (perfect concordance) (Neuendorf, 2002). The outcomes are detailed below.

Table 6. Percentage Agreement for Codes Developed

EMS	Rater 1Total Codes Identified	Rater 2 Total Codes Identified	Codes Agreed	Percentage Agreement
Approval Seeking	36	33	31	0.90
Insufficient Self-Control	37	34	30	0.84
Dependency	40	36	35	0.93
Emotional Deprivation	45	41	38	0.88
Negativity	26	25	23	0.90

Of note, codes developed were often termed the same thing or were synonyms of the same words or phrases. Due to this, language was taken into account to try and ascertain the best wording possible to clearly define what was being represented. Furthermore it

was acknowledged that extra codes developed by one rater or the other were often able to be grouped together due to overarching similarities with existing codes.

Discussion

The overall aim of this research was to look at the theoretical constructs of schema therapy, exploring how EMS function for women detained under section. It also posed the question of whether schemas are processed differently when triggered, as to whether this had an impact on type of risk. Overall it was thought that this could help determine the usefulness of the model with female forensic populations and how it could be used within practice.

Templates. Upon analysing data a general template was developed which represented all the schemas explored. Hierarchical themes arising from this appeared to resemble that of a functional analysis whereby the situational circumstances were proceeded by internal experiences and actions, ultimately followed by consequences. Interestingly the same hierarchical templates appeared to take shape, thus giving reassurance and credibility to the interpretative process. What was noted however was that rater 2 identified external and internal methods of coping responses with additional strategies that were left un-named. Alternatively, rater 1 had the overall theme of coping responses, yet after going through a greater number of interviews identified the benefits of utilising the schema model itself with avoidance, surrender, overcompensation and framing. Upon review, it was deemed appropriate to apply this as it appeared to capture the full range of strategies utilised, but also enabled identification of internal and externalisation as noted by rater 2, particularly seeming to occur within avoidance

strategies. Of note however, triggering events themselves could also be internal or external to the individuals and much the same for outcomes. When considering the templates it is recognised that these may have been influenced by the type of interview questions asked. Nevertheless it appears to provide a good overall picture of people's experiences and also highlights the potential importance of having this information to hand when developing formulations.

Regarding coding within each theme, this was somewhat different for each specific schema although many similarities and cross-overs were identified. In particular, emotional responses were often those considered to be uncomfortable in nature (upset, angry, sad) which participants found difficult to tolerate. Of note, such emotional responses identified are often linked with the threat system when considering this from a biological perspective (Lee, 2012). Regarding codes represented within the theme of coping responses, self-harm, withdrawal, aggression and self-sacrifice were regularly highlighted. This also seemingly fits with a biological understanding of responses to threat in that such behaviours would also represent fight, flight and freeze. Meanwhile, methods of framing had a tendency to incorporate reflection, perspective taking, acceptance and consequential thinking. It is interesting to note that framing responses placed greater importance on thinking skills, whereas surrender, avoidance and overcompensation had a greater emphasis on behaviours. This could have a particular impact for therapy, in recognising that it is the capacity to slow thinking down and consider varying factors that individual's recognise as most helpful to take them out of the maladaptive maintenance cycle.

When considering the function of individuals' presentations it was hypothesised that the outcomes identified were likely to be in order to fulfil primary needs as reflected by schema theory (Young et al., 2003). On evaluation this often appeared to be the case; the main objective seemingly to feel safe. This would be consistent with Maslow's (1943) hierarchy of needs taking into account that if basic physiological needs are accounted for the next requirement for any human being is that of safety. Nevertheless, for the majority of time, maladaptive responses to attaining these goals were implemented which started to become part of a vicious cycle reinforcing the existing thoughts and feelings. Upon experiencing distress from the uncomfortable emotions felt, it is considered that this would trigger the threat system. This would then encourage a quick biological response of fight, flight or freeze (Lee & James, 2012). Whilst this may have been adaptive for participants at some point in their lives (considering the high degree of trauma noted), potentially keeping them safe and attaining what they need most, repeating the same behaviours are seemingly hindering progression and capacity to change. Alternatively some of the outcomes resulting from framing behaviours met their primary needs whilst exiting the existing problematic cycle. It is acknowledged that with this however, resultant outcomes were not always identified for framing behaviours. Due to this, such responses may be less likely to be utilised if participants are unaware of the positive consequences these could have. Alternatively it may be that participants that have tried or are in the process of change to utilise more pro-social strategies have not been successful if skills are still being developed, or have not yet had the opportunity to see the resultant outcomes. When participants did recognise the outcomes of framing behaviours

however, it is noted that a more stable sense of security and safety was identified, rather than just short term safety.

Endorsement. On completion of the interviews, all schemas were endorsed by at least one participant, giving recognition to the EMS themselves. Of note, all participants (N=10) endorsed emotional deprivation. This would seemingly be consistent with high levels of trauma experienced amongst female patients within forensic services (Jeffcote & Watson, 2004). Self-sacrifice was the only other schema to be endorsed by all 10 participants. Initially this was not expected, however bearing in mind that it came up as a coping response when discussing many of the other schemas, this begins to highlight a level of trying to engage others to gain acceptance, the need to be loved, avoid rejection and prevent emotional deprivation. Alternatively it appears to become a method to avoid one's own presenting problems. When thinking of self-sacrifice, on reflection it would seem fitting that this was more likely to be represented in those who chose to be involved in the research, with the nature of participation involving sacrificing time, effort and concentration despite having no impact on treatment progress.

The second most highly endorsed (N=9) schemas included that of social isolation and defectiveness; often feeling different to others and that something is inherently wrong with them. Greater sensitivity to such EMS may be resultant from the emotional deprivation experienced through life by care givers, which then transfer to other situations (i.e. groups) and the tendency to place blame on themselves if perceiving that they are the common factor. Aside from this, approval seeking was also just as common, which may act in a similar way to that of self-sacrifice, to try and gain a degree of acceptance. Lastly, insufficient self-control was also endorsed by 9 of the 10 participants;

this being heavily linked with self-harm and aggression. Considering a physiological perspective once again, this could be linked to the rapid response process that takes place, if threat is perceived (Lee & James, 2012) by either internal or external events. On the opposite end of the scale, enmeshment and dependency were minimally endorsed, being acknowledged by only three and four participants respectively. It is hypothesised that owing to the high level of emotional deprivation, in that individuals learn to accept people are not there for them; becoming too over-involved or dependent on others would put them at risk of being 'let down' again and susceptible to being hurt despite what they may want from interactions and relationships. Therefore it appears the instinctive response is to consider, "I can only rely on me", as stated by pF1, which would meet the core emotional need of keeping oneself safe whilst trying to minimise the potential to feel vulnerable.

Throughout the interview/ analysis process, the tendency to acknowledge that an EMS had been experienced before yet dismiss that it was a current problem was an arising theme in itself. The use of statements that would block or divert questioning would also occur at times. It was considered that upon observing this the schema was still likely to be active, unless able to be reframed, and that the tendency for this was more due to inability to tolerate the associated perceptions and emotional states activated. This is suggested as when participants were questioned, they would often still emotionally connect with the EMS to an extent. Nevertheless this would allow them a degree of safety and enable them to detach enough to be able to persist with the interview.

Risk of Harm. Regarding risk, participants identified self-sacrifice, enmeshment, vulnerability and approval seeking as schemas that shared greater links with risk to self

with no risk to others identified. Risks to self were of self-harm, substance use or being left vulnerable to the exploits of others. Acknowledging the tendency for such schemas to involve seeking acceptance but feeling vulnerable, turning harmful actions inward, and detach away from care-givers; this may have links with anxious ambivalent attachment styles as highlighted by Ainsworth & Bell (1970). This appears so in the somewhat love/ hate relationships detailed. Interestingly, negativity and failure were schemas purely associated with risk-taking behaviours directed towards others; this being inclusive of arson, weapon use and physical and verbal aggression. What is apparent is a tendency to exhibit an external locus of control, perceiving that others are to blame for difficulties arising. Considering reasons for this, it may be in part due to the inability to tolerate own responsibility within these aspects which therefore becomes directed towards others.

Aside from entitlement, the remaining schemas resulted in participants discussing both risks to self and others. When looking at the type of risk, observations of data indicate aspect of blame and judgement within the 'perceptions' theme to be of significance. This is noted regarding whether blame is placed upon oneself for events occurring or whether they perceive it to be influenced more by those around them. The tendency to go down one route or the other seemed to be one of the potential determining factors when it comes to risk. For example, self-blame, criticalness and sense of defectiveness appeared to provoke self-harming, withdrawal and isolation behaviours on numerous occasions. Alternatively perceiving others are at fault was much more closely linked with risks to be externalised outwards.

Entitlement however, was the only EMS where participants did not highlight to be associated with any risks. When considering entitlement in itself, this EMS would often

involve a feeling of being deserving of things; therefore acceptance of risk may not occur if it does not fit with 'being good and worthy' of what they are seeking.

Presentation /Modes.

Modes represented. Upon evaluation of the coding process and analysis, a good illustration of participants' presentations started to be developed. Of interest was the general tendency for childlike modes to be identified. On inspection it appears that all childlike modes (vulnerable, angry, impulsive, and lonely) were represented at some point in the analysis. Hypotheses about why this might be involves potential deficits in emotional maturation; this being impacted upon by the amount and degree of past trauma experienced within this population. It is understood through childhood that a sense of safety is required for healthy growth and development of skills, thus enabling the ability to regulate arousal in the face of perceived threat, impose rational thinking, and develop and maintain healthy adult relationships. Without a stable, secure base however there is limited opportunity for a frame of reference, social learning or the chance to try alternative strategies if frequently feeling in danger (Ainsworth & Bell, 1970; Bowlby, 1969; Howe, 2011).

Detached self-soother and detached protector were also commonly noted for participants with the level of isolation, self-harming and substance use highlighted. Again this would demonstrate an inability to tolerate uncomfortable affect. Additionally if past trauma has been experienced, detaching from one's surrounding could have previously been the most helpful strategy for them to use in the past (Foa & Hearst-Ikeda, 1996), but has become maladaptive in nature with repeated habitual use.

Modes Underrepresented. Despite the above modes being recognised, over-compensatory modes developed for the forensic population (Bernstein et al., 2007) were not represented. Potentially this may be due to such modes being developed through observations of a male forensic population, therefore highlighting this may not be just transferred to women. This in itself would be further evidence to support the DOH (2002) recommendations that gender specific services are required. Alternatively however the sample itself may not have included individuals who envelop such characteristics or participants may not have disclosed these coping responses if considering them to be socially unappealing. With the sample being taken from a low secure service rather than a high secure environment like the initial observations from Bernstein et al., (2007) it could be related to individuals with different type of offences or offence style that are considered to demonstrate such mode presentations.

Additional Modes Identified. As previously noted, the 'self-sacrificing' EMS was identified by all participants. In addition, self-sacrifice was represented as a coping response to many other schemas and situations. Despite this being indicated it does not seem to feature in existing schema modes. Whilst 'compliant surrenderer' mode stresses the tendency for individuals to give in to the needs and wishes of others, it appears to bring a greater focus to subjugating ones needs. It does not seem to highlight the voluntary nature of putting themselves forward to do things for others and sacrificing their time in the hope that people will like them and give them a sense of safety. Taking the amount of evidence gathered regarding these characteristics in this research, it would lend weight to there being an additional schema mode within female forensic populations. From review it would appear that this seems to incorporate a tendency to

voluntarily do things for others such as buying gifts, making drinks for people, and making effort to please others in a number of ways. However the way in which this is portrayed was in a manner that may come across as childlike/ needy in an attempt to gain affection or avoid rejection. Due to this it is strongly suggestive that a 'pleasing child mode' or something of this nature may exist.

How Do Outcomes Fit with Previous Research. Within the research field preliminary investigations have started to link EMS with various aspects of risk. For example, suggestions that EMS of mistrust, emotional deprivation, social isolation and insufficient self-control are able to distinguish between those who self-harm as a method of coping compared to those who do not (Castille et al., 2007). Similar reports of the ability to differentiate were founded by Dale et al., (2011) regarding suicidal behaviour. Within this investigation however, all EMS aside from negativity, failure and entitlement were linked with risk to self, although qualitative analyses to make a distinction between the intensity of EMS held was not conducted. Nevertheless, risk to self was not based purely on acts of self-harm but included substance misuse and vulnerability to others.

Regarding risk to others, 12 of 18 EMS were shown to be related. Only negativity and failure were solely associated with this, with no overlapping risk to self. As noted in Chapter One, abandonment, mistrust, defectiveness, entitlement and insufficient self-control have previously been linked with aggression (Messman-Moore & Coates, 2008; Tremblay & Dozois, 2009); although evidence between investigations does not sufficiently correspond. Differences that are also occurring between this investigation and existing literature however may be due to gender differences and lack of qualitative measurement to have a more objective comparator.

Whilst it would be helpful to evaluate findings of this exploratory analysis against other like-minded research investigations regarding schema modes and presentations with female forensic patients, multiple searches revealed no validated studies to make such comparisons with.

Integration with Other Theories/ Models. Throughout the discussion a number of psychological perspectives have been noted. With the nature of schema therapy this is to be expected as it utilises various aspects of different models to form the basis of therapy (Young et al., 2003). Three main perspectives are acknowledged here in relation to this population however; this being biological (Lee & James, 2012), attachment style (Ainsworth & Bell, 1970; Bowlby, 1969) and strain theory (Agnew & Passas, 1997).

Biological Perspective. From a biological perspective it is considered that individuals are influenced by interactions between our inborn temperament and environment (Bates, Dodge, Pettit & Ridge, 1998; Maccoby, 2000). Neural pathways become strengthened as we grow, becoming closely linked with the formation of memories (body, emotion focused or event memories) over our lifetime to help provide context to new information learnt. Throughout new daily interactions our senses pick up on stimuli from the environment which enters the brain at the thalamus. This directs information to the appropriate areas for it to be processed. Initial processing is registered within the amygdala which forms part of the 'old brain', storing memories associated with physical sensations and emotions and checking for signs of threat. The hippocampus then verifies this with memories of events to help provide context to incoming information and decide whether sense of safety is compromised at the present moment or not. For individuals who have experienced past trauma however, research has evidenced

that resultant stress can have a damaging effect on the hippocampus, thereby compromising one's ability to put things into context (Bremner, 2001). This can also impact on integration of information via the cortex which would allow information to be cognitively processed (LeDoux, 1996).

If EMS arising are attached to significant life events from the past (particularly if traumatic), these have the potential to be highly emotionally laden causing rapid stimulation of the affect regulation systems. With the majority of schemas being associated with uncomfortable emotional states it is suggestive of the threat system being triggered within the amygdala in order to keep safe (Lee & James, 2012). This may result however in being quick to place blame in self or others and bring about rapid behavioural responses (i.e. fight, flight or freeze). In order to bring about the potential for change it would seem necessary for a feeling of safety to be developed in order to reduce stimulation of the amygdala and allow other parts of the brain, such as the hippocampus and frontal cortex, to become actively involved in the thinking process. With this suggested it would indicate the importance of relational support and development of therapeutic interactions, to allow for patients to feel somewhat comfortable within their environment. Research has identified that with practice the plasticity of the brain can be manipulated accordingly to help with development (Kolassa & Elbert, 2007). Ultimately this would allow the pace of the thinking process to be slowed rather than acting instinctively, which could help step out of the pre-existing maintenance cycles noted when schemas are triggered.

Attachment Theory. On a relational level attachment theory is worth noting. This seems poignant considering the implications that interactions appear to have between

significant others and the presentations noted following schema activation. Bowlby (1969) and Ainsworth and Bell, (1970) identified how secure, avoidant and ambivalent attachment styles may form during development. Secure attachments appear to be born out of nurturing relationships whereby individuals may present as somewhat upset at the separation of a significant other but have the capacity to adapt to this and respond in an understanding manner when reunited (Ainsworth & Bell, 1970). From evidence collated this would map on to framing responses giving rise to what would be termed 'healthy adult mode' in schema terms. Whilst aspects of this were identified, it was not reported to a high degree throughout the interviews conducted. Alternatively however, anxious avoidant attachments were more frequently identified, seeming more dismissive and lacking interest in significant others, spending greater time directing attention to what is going on around them or making efforts to keep people at a distance. Finally anxious resistant attachment styles demonstrate a need to be close to the care-giver and demonstrating a degree of dependency, becoming very distressed upon separation, but also rejecting upon support being offered (Ainsworth & Bell, 1970). From the analysis, what often seems to be observed are anxious avoidant or resistant attachment styles having difficulty in forming or maintaining relationships; this then reinforcing maladaptive interactions.

Strain Theory. One further theory of note is that of Strain Theory (Agnew & Passas, 1997). This proposes the extent to which disruptive interactions with others can generate uncomfortable emotions and when there are difficulties in tolerating this, can lead on to criminal behaviour. Social circumstances that may create strain on women are thought to be born out of disruptive relationships, familial pressures, lack of goal

attainment, and discrimination from society. The degree of vulnerability is also considered to be heightened as compared to men, for women being likely victims of abuse. Whilst no comparisons with males are made within this research project, the situational triggers identified would concur with Strain Theory's proposal. With heightened arousal from strain and pressures experienced, it is considered the capacity to implement helpful, socially acceptable skills would be limited. Whilst anger and resentment has a tendency to be externalised and linked with more criminal behaviours, it is recognised that females are more inclined to try and suppress some of the emotion felt, this leading to more passive-aggressive acts (i.e. fire-setting).

Broidy and Agnew (1997) also acknowledge the capacity for internalisation within women's thinking and behaviour as did Agnew and Passas (1997); however they considered how this could be preventative for female offending and more indicative of becoming self-destructive and avoidant rather than this being directed towards others. With the reduced tendency as compared to men to be part of larger social groups, the burden to present oneself as leader and at the top of the hierarchy does not seem as applicable. Yet the importance of maintaining close positive relationships for significant others is greater and it may therefore be a protective factor regarding female criminality (Broidy & Agnew, 1997).

Implications for Practice. Considering the high degree of trauma in the histories of patients within female forensic (Warren, Loper & Komarovskaya, 2009; WHO, 2014) services it appears patients' schema activation is heightened, emotionally sensitive, and that attachments become skewed, often feeling a sense of threat and lack of safety from the environment and those around them. From this maladaptive means are used in an

effort to seek out and obtain primary needs; the main primary need being aspects of safety. This highlights the importance of developing therapeutic relationships within services as it could help lower the sense of threat, and allow patients the opportunity to slow their cognitive processing down, rather than feeling the need to act on impulse (fight, flight freeze). It appears physiologically that the body needs to be soothed to an extent before it is possible to develop or consider alternative coping strategies. Re-parenting and empathic challenging from staff could also enable patients to feel more comfortable in being able to express themselves, to develop a sense of their own identity whilst also becoming aware of appropriate boundaries (Young et al., 2003).

With the development of hierarchical templates within each schema there is the potential for this to be used within a handbook for practitioners to help identify likely triggers, associated perceptions, emotional content and likely presentation. Potentially this could be used following the identification of schemas from the Young Schema Questionnaire (Young & Brown, 2003), then used in conjunction with a patient's history and/ or identification of locus of control to highlight likely risk pathways. This could not only be used to help build insight with the patient but may be particularly useful for multi-disciplinary team working and sharing formulations. The templates create a visual format to work with and ease understanding.

Limitations. Whilst every effort has been made to make this research valid, reliable and of high quality, it is acknowledged that there are limitations within the process that could impact on such outcomes.

Upon producing the semi-structured interview, it is noted that definitions of schemas were taken from Young et al., (2003). Despite this, wording was altered slightly

to help ensure understanding for the participants. It is recognised however that even slight changes in the language can alter people's perception; this being demonstrated within research conducted by Loftus (1975). In effect, this could alter what was discussed and the participants intended meaning. Of note it is suggested that questionnaires are used so as not to ask about schemas directly. Nevertheless this could enable avoidance of the subject area or denial. Alternatively the individual may not fully recognise the EMS occurring unless they are asked about numerous examples. Due to this it may skew information gathered by asking directly if they had experienced such difficulties with one description, as was used in the interview process. One further limitation identified regarding the interview was the length of it which could impact on motivation to complete and impede the fullness of answers given. Nevertheless this appeared to be circumvented by offering breaks or to be undertaken over a number of sessions.

One of the main difficulties was with regard to selection of participants. Due to the research investigating female secure services, mental health is directly implicated. Furthermore, the aim of the questions was to uncover some of the more difficult life issues experienced and underlying core beliefs which have the potential to destabilise or cause unwarranted stress if the timing was inappropriate. Because of this, opportunity sampling or random sampling could not be utilised, rather participants had to be carefully selected and reviewed in order to ensure no undue harm was to occur. Capacity to consent was also reviewed and limited the participants available, so even though there may have been individuals who would have been interested in the study or may not have been unduly affected by the content, they were not approached due to lack of capacity. As a result, it seemed more individuals with personality disorder were able to participate

than those with mental illness and this bias must therefore be taken into account. In order to gain a wider pool of participants and help with generalizability, further secure hospitals should be considered for future research.

During the review of interview transcriptions template analysis was used. This allows for a flexible approach and as indicated does not stick to one epistemological position (King, 2004). Whilst it would be beneficial to be as objective as possible, with the nature of research being qualitative there is always likely to be a degree of interpretation that could differ from one researcher to the next. Despite having a high percentage agreement between researchers coding the transcripts the potential for bias remains. To ensure the analysis was more robust, further inter-rater coding would have been beneficial by applying Cohen's Kappa. However due to the sheer amount of data collected this was not possible to establish within the time-frames available for this investigation.

Future Recommendations. Considering the limitations raised it is recommended that a larger study is conducted around several female secure establishments, therefore having the potential to gain a greater number of participants. This in turn would help improve reliability. Whilst this has been conducted only in a low secure environment, it may be interesting to see whether this remains the same throughout security levels (i.e. from high secure down to locked rehabilitation), additionally how it compares to males.

Furthermore, it is recommended that the semi-structured interview be reviewed by a wider body of independent individuals to ensure the meanings of questions are effectively portrayed, and ensure validity. Further checks and independent analysis from

a number of researchers could also provide an improved level of inter-rater reliability, giving greater clarity regarding objectivity.

With the nature of the investigation being an initial exploratory study, a wealth of data has been obtained. This could be used as a platform to look at a number of areas, bringing greater focus to risk, mental disorders, specific coping responses, perceptions, schemas or modes. Unfortunately that was not within the scope of this investigation and therefore was unable to be taken further, although provides a broad overview of what might be observed within female secure services.

Summary

This investigation set out to qualitatively explore how EMS function for female forensic patients and the impact they have on risk related behaviours. Endorsement of EMS provided evidence for the existence of all 18 schemas identified by Young et al., (2003) although not all schema modes were represented. Of note, greatest weight was gained to suggest the presence of childlike and detached modes with supportive information obtained to suggest an additional child mode; that of a 'pleasing child' who makes effort to voluntarily do things for others in the hope of acceptance and minimising rejection.

Risks identified included harm to self and others, with the female participants often leaving themselves vulnerable, responding to events in order to seek out primary needs; the most significant one being that of safety. With schema activation it is recognised that there appears to be a biological impact and implicates difficulties with attachments and interactions with others. Due to this the importance of the therapeutic relationship is identified to enable patients to feel comfortable and soothed enough to

work on cognitive and social skills. Identification of outcomes and the benefits of making such changes would also seem important in helping develop and maintain patient engagement.

Due to there being limited research conducted in female secure units regarding schema theory, this study set out to ascertain how schemas function for women in secure hospitals determining its appropriateness and suitability for this population. This is necessary considering guidance from the DOH (2002) identifying that assessments and therapies should not merely be transferred from one population to the other but there should be an evidence base specific for the population at hand. From the data obtained it is suggested that schema therapy would be suitable to use within a female secure environment., although caution should be taken with existing assessments and recognition given to the difference in presentation/ modes likely to be observed. This in turn would ensure patient's needs are met and risks addressed, being supportive of the recovery and rehabilitation process.

CHAPTER FIVE: DISCUSSION

The foundation of this thesis was based around the theoretical concepts of schema and the practical application of schema based therapy; the aim being to gain a greater understanding of the current use and effectiveness of the schema model and how it might apply to women within the forensic system. This was deemed to be of importance considering increasing reports of schema based therapies being implemented within different services over the past decade, with minimal indication of an evidence base for working with risk related behaviour specific for females.

Outcomes

Chapter One. Within Chapter One the need for healthcare, therapeutic intervention and assessment being responsive to specific populations was acknowledged (DOH, 2002). This was considered to be of particular importance for female forensic services as many of the resources available and guidelines provided regarding therapeutic input has often been evidence based for men. Nevertheless, female criminality varies greatly to that of males, in the nature, onset and duration of offending, with a high level of victimization also being recognized. A higher level of mental disorder as compared to men also seems evident, with women predominantly being diagnosed with anxiety, depression, PTSD and borderline personality disorder. With such differences in mind, it was considered that this could have a major impact upon theory development regarding risk related behaviours and what support may be of greatest benefit to aid rehabilitation (Coombes, 2013; Gelsthorpe & Morris, 1994).

Upon acknowledging the need for services to be gender sensitive, schema theory and practice has been reviewed throughout each chapter in relation to this. To gain an appreciation for how schema therapy and the model behind it was developed, the initial introduction provided a frame of reference regarding the constructs used and methods of assessment and delivery. It was acknowledged how the term schema came to fruition, understanding this as a mental structure which provides a pattern or template to help integrate new information with existing knowledge. Such schemas may be held about other people, our environment or ourselves and can often aid interactions (Riso et al., 2006; Young et al., 2003). Nevertheless, Young (1990) identified the relentlessness of schemas and brought attention to those that may become dysfunctional in nature, using the term early maladaptive schema (EMS). With this, the importance of early developmental influences were recognised and it was understood that whilst EMS develop to provide an overall framework, presentational shifts may occur from moment to moment giving rise to modes (Young et al., 2003).

Chapter Two. Following an understanding of how schema theory developed, it was deemed necessary to look at part of the assessment process which helps to determine the degree of change and overall effectiveness of treatment. For this the Young Schema Inventory (Young & Brown, 1990) was of interest, which is used to help identify EMS present. Upon review it was considered that this assessment had the fundamental capacity to be valuable within research and clinical practice, meeting criteria for adequate psychometric properties set out by Kline (1986). This includes sufficient test-retest reliability, internal consistency (Schmidt et al., 1995; Lee et al., 1999) and although there are some inconsistencies observed, on the whole there is support for the theoretical

constructs ensuring it is valid. With copies of the questionnaire being translated and used on an international basis, support for this is beginning to grow worldwide (Rijkeboer & Bergh, 2006; Rijkeboer et al., 2011). Nevertheless, norms to differentiate between males and females are not currently available, therefore it was considered that this would be of benefit to ensure the assessment is gender sensitive in line with DOH (2002) guidelines.

Chapter Three. Within Chapter Three a systematic review was detailed looking at where and when schema based therapies have been used and for what purposes. Outcomes highlighted that it is becoming more widely used across multiple settings (outpatient and inpatient) and in order to help treat a range of difficulties, this being inclusive of;

- Substance misuse (Ball et al., 2011),
- PTSD (Cockram et al., 2010),
- Depression (Carter et al., 2013),
- Personality disorder (Farrell et al., 2009; Geisen-Bloo et al., 2006),
- Eating disorders (Simpson et al., 2010)
- Agoraphobia (Gude & Hoffart, 2008)
- Forensic risk (Tarrier et al., 2010)

Dependent on the nature of problems arising, therapeutic focus also differed from EMS to schema modes and identified schema mode work being recommended for more complex cases (Beckley, 2007; Bernstein et al., 2007). The capacity to provide this on an individual or group basis was also demonstrated. Whilst various methods are used, efforts appear to have been made to try and maintain treatment integrity throughout facilitating

the opportunity for comparisons to be made between research investigations, different therapists or countries of origin.

An outstanding concern for the quality of reviews and research is owing to the minimal number of RCTs at present. Although case studies and small scale designs enable a greater depth of understanding regarding treatment process, they also introduce the potential for bias within investigation. Further to this, there remains a sparse evidence base within the forensic field, therefore recommendations suggest the need to further explore how this form of therapy is used and the resultant impact. Of note however, the DOH (2002) review regarding the need for gender awareness and the importance of services offered being appropriate for specific populations needs to be accounted for. Within secure services the development, investigation and evaluation of SFT has started to take place with male patients (Beckley & Gordon, 2010; Bernstein et al., 2007; Tarrier et al., 2010) although there is currently no female specific research for secure services identified to date.

Chapter Four. Owing to the increasing interest in schema theory and SFT, Chapter Four explores the potential use of this with women in secure services. This seemed to be a logical step in the progression of research considering the development of theory and review of application has been primarily based within community, generic inpatients or male forensic populations. In order to achieve this template analysis was used to evaluate qualitative information gathered from female patients within secure services regarding EMS, trigger factors and the resultant impact.

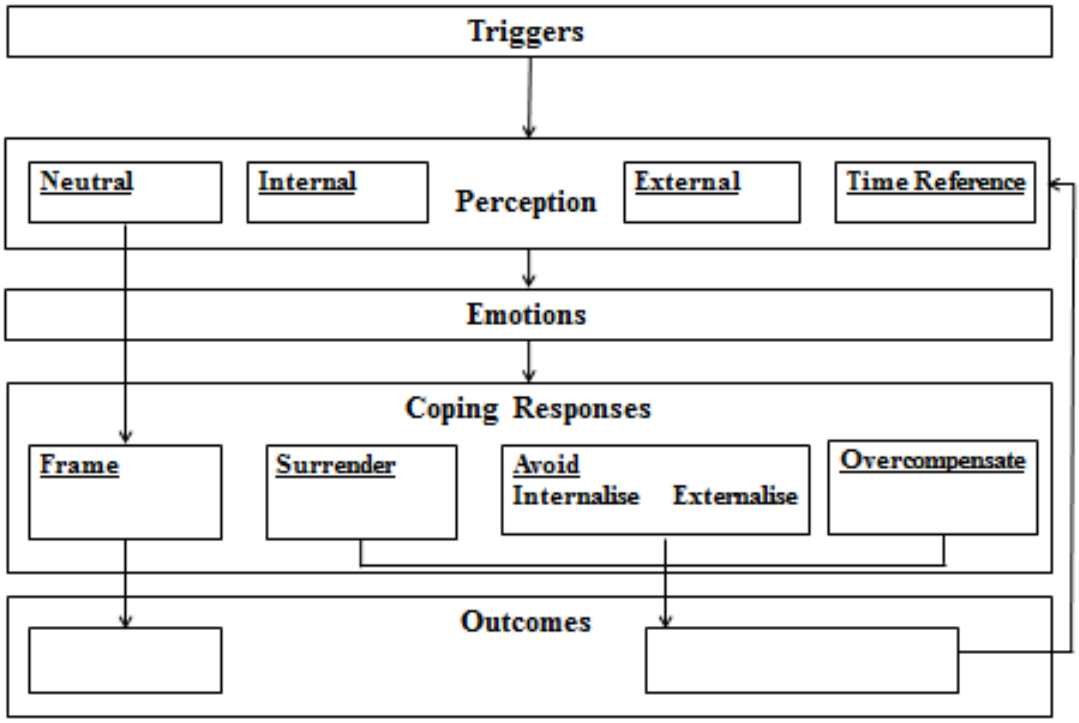
Outcomes of the analysis provided a template which represents the participant's self-reported experiences when EMS were triggered (please see Figure 3. for template).

The overall structured themes of this remained the same for each one, although the codes within tended to differ. Upon review, it begins to provide links with risk, whereby self-sacrifice, approval seeking, enmeshment and vulnerability were shown to be associated solely with risk to self. The reported perceptions, emotional responses and presentations if affected by these EMS were also considered to show overlaps with anxious ambivalent attachment styles as highlighted by Ainsworth & Bell (1970). Alternatively failure and negativity primarily induced an external locus of control and demonstrated a relationship with arson, aggression and weapon use. All remaining EMS apart from entitlement seemed to be linked with both risk of harm to self and others, with the discriminating factor being whether judgmental or blaming statements were placed in an internal or external direction. Further to the aspect of risk, the template developed also highlighted responses that may have a tendency to help maintain behaviour and provided indications for healthy adult responses with potential exit strategies for the cycle. Some examples of this included the ability to reflect, self-soothe, reframe problems, develop meaningful relationships and a degree of acceptance.

Whilst the primary focus of the study was on EMS, observations were made with regards to schema modes, the most apparent being childlike in nature. One overwhelming tendency was noted to be that of making the effort to please or do things for others, in an attempt to gain affection or acceptance. Whilst there is an existing mode of ‘compliant surrenderer’, which may be deemed to be somewhat similar, this does not appear to capture the essence or the effort that these ladies go to at times to make people happy in their search for attention or affection. Instead it denotes that individuals go along with and/ or are passive when it comes to engaging or doing things others want them to do.

Due to this it is suggested that an additional mode exists, namely the 'pleasing chid mode'. Modes inclusive of detachment were also commonly represented indicating problems in tolerating difficult emotions experienced.

Figure 3. Formulation Template Developed for Female Forensic Service Users



Theoretical Implications

From the qualitative information gathered within Chapter Four regarding female secure services, the importance of considering early life experiences and potential disruption to emotional maturation is highlighted, with this seemingly being observed within modal presentations, and a new childlike mode being highlighted. In line with schema theory, the interaction between biology and environment is considered key. However greater

emphasis could be placed on social learning from those around them and disruption to brain biology if they have experienced highly traumatic or disruptive daily living with this being known to impact on the emotion recognition/ regulation system (Pine, 2003). This in turn could influence assessment, therapeutic exercises employed and avenues for exploration with the patient.

Overall the number of males involved in the criminal justice system (i.e. offence charges, in prison or in secure settings) greatly outweighs the number of females (Rutherford & Duggan, 2007). It is therefore understandable that research in the forensic field is skewed towards this population. Despite this, it does not lessen the importance of research and an understanding to be developed with women, in spite of fewer numbers, to ensure effective practice.

Practical Implications

In review of outcomes from the preceding chapters, implications in relation to practice can be noted.

Assessment. Regarding assessment of EMS, use of questionnaires has begun to expand worldwide, allowing for comparisons to be made internationally (Lee et al., 1999; Schmidt et al., 1995). Nevertheless, different versions of this are available and therefore outcomes may not always be standardized. Additionally, a clear evidence base for the latest version of Young Schema Questionnaire-L3a is not reported. In terms of the questionnaire itself, it also particularly lengthy with a large quantity of items (Fairbanks, 2004). This may therefore impact on patient fatigue, concentration and engagement. With

this being one of the first processes to undertake within SFT it could potentially act as a deterrent to further engagement.

When considering use of the EMS within forensic settings, there is currently minimal support identifying EMS with particular risk behaviours. If further research was able to distinguish whether there are relationships or not, this could help early intervention or allow for staff in secure settings to be more informed of risks that are likely to occur. Although this would have to be formulated on an individual basis within clinical practice, clinicians could benefit from having an overview of any associations to be aware of. Whilst the nature of offender profiles may be to vast when considering overall risk to self or others, greater distinctions may become evident if different offence types are looked at individually and broken down in to respective profiles (i.e. internet sex offenders, paedophiles' or those who sexually offend against adults).

Treatment. Outcomes of the research investigation are supportive of the view that both assessment and treatments offered should be specific to the population at hand with gender specific needs taken into account. If this does not occur it could lead to important aspects of mental well-being or risk being overlooked. When taking women in forensic services into account and SFT, this appears to be the case, with a lack of prior awareness of how much childlike presentations are likely to be observed. Therefore, whilst direct risk of harm to self or others may be identified through existing avenues, the extent to which they may leave themselves vulnerable or engage in behaviours which may be targeted for exploitation could be missed.

Overall however, schema theory and exploration of EMS does seem to support an understanding of patient's internal experiences and presenting behaviours. With the

wealth of information gathered within Chapter Four this could be used, assisting staff within supervision to help build awareness for their clinical practice. Additionally, the themes and template generated could be used with patients to aid insight when developing individualised formulations. It is considered that this could be presented in the form of written words, or patients could use pictures to represent each aspect, dependent on their preferred style of working.

Thesis Strengths and Limitations

The information contained in this thesis complements the growing interest in the theoretical concepts of Young's (1990, 1999) Schema model and SFT (Young et al., 2003). This has been of benefit to add to the literature base, particularly on women within secure services. Despite this, limitations are acknowledged.

Within Chapter Two, efforts were made to review the assessment measure which is used most commonly to look at EMS. Difficulties underpinning this however lie in the seemingly minimal statistical review and exploration of the latest YSQ-L3a (Young & Brown, 2003). Due to this a focus was brought on the initial assessment measure introduced. Whilst adequate psychometric properties have been demonstrated, further exploration is required on the latest versions to ensure it is consistent or improved from the previous assessment. As new constructs have also been introduced, it would be necessary to validate these, review their reliability and ability to discriminate. Multiple investigations around the questionnaire would only serve to help improve the measures and understanding of its evidence base, allowing for alterations to be made if necessary and increase its psychometric power.

Regarding Chapters Three and Four, the potential for bias is considered to be the greatest limiting factor. Within the literature review this is undermined by limitations to the number of studies and settings explored with a lack of RCTs available. Within the research however, the interview process itself would benefit from further validation and additional inter-rater checks to reduce interpretation bias.

Future Research

Throughout the preceding chapters the development of schema theory and SFT was acknowledged, with a body of evidence often gained from community, inpatient or forensic male populations. Within all areas it would be of benefit for larger scale studies and RCTs to be conducted to increase the literature base and the quality of evidence gained to date. Owing to the lack of research on female forensic mental-health patients however, a gap in the literature still exists and requires expansion.

For future research conducted it is recommended that diagnoses or symptom traits targeted are clearly identified with a protocol set out for the recruitment procedure (i.e. referral or voluntary) and the setting in which assessment or treatment is delivered. With research studies still being limited, both qualitative and quantitative investigations would be of benefit to generate the wealth of information required at this stage, although power calculations could be used to identify numbers required for study if quantitative analyses are being used. To add weight to qualitative research investigations it would also be helpful to use the YSQ with participants to see if it picks out the same EMS as identified from the interviews.

Regarding the process of assessment and treatment, it is considered that both require further exploration. Assessment measures for schema would benefit from further analysis and development of norms for differing populations. Whilst this may not be possible regarding different forensic populations due to the varied nature of offence typologies, this could potentially be considered in terms of inpatient males and females and outpatients males and females. Qualitatively evaluating links with various elements of risk would also be of particular use however, in order to support the development of formulations within treatment and rehabilitation through mental-health secure services.

If a focus is brought to therapy, evaluating comparative treatments would be of benefit in order to deduce effectiveness. In this instance however, consideration of how to work with attrition rates would be required, clarity of assessment measures, assessment time-frames and follow-up periods would be helpful to establish. Ensuring treatment remains true to its model and having assessors independent of the programme would also help reduce bias. Finally, awareness of confounding variables would be necessary to ensure the outcomes of treatment are fully understood, enhancing validity and reliability.

One further avenue to consider is the role schemas with a positive outlook have rather than focusing merely on maladaptive ones. This may give the opportunity to enhance and use existing skills individuals have, building a sense of mastery to aid sense of well-being and rehabilitation and balance with those that are more problematic.

Conclusions

In summary there is evidence to suggest that Young's (1990) SFT is developing increasing interest for use with various clinical problems, within different settings and

starting to be used on an international basis. With this there is a growing body of evidence beginning to be built on its effectiveness (Masley et al., 2011).

Despite this there remain concerns with the latest assessment methods as psychometric properties have been researched more thoroughly for earlier versions of the measure rather than the latest YSQ-L3a (Young & Brown, 2003). Therefore further analyses are warranted. In order to combat this within practice, clinical research investigating treatment methods appear to have implemented a plethora of outcome measures indicating the impact not only on EMS but on diagnostic symptoms also. What appears to be highlighted from the current research with female forensic mental health patients however is the necessity to ensure assessment measures, therapy and an understanding of theoretical models are specific to the population at hand rather than assuming their ability to be transferrable. This is not to say that certain aspects of assessment and treatment will not remain the same and be equally successful; but taking the opportunity to acknowledge additional factors may need accounting for. Regarding differences within secure services, gender is of importance. For example, differing prevalence of offence types, different risk factors (DOH, 19998; Rutherford & Duggan, 2007), and alternative pathways into forensic units (Coid, 2000; Stafford, 1999) exist. If this is not recognised it could lead to therapeutic outcomes being less effective than is possible, potentially causing frustrations for patient, clinician, funding bodies and the wider society. In order to capture the essence of theoretical aspects and practice it is considered that a combination of qualitative and quantitative exploration would be of benefit with further narrowing of the research questions set out. Overall such investigations could help to enhance the literature base, seek clarity on psychometric

properties and develop norms for assessment whilst establishing associations with symptoms or risk. In turn, data would provide guidance on how the schema model can be utilized within female forensic mental health services and most effectively be put into practice.

REFERENCES

Abramson, L. Y., Metalsky, G. I., & Alloy, L. B. (1989). Hopelessness depression: A theory-based subtype of depression. *Psychological Review, 96,* 358-372. doi.org/10.1037//0033-295X.96.2.358.

Agnew, R. , & Passas, N. (1997). *The future of anomie*. Boston, MA: Northeastern University Press.

Ainsworth, M. D. S., & Bell, S. M. (1970). Attachment, exploration, and separation: Illustrated by the behavior of one-year-olds in a strange situation. *Child Development, 41*, 49-67. doi.org/10.2307/1127388.American Psychiatric Association (1994). *Diagnostic and statistical manual of mental health disorders* (4th ed). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Arieti, S., & Bemporad, L. (1980). The psychological organization of depression. *American Journal of Psychiatry, 137*, 1360-1365.

Arntz, A., van den Hoorn, M., Cornelis., J., Verheul, R., van den Bosch, W., & de Bie, A. (2003). Reliability and validity of the borderline personality disorder severity index. *Journal of Personality Disorder, 17*, 45-59. doi.org/10.1521/pedi.17.1.45.24053.

Arntz, A., van Genderen, H., & Drost, J. (2011). *Schema therapy for borderline personality disorder*. Chichester, West Sussex: John Wiley and Sons.

Arntz, A., & Jacob, G. (2012). *Schema therapy in practice: An introductory guide to the schema mode approach.* West Sussex: John Wiley & Sons.

Atalay, H., Atalay, F., Karahan, D., & Caliskan, M (2008). Early maladaptive schemas activated in patients with obsessive-compulsive disorder: A cross-sectional study. *International Journal of Psychiatry in Clinical Practice, 12*, 268-279. doi.org/10.1080/13651500802095004.

Ball, S. A. (1998). Manualized treatment for substance abusers with personality disorders: Dual focus schema therapy. *Addictive Behaviors, 23*, 883-891. doi.org/10.1016/S0306-4603(98)00067-7.

Ball, S. A. (2003). Treatment of personality disorders with co-occurring substance dependence: Dual focused schema therapy. In J. J. Magnavita, (Ed.), *Handbook of personality disorders; theory and practice* (pp.393-425).New York: Wiley.

Ball, S. A. (2007). Comparing individual therapies for personality disordered opioid dependent patients. *Journal of Personality Disorders, 21*, 305-321. doi.org/10.1521/pedi.2007.21.3.305.

Ball, S. A., & Cecero, J. J. (2001). Addicted patients with personality disorders: traits, schemas, and presenting problems. *Journal of Personality Disorders, 15*, 72–83. doi.org/10.1521/pedi.15.1.72.18642.

Ball, S. A., Cobb-Richardson, P., Connolly, A. J., Bujosa, C. T., & O'Neall, T. W. (2005). Substance abuse and personality disorders in homeless drop-in center clients: Symptom severity and psychotherapy retention in a randomized clinical trial. *Comprehensive Psychiatry, 46*, 371-379. doi.org/10.1016/j.comppsych.2004.11.003.

Ball, S. A., & Young, J. E. (1999)**.** *Early maladaptive schemas questionnaire-research*. New Haven, CT: Yale University School of Medicine.

Ball, S. A., & Young, J. E. (2000). Dual focus schema therapy for personality disorders and substance dependence: Case study results. *Cognitive and Behavioural Practice*. *7*, 270-281. doi.org/10.1016/S1077-7229(00)80083-8.

Bamber, M. (2004). The good, the bad and defenceless Jimmy: A single case study of schema mode therapy. *Clinical Psychology and Psychotherapy*, *11*, 425-438. doi.org/10.1002/cpp.422.

Bamber, M., & McMahon, R. (2008). Danger-early maladaptive schemas at work!: The role of early maladaptive schemas in career choice and the development of occupational stress in health workers. *Clinical Psychology and Psychotherapy, 15*, 96-112. doi.org/10.1002/cpp.564.

Bartlett, F. C. (1932). *Remembering: A study in experimental and social psychology.* Cambridge, UK: Cambridge University Press.

Bates, J. E., Dodge, K. A., Pettit, G. S., & Ridge, B. (1998). Interaction of temperamental resistance to control and restrictive parenting in the development of externalizing behavior. *Developmental Psychology, 34*, 982–995. doi.org/10.1037//0012-1649.34.5.982.

Beck, A. T. (1967). *Depression: Causes and treatment*. Philadelphia: University of Pennsylvania Press.

Beck, A. T. (1983). Cognitive therapy of depression: New perspectives. In P. J. Clayton & J. E. Barrett (Eds.), *Treatment of depression: Old controversies and new approaches* (pp. 265-290). New York: Raven.

Beck, A. T. (1997).The past and future of cognitive therapy. *Journal of Psychotherapy Practice and Research, 6*, 276–284. doi.org/10.1037//0022-006X.61.2.194.

Beck, A. T., & Emery, G. (1985). *Anxiety disorders and phobias: A cognitive perspective*. New York: Basic Books.

Beck, A. T., Freeman, A., & Davis, D. D., & Associates. (2004). *Cognitive therapy for personality disorders (2nd ed.).* New York: Guilford Press.

Beck, A. T., Rush, J., Shaw, B., & Emery, G. (1979). *Cognitive therapy of depression*. New York: Guilford Press.

Beck, A. T., Steer, R. A., & Brown, G. K. (1996). *Manual for the Beck Depression Inventory–II.* San Antonio, TX: Psychological Corporation.

Beckley, K. (2007). Schema therapy. Retrieved 5th August 2013 from http://contemporarypsychotherapy.org/vol-2-no-2/schema-theray/

Beckley, K., & Gordon, N. (2010). Schema therapy within a high secure setting. In A. Tennant and K. Howells (Eds.), *Using time, not doing time: Practitioner perspectives on personality disorder and risk* (pp. 95-108). Chichester, UK: John Wiley and Sons.

Belknap, J. (2007). *The invisible woman: Gender crime and justice (Rev. ed.)*. Cincinnati, OH: Wadsworth.

Berne, E. (1961). *Transactional analysis in psychotherapy*. New York: Grove Press.

Bernstein, D. P., Arntz, A., & de Vos, M. (2007). Schema focused therapy in forensic settings: Theoretical model and recommendations for best clinical practice. *International Journal of Forensic Mental Health*, 6, 169-183. doi.org/10.1080/14999013.2007.10471261.

Bird, L., & Faulkner, A., (2000). *Suicide and self-harm*. London: The Mental Health Foundation.

Blanchette, K., & Brown, S. L. (2006). *The assessment and treatment of women offenders: An integrative perspective*. Chichester, UK: Wiley.

Blenkiron, P. (2010). *Stories and analogies in cognitive behaviour therapy*. West Sussex: John Wiley & Sons.

Block, C. R., Blokland, A. A. J., Werff, C. van der., Os, R. van., & Nieuwbeerta, P. (2010). Long term patterns of offending in women. *Feminist Criminology, 5*, 73-107. doi: 10.1177/1557085109356520.

Bloom, B., Chesney-Lind, M., & Owen, B. (1994). *Women in California prisons: Hidden victims of the war on drugs*. San Francisco, CA: Center on Juvenile and Criminal Justice.

Bowlby, J. (1969). *Attachment: Attachment and Loss: Vol. 1. Loss*. New York: Basic Books.

Broidy, L., & Agnew, R. (1997). Gender and crime: A general strain theory perspective. *Journal of Research in Crime and Delinquency, 34*, 275-306.

Bremner, J. D. (2001). Hypotheses and controversies related to effects of stress on the post-traumatic stress disorder. *Hippocampus, 11*, 75-81.

Brooks, J., & King, N. (2012). Qualitative psychology in the real world: The utility of template analysis. In: 2012 British Psychological Society Annual Conference, 18th - 20th April 2012, London, UK. (Unpublished).

Carter, J. D., McIntosh, V. V., Jordan, J., Porter, R. J., Frampton, C. M., & Joyce, P. R. (2013). Psychotherapy for depression: A randomized clinical trial comparing schema therapy and cognitive behavior therapy. *Journal of affective disorders, 151*, 500-505. doi.org/10.1016/j.jad.2013.06.034.

Centre for Reviews and Dissemination. (2009). *Systematic Reviews: CRD's Guidance for Undertaking Reviews in Healthcare*. York: York Publishing Services Ltd.

Clarke-Carter, D. (2010). *Quantitative psychological research: The complete student's companion*. New York: Psychology Press.

Clarke, J., & Wilson, P. (2012). *Forensic psychology in practice: A practitioner's handbook*. Hampshire: Macmillan Publishers.

Cockram, D. M., Drummond, P. D., & Lee, C. H. (2010). Role and treatment of early maladaptive schemas in Vietnam veterans with PTSD. *Clinical Psychology and Psychotherapy, 17,* 165-182. doi.org/10.1002/cpp.690.

Coid, J., Gault, S., & Jarman, B. (2000). Women admitted to secure forensic psychiatric services I: Comparison of women and men. *Journal of Forensic Psychiatry, 11*, 275–295.

Coida, J., Kahtanb, N., Gaultc, S., & Jarmand, B. (2000). Women admitted to secure forensic psychiatry services: I. Comparison of women and men. *The Journal of Forensic Psychiatry, 11,* 275-295. doi:10.1080/09585180050142525.

Conte, H. R., Plutchik, R., Karasu, T. B., &Jerrett, I. (1980). A self-report borderline scale: Discriminative validity and preliminary norms. *Journal of Nervous and Mental Disease,* 100, 428-435. doi.org/10.1097/00005053-198007000-00007.

Coombes, P. (2013). Female offenders. In J. Clarke, & P. Wilson (Eds.), *Forensic psychology practice: A practitioner's handbook.* (pp. 154-171). Hampshire: Macmillan Publishers.

Crabtree, B. F., & Miller, W, L. (1999). *Doing qualitative research*. California: Sage.

Criminal Damage Act. (1971). Chapter 48. London: Published By Her Majesty's Stationery Office.

Daffern, M., Jones, L., & Shine, J. (Eds.). (2010). *Offence paralleling behaviour: A case formulation approach to offender assessment and intervention.* WestSussex: John Wiley & Sons.

Dawes, S. L., Beech, A. R., & Coombes. P. (2010). Early maladaptive schemas in a female forensic population. (Masters dissertation, University of Birmingham, UK).

Department of Health. (1998). *In-patients formally detained in hospitals under the mental health act 1983 and other legislation, England 1987–88 and 1992–93 to 1997–98* (Statistical Bulletin). London: Department of Health.

Department of Health (2002). *Women's mental health: Into the mainstream*. London: Department of Health.

Derogatis, L. R. I. (1992a). *The brief symptom inventory*. MD: Clinical psychometric research.

Derogatis, L. (1994). *The SCL-90-R: Administration, scoring and procedures manual* (3rded.). Minneapolis, MN: National Computer Systems.

Dickens, G. L., Sugarman, P. A., & Gannon, T. A. (Eds.) (2012). *Firesetting and mental health; Theory, research and practice.* London: RPsych Publications.

Dornyei, Z., & Taguchi, T. (2010). *Questionnaires in second language research: Construction, administration and processing* (2nd ed). New York: Routledge.

Drennan, G., & Alred, D. (Eds.). (2012*). Secure recovery: Approaches to recovery in forensic mental health settings.* Oxon: Routledge.

Egger, M., Schneider, M., & Davey Smith, G. (1998). Spurious precision? Meta-analysis of observational studies. *British Medical Journal,* 316, 140–144. doi.org/10.1136/bmj.316.7125.140.

Endicott, J., Sptizer,R. L., Fleiss, J. L., &. Cohen, J. (1976). The global assessment scale: A procedure for measuring overall severity of psychiatric disturbance. *Archives of General Psychiatry,* 33, 766-771. doi.org/10.1001/archpsyc.1976.01770060086012.

Ethics Committee of the British Psychological Society. (2009). *Code of ethics and conduct.* Leicester: Ethics Committee of the British Psychological Society.

EuroQol Group. (1990). EuroQol-a new facility for the measurement of health related quality of life. *Health Policy*, 16, 199-208.

Fairbanks, A. J. (2004). Comparison of long and short versions of Young's Schema Questionnaire in personality disordered and general population individuals. Unpublished doctoral dissertation, University of Liverpool, UK.

Farrell, J. M., Shaw, I. A., & Webber, M. A. (2009). A schema-focused approach to group psychotherapy for outpatients with borderline personality disorder: A randomized control trial. *Journalof Behavior Therapy and Experimental Psychiatry*, 40, 317-328. doi.org/10.1016/j.jbtep.2009.01.002.

First, M. B., Spitzer, R. L., Gibbon, M., & Williams, J. B. W. (1995). *Structured clinical interview for DSM-IV axis 1 disorders.* New York: Biometrics.

First, M. B., Spitzer, R. L., Gibbon, M., Williams, J. B. W., & Benjamin, L. (1994). *Structured clinical interview for DSM-IV axis II personality*. New York: Biometrics.

Forbes, D., Creamer, M., & Biddle, D. (2001).The validity of the PTSD checklist as a measure of symptomatic change in combat-related PTSD. *Behaviour Research and Therapy, 39,* 977-986. doi.org/10.1016/S0005-7967(00)00084-X.

Foa, E.B., & Hearst-Ikeda, D. (1996). Emotional dissociation in response to trauma: An information-processing approach. In L.K. Michelson & W.J. Ray (Eds.), *Handbook of dissociation: Theoretical and clinical perspectives* (pp. 207-222). New York: Plenum Press.

Geisen-Bloo, J., van Dyck, R., Spinhoven, P., van Tilburg, W.,Dirksen, C., van Asselt, T., Kremers, I., Nadort, M., & Arntz, A. (206). Outpatient psychotherapy for borderline personality disorder: Randomized trial of schema-focused therapy vs transference-focused psychotherapy. *Archives of General Psychiatry, 63,* 649-658. doi.org/10.1001/archpsyc.63.6.649.

Gelsthorpe, L., & Morris, A. (1994). Juvenile justice 1945-1992. In M. Maguire, R. Morgan, & R. Reiner (Eds.), *The Oxford Handbook of Criminology,* (pp. 949-993). Oxford, England: Clarendon Press.

Greenland, S. (1994). Quality scores are useless and potentially misleading: Reply to "re: a critical look at some popular analytic methods". *American Journal of Epidemiology,* 140, 300-301.

Gude, T., & Hoffart, A. (2008). Change in interpersonal problems after cognitive agoraphobia and schema-focused therapy versus psychodynamic treatment as usual of inpatients with agoraphobia and cluster C personality disorders. *Scandiavian Journal of Psychology, 49,* 195-199. doi: 10.1111/j.1467-9450.2008.00629.x.

Gude, T., Monsen, J. T., & Hoffart, A. (2001). Schemas, affect consciousness and cluster c personality pathology: A prospective one year follow up study of patients in a

schema focused short term treatment program. *Psychotherapy Research, 11*, 85-98. doi: doi.org/10.1093%2Fptr%2F11.1.85.

Guilford, J. P. (1956). *Fundamental statistics in psychology and education.* New York: McGraw Hill.

Hammersley, M. (1992). Ethnography and realism. In M. Hammersley (Ed.) *What's wrong with ethnography?* London: Routledge.

Health & Care Professions Council. (2008). *Standards of conduct, performance and ethics.* London: Health and Care Professions Council.

Hedley, L.M., Hoffart, A., & Sexton, H. (2001). Early maladaptive schemas in patients with panic disorder with agoraphobia. *Journal of Cognitive Psychotherapy: An International Quarterly, 15,* 131-142.

Hoffart A, Sexton H, Hedley L. M, Wang, C. A., Holthe, H., Haugum, J. A., Nordahl, M., Hovland, O. J., & Holt, A. (2006). The structure of maladaptive schemas: A confirmatory factor analysis and psychometric evaluation of derived scales. *Cognitive Therapy Research, 29*, 627-644. doi.org/10.1007/s10608-005-9630-0.

Hogan, T. P. (2003). *Psychological testing: A practical introduction*. Hoboken, NJ: Jon Wiley and Sons.

Horowitz, L. M., Rosenberg, S. E., Baer, B. A., Ureno, G., & Villasenor, V. S. (1988). Inventory of interpersonal problems: Psychometric properties and clinical applications. *Journal of Consulting and Clinical Psychology*, 56, 885-892. doi.org/10.1037//0022-006X.56.6.885.

Howe, D. (2011). *Attachment across the life course: A brief introduction*. London: Palgrave Macmillan.

Howells, K., Day, A., & Thomas-Peter, B. (2004).Changing violent behaviour: Forensic mental health and criminological models compared. *Journal of Forensic Psychiatry and Psychology*, 15, 391– 406. doi.org/10.1080/14789940410001655907.

Jacob, G. A., & Arntz, A. (2013). Schema therapy for personality disorders—A review. *International Journal of Cognitive Therapy*, *Innovations and Advances in the Cognitive-Behavioral Therapies*, *6*, 171-185. doi: 10.1521/ijct.2013.6.2.171

Jakes, S. C., & Rhodes, J. (2003). The effect of different components of psychological therapy on people with delusions: Five experimental single cases. *Clinical Psychology and Psychotherapy*, 10, 302-315. doi.org/10.1002/cpp.373.

Janssen, M. F., Birnie, E., & Bonsel, G. J. (2007). Evaluating the discriminatory power of EQ-5D, HU12 and HU13 in a US general population survey using Shannon's indices. *Qualitative Life Research, 16*, 895–904.

Jeffcote, N., & Watson, T. (2004). *Working therapeutically with women in secure mental health settings.* London: Jessica Kingsley Publishers.

Jovev, M., & Jackson, H. J. (2004). Early maladaptive schemas in personality disordered individuals. *Journal of Personality Disorders, 18*, 467–478. doi.org/10.1521/pedi.18.5.467.51325.

Jumper, S. A. (1995). A meta-analysis of the relationship of child sexual abuse to adult psychological adjustment. *Child Abuse and Neglect*, 19, 715-728. doi.org/10.1016/0145-2134(95)00029-8.

Kellogg, S., & Young, J. (2013). *Schema mode inventory 1.1*. New York: Schema Therapy Institute.

Kienast, T., & Foerster, J. (2008). Psychotherapy of personality disorders and concomitant substance dependence. *Current Opinion in Psychiatry*, 21, 619-624. doi.org/10.1097/YCO.0b013e32830d365c.

King, N. (1998). "Template Analysis". In G. Symon & C. Cassell, (Eds.). *Qualitative Methods and Analysis in Organisational Research: A Practical Guide*. London: Sage.

King, N (2004) Using templates in the thematic analysis of text, in C. Cassell and G.Symon (Eds.) *Essential Guide to Qualitative Methods in Organizational Research*. London: Sage.

Kline, P. (1986). *Handbook of test construction*. London: Methuen.

Kline, R. B. (2010). *Principles and practice of structural equation modeling* (3rd ed.). New York: Guilford Press.

Kreibig, S. D. (2010). Autonomic nervous system activity in emotion: A review. *The biopsychology of emotion: Current theoretical and empirical perspectives, 84*, 394-421. doi./10.1016/j.biopsycho.2010.03.010.

Kolassa, I. T., & Elbert, T. (2007). Structural and functional neuroplasticity in relation to traumatic stress. *Current Directions in Psychological Science, 16*, 321-325. doi.org/10.1111/j.1467-8721.2007.00529.x.

Langer, J. A. (1990).The Process of Understanding: Reading for Literary and Informative Purposes. *Research in the Teaching of English, 24*, 229-260.

LeDoux, J. E. (1996). *The Emotional Brain: The mysterious underpinnings of emotional life*. New York: Simon and Schuster.

Lee, D., & James, S. (2012). *The compassionate mind approach to recovering from trauma using compassion focused therapy.* London: Robinson.

Lee, C. W., Taylor, G., & Dunn, J. (1999). Factor structure of the schema questionnaire in a large clinical sample. *Cognitive Therapy and Research, 23*, 441-451.

Linehan, M. M. (1993a). *Cognitive behavioral therapy of borderline personality disorder.* New York: Guilford Press.

Linehan, M. M. (1993b). *Skills training manual for treating borderline personality disorder.* New York: Guilford Press.

Lobbestael, J. (2012). Experimental Studies of Schema Modes. In M. van Vreeswijk, J. Broersen & M. Nadort (Eds.), *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research and Practice*, Chichester, UK: John Wiley & Sons. doi: 10.1002/9781119962830.ch38.

Lobbestael, J., van Vreeswijk, M., Spinhoven, P., Schouten, E., & Arntz, A. (2010). Reliability and Validity of the Short Schema Mode Inventory (SMI). Behavioural and Cognitive Psychotherapy, 38, 437-458. doi:10.1017/S1352465810000226.

Loftus, E. F. (1975). Leading questions and the eyewitness report. *Cognitive Psychology, 7,* 560- 572. doi.org/10.1016/0010-0285(75)90023-7.

Long, C. G., Fulton, B. & Hollin, C. R. (2008). The development of a 'best practice' service for women in a medium-secure psychiatric setting: Treatment components and evaluation. *Clinical Psychology and Psychotherapy, 15,* 304–319. doi: 10.1002/cpp.591.

Loper, A.B. (2003). The relationship of maladaptive beliefs to personality and behavioural adjustment among incarcerated women. *Journal of Cognitive Psychotherapy, 17,* 253-266. doi.org/10.1891/jcop.17.3.253.52533.

Maccoby, E. E. (2000). Parenting and its effects on children: On reading and misreading behavior genetics. *Annual Review of Psychology, 51,* 1–27.

Masley, S., Gillanders, D., Simpson, S., & Taylor, M. (2011). A systematic review of the evidence base for Schema Therapy. *Cognitive Behaviour Therapy, 19,* 1-18.doi: 10.1080/16506073.2011.614274.

Maslow, A. H. (1943). A theory of human motivation. *Psychological Review, 50,* 370-96.

Mason, D., Birmingham, L., & Grubin, D. (1997). Substance use in remand prisoners: A consecutive case study. *British Medical Journal, 315,* 18-21. doi.org/10.1136/bmj.315.7099.18.

McFarland, L. A., Ryan, A. M., & Ellis, A. (2002). Item placement on a personality measure: Effects on faking behavior and test measurement properties. *Journal of Personality Assessment, 78,* 348–369. doi.org/10.1207/S15327752JPA7802_09.

McLellan, A. T., Kushner, H., Metzger, D., Peters, R., Smith, I., Grissom, G., Pettinati, H., & Argeriou, M. (1992). The fifth edition of the addiction severity index. *Journal of Substance Abuse Treatment, 9,* 199-213. doi.org/10.1016/0740-5472(92)90062-S.

Meichenbaum, D. (1997). Cognitive behaviour therapy. In A. Baum, S. Newman, J. Weinman, R. West & C. McManus (Eds.), *Cambridge Handbook of Psychology, Health and Medicine* (pp. 200-206). Cambridge, UK: Cambridge University Press.

Miller, W. R., & DelBoca, F. K. (1994). Measurement of drinking behaviour using the Form 90 family instruments. *Journal of Studies of Alcohol*, *12*, 112-117.

Miller, L. A., McIntire, S.A., & Lovler, R. L. (2011). *Foundations of psychological testing: A practical approach* (3rd ed.). Thousand Oaks, CA: SAGE.

Millon, T. (1994). *Millon Clinical Multiaxial Inventory-II*. MN: NCS, Inc.

Morrison, N. (2000). Schema-focused cognitive therapy for complex long-standing problems: A single-case study. *Behavioural and Cognitive Psychotherapy, 28*, 269-283.

Nadort, M., Arntz, A., Smit, J. H., Giesen-Bloo, J., Eikelenboom, M., Spinhoven, P., van Asselt, T., Wnsig, M., & van Dyck, R. (2009). Implementation of outpatient schema therapy for borderline personality disorder with versus without crisis support by the therapist outside office hours: A randomized control trial. *Behaviour Research and Therapy*, *47*, 961-973. doi.org/10.1016/j.brat.2009.07.013.

National Institute for Mental health in England. (2003). *Personality disorder: No longer a diagnosis of exclusion.* London: Department of Health.

National Institute for Health and Clinical Excellence. (2008). *Cognitive behavioural therapy for the management of common mental health problems: Commissioning guide implementing NICE guidance.* London: National Institute for Health and Clinical Excellence.

Nauth, L. (1995). Power and control in the male antisocial personality. *Journal of Rational Emotive and Cognitive Behavior Therapy, 13,* 215-224. doi.org/10.1007/BF02354513.

Neuendorf, K. A. (2002). *The content analysis guidebook.* Thousand Oaks, CA: Sage Publication**.**

Nordahl, H. M., Haulthe, H., & Haugum, J. A. (2005). Early maladaptive schemas in patients with or without personality disorders: Does schema modification predict symptomatic relief? *Clinical Psychology and Psychotherapy*, *12*, 142-149. doi.org/10.1002/cpp.430.

Nordahl, H. M., & Nysaeter, T. E. (2005). Schema therapy for patients with borderline personality disorder: A single case series. *Journal of Behavior Therapy*, *36*, 254-264. doi.org/10.1016/j.jbtep.2005.05.007.

Nunnally, J. C., & Bernstein, I. H. (1994). *Psychometric theory* (3rd ed.). New York: McGraw-Hill.

Nysaeter, T.E., & Nordahl, H.M. (2008)**.** Principles and clinical application of schema therapy for patients with borderline personality disorder. *Nordic Psychology, 60*, 249-263. doi.org/10.1027/1901-2276.60.3.249.

Piaget, J. (1948). *The moral judgment of the child*. (M. Gabains, Trans.). Glencoe, IL: Free Press.

Oei, T. P. S., & Baranoff, J. (2007). Young schema questionnaire: Review of psychometric and measurement issues. *Australian Journal of Psychology, 59,* 78-86. doi.org/10.1080/00049530601148397.

Rafaeli, E., Bernstein, D.P., & Young, J. E. (2011). *Schema Therapy: the CBT distinctive features series.* New York, NY: Routledge.

Richardson, G. (2005). Early maladaptive schemas in a sample of British adolescent sexual abuser: Implications for therapy. *Journal of Sexual Aggression: An*

international, interdisciplinary forum for research, theory and practice, *11*, 259-267. doi:10.1080/13552600500402419.

Rijkeboer, M. M., Bergh, H. van den., & Bout, J. van den. (2005). Stability and discriminative power of the Young Schema Questionnaire in a Dutch clinical versus non- clinical populations. *Journal of Behavior Therapy and Experimental Psychiatry, 36,* 129-144. doi.org/10.1016/j.jbtep.2004.08.005.

Rijkeboer, M. M., Bergh, H. van den., & Bout, J. van den. (2011). Item bias analysis of the young schema-questionnaire for psychopathology, gender, and educational level. *European Journal of Psychological Assessment*, *27*, 65–70. doi.org/10.1027/1015-5759/a000044.

Rijkeboer, M. M., & van den Bergh, H. (2006). Multiple group confirmatory factor of the Young Schema-Questionnaire in a Dutch clinical versus nonclinical sample. *Cognitive Therapy and Research, 30*, 263–278.

Riso, L.P., Froman, S.E., Raouf, M., Gable, P., Maddux, R.E., Turini-Santorelli, N., Penna, S., Blandino, J.A., Jacobs, C.H., Cherry, M. (2006). The long-term stability of early maladaptive schemas. *Cognitive Therapy and Research 30*, 515–529. doi.org/10.1007%2Fs10608-006-9015-z.

Robinson, C. (2013). Women's custodial estate review. National Offender Management Service. Retrieved March 5, 2014, from https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/252851/womens-custodial-estate-review.pdf

Rounsaville, B. J., Kranzier, H. R., Ball, S., Tennen, H., Poling, J., &Triffleman, E. (1998). Personality disorders in substance abusers: Relation to substance abuse. *The Journal of Nervous and Mental Disease*, 186, 87-95. doi.org/10.1097/00005053-19.

Rutherford, M., & Duggan, S. (2007).*Forensic mental health services: Facts and figures on current provision*. London: The Sainsbury Centre for Mental Health. 9802000-00004.

Saariaho, T. H., Saariaho, A, S., Karila, I. A., & Joukamaa, M. I. (2011). Early maladaptive schemas in Finnish adult chronic pain patients and a control sample. *Scandinavian Journal of Psychology, 52*, 146-153. doi.org/10.1111/j.1467-9450.2010.00849.x.

Schmidt, N. B., Joiner, T. E., Young, J. E., & Telch, M. J. (1995). The Schema Questionnaire: Investigation of psychometric properties and the hierarchical structure of maladaptive schemas. *Cognitive Therapy and Research, 19*, 295-321. doi.org/10.1007/BF02230402.

Segal, Z. V., & Vella, D. D. (1990). Self-schema in major depression: Replication and extension of priming methodology. *Cognitive Therapy and Research, 14*, 161-176. doi.org/10.1007/BF01176207.

Seligman, M. E. P. (2005). The effectiveness of psychotherapy: The consumers reports study. *The American Psychologist, 50*, 965-974.

Simpson, S. G., Morrow, E., van Vreeswijk, M., & Reid, C. (2010). Group schema therapy for eating disorders: a pilot study. *Frontiers in Psychology, 1*.

Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.). *Qualitative Psychology* (2nd ed.). London: Sage.

Snaith, R., & Zigmond, A. (1994). The hospital anxiety and depression scale. Windsor, ON, Canada: NFER-Nelson.

Stafford, P. (1999). *Defining gender issues: Redefining women's services*. London: WISH.

Stattin, H., Magnusson, D., & Reichel, H. (1989). Criminal activity at different ages: A study based on a Swedish longitudinal research population. *British Journal of Criminology, 29*,368-385.

Stone, E. F., Stone, D. L., & Gueutal, H.G. (1990). Influence of cognitive ability on responses to questionnaire measures: Measurement precision and missing response problems. *Journal of Applied Psychology, 75,* 418–427. doi.org/10.1037//0021-9010.75.4.418.

Strauss, A., Corbin, J., (1990). *Basics of qualitative research: Grounded theory procedure and techniques*. London: Sage.

Stopa, L., Thorne, P., Waters, A., & Preston, J. (2001). Are the short and long forms of the Young Schema-Questionnaire comparable and how well does each version predict psychopathology scores? *Journal of Cognitive Psychotherapy, 15,* 253-272.

Tarrier, N., Dolan, M., Doyle, M., Dunn, G., Shaw, J., & Blackburn, R. (2010). Exploratory randomised control trial of schema modal therapy in the personality disorder service at Ashworth Hospital. *Ministry of Justice Research Series,* 5-10.

Tolan, P. H., & Thomas, P. (1995). The implications of age of onset for delinquency risk, II: Longitudinal data. *Journal of Abnormal Child Psychology, 23*, 47-65. doi.org/10.1007/BF01447087.

Van der Kolk, B. A., Perry, P. C., & Herman, J. L. (1991). Childhood origins of self-destructive behaviour. *American Journal of Psychiatry, 148,* 1665-1671.

Wagoner, B. (2013). Bartlett's concept of schema in reconstruction. *Theory and Psychology, 23,* 553 –575. doi: 10.1177/0959354313500166.

Waller, G., Leung, N., & Thomas, G. (1999). Core beliefs in anorexic and bulimic women. *Journal of Nervous and Mental Disease, 187,* 736-741.

Waller, G., Ohanian, V., Meyer, C., & Osman, S. (2000) Cognitive content among bulimic women: The role of core beliefs. *International Journal of Eating Disorders, 28,* 235-241. doi.org/10.1002/1098-108X(200009)28:2<235::AID-EAT15>3.3.CO;2-T.

Waller, G., Meyer, C., & Ohanian, V. (2001). Psychometric properties of the long and short versions of the Young Schema Questionnaire: Core beliefs among bulimic and comparison women. *Cognitive Therapy and Research, 25,* 137-147.

Waring, T., & Wainwright, D. (2008). Issues and challenges in the use of template analysis: Two comparative case studies from the field. *The Electronic Journal of Business Research Methods, 6,* 85-94.

Warren, J. I., Loper, A. B., & Komarovskaya, I. (2009). Symptom pattern related to trauma exposure among female inmates with and without a diagnosis of posttraumatic stress disorder. *Journal of the American Academy of Psychiatry and the Law Online, 37,* 294–305.

Welburn, K., Coristine, M., Dagg, P., Pontefract, A., & Jordan, S. (2002). The Schema-Questionnaire-short form: Factor analysis and relationship between schemas and symptoms. *Cognitive Therapy and Research, 26,* 519-530. doi.org/10.1023/A:1016231902020.

White, N. A., & Piquero, A. R. (2004). A preliminary empirical test of Silverthorn and Frick's delayed-onset pathway in girls, using an urban, African-American, US-based sample. *Criminal Behaviour and Mental Health, 14,* 291-309.

WHOQOL Group TW. (1998). The World Health Organization quality of life assessment (WHOQOL): Development and general psychometric properties. *Social Science and Medicine, 46*, 1569-1585.

Willig, C. (2008). *Introducing qualitative research methods in psychology (2nd ed.)* Maidenhead: McGraw Hill/Open University Press.

Willmot, P., & Gordon, N. (2011). *Working positively with personality disorder in secure settings: A practitioner's perspective.* West Sussex: John Wiley & Sons.

World Health Organization. (2014). Gender disparities in mental health. Retrieved March 11, 2014, from http://www.who.int/mental_health/prevention/genderwomen/en/

Young, J. E. (1990). *Cognitive therapy for personality disorders: A schema-focused approach.* Sarasota, FL: Professional Resource Exchange.

Young, J. E. (1994). Cognitive therapy for personality disorders: A schema-focused approach (Rev. ed.). Sarasota, FL: Professional Resource Press.

Young, J. E. (1999). *Cognitive therapy for personality disorder: A schema-focused approach* (3rded.). Sarasota, FL: Professional Resource Press.

Young, J., Arntz, A., Atkinson, T., Lobbestael, J., Weishaar, M., van Vreeswijk, M., & Klokman, J. (2013). Young schema mode inventory: Version 1.1. New York: Schema Therapy Institute.

Young, J. E., & Brown, G. (1990). *Young Schema Questionnaire*. New York: Cognitive Therapy Center of New York.

Young, J. E., & Brown, G. (1991). In J. E. Young (Ed).*Young Schema Questionnaire (2nded.). Cognitive therapy for personality disorders: A schema –focused approach* (rev. ed.). Sarasota, FL: Professional Resource Press.

Young, J. E., & Brown, G. (1994). Young Schema-Questionnaire (2nd ed.). In J. E. *Young, Cognitive therapy for personality disorders: A schema-focused approach* (Rev. ed., pp. 63–76). Sarasota, FL: Professional Resource Press.

Young, J. E., & Brown, G. (1999). *Young schema questionnaire: Short version.* New York: Cognitive Therapy Center of New York.

Young, J. E., & Brown, G. (2003).*Young Schema Questionnaire-L3a*. New York: Cognitive Therapy Centre of New York.

Young, J., & Behary, W. T. (1998). Schema-focused therapy for personality disorders. In N. Tarrier, A. Wells, & G. Haddock (Eds.), *Treating complex cases: The cognitive behavioural therapy approach* (pp. 340–376). Chichester: Wiley.

Young, J. E., Klosko, J. S., &Weishaar, M. E. (2003). *Schema therapy: A practitioner's guide*. New York: The Guilford Press.

Zanarini, M. C. (2009). Clinical overview: Psychotherapy of borderline personality disorder. *Acta Psychiatrica Scandinavica*: 120, 375- 377.

Zuckerman, M., & Lubin, B. (1985). *The multiple adjective checklist revised*. San Diego, CA: Edits.

Appendix A

Schemas and schema domains contained in YSQ & YSQ-2ed (Young & Brown, 1990; Young & Brown, 1994)

	Early maladaptive schema	Domain
1	Abandonment/ Instability (Expectation that others will leave or be unable to provide support)	
2	Mistrust/ Abuse (Consider that people will harm, cheat or lie to them in some way)	Instability & Disconnection (Anticipation that emotional support, feelings of safety and security will not be met)
3	Emotional Deprivation (Belief that the need for emotional support will not be met by others)	
4	Functional Dependence (The feeling that one is incompetent in daily living and requires substantial support from others)	Impaired Autonomy (Incorporates concepts related to self-identify and ability to function separate from others)
5	Vulnerability to harm or illness (Expectation that a catastrophe will occur at any moment)	
6	Enmeshment (Significant over-attachment to others often contributing to uncertainty about one's own identity)	
7	Defectiveness/ Shame (Belief that one is unwanted, unlovable, or that something is inherently wrong with them)	Undesirability (Contains expectations of poor

8	Social Undesirability (Belief that one is different from others and often feels on the outside of groups)	performance and issues of low self-worth)
9	Failure to achieve (Expectation that one will fail or has failed, considering that they do not live up to others in terms of achievement)	
10	Subjugation (Feeling coerced or the need to submit to others wishes often to avoid confrontation or rejection)	Restricted Self-Expression (Indicates tendencies to place strict controls on expression of feelings)
11	Emotional Inhibition (Lack of emotional expression and over controlled actions to avoid embarrassment, shame, disapproval)	
12	Self-sacrifice (Voluntarily doing things for others often to please, avoid feelings of guilt or selfishness)	Other Directedness (Tendencies to spend disproportionate amounts of energy and focus on the thoughts and feelings of others at the cost of one's own needs)
13	Unrelenting Standards (The need to strive for high expectations/ perfection often to avoid criticism)	
14	Negativity/ Pessimism (The expectation that things will go wrong in a wide range of areas with a minimisation of the positive aspects of life)	
15	Entitlement (The feeling that one is special and deserves privileges above others)	Impaired Limits (Deficits in exercising control, considering the rights of others or setting realistic goals)
16	Insufficient Self Control (Difficulty in exercising constraint over urges, impulses or expression of emotion)	

Appendix B

Schemas and schema domains contained within YSQ-L3a (Young & Brown, 2003)

	Early maladaptive schema	Domain
1	Abandonment/ Instability (Expectation that others will leave or be unable to provide support)	
2	Mistrust/ Abuse (Consider that people will harm, cheat or lie to them in some way)	Disconnection and Rejection (Anticipation that emotional support, feelings of safety and security will not be met)
3	Emotional Deprivation (Belief that the need for emotional support will not be met by others)	
4	Defectiveness/ Shame (Belief that one is unwanted, unlovable, or that something is inherently wrong with them)	
5	Social Isolation/ Alienation (Belief that one is different from others and often feels on the outside of groups)	
6	Dependence/ Incompetence (The feeling that one is incompetent in daily living and requires substantial support from others)	Impaired Autonomy and Performance (Incorporates concepts related to self-identify and ability to function separate from others)
7	Vulnerability to harm or illness (Expectation that a catastrophe will occur at any moment)	
8	Enmeshment/ Undeveloped self (Significant over-attachment to others often contributing to	

	uncertainty about one's own identity)	
9	Failure (Expectation that one will fail or has failed, considering that they do not live up to others in terms of achievement)	
10	Entitlement/ Grandiosity (The feeling that one is special and deserves privileges above others)	Impaired Limits (Deficits in exercising control, considering the rights of others or setting realistic goals)
11	Insufficient Self Control/ Self Discipline (Difficulty in exercising constraint over urges, impulses or expression of emotion)	
12	Subjugation (Feeling coerced or the need to submit to others wishes often to avoid confrontation or rejection)	Other Directedness (Tendencies to spend disproportionate amounts of energy and focus on the thoughts and feelings of others at the cost of one's own needs)
13	Self-sacrifice (Voluntarily doing things for others often to please, avoid feelings of guilt or selfishness)	
14	Approval Seeking/ Recognition Seeking (The need for attention, praise or recognition from others to help provide reassurance and a sense of being part of a group)	
15	Negativity/ Pessimism (The expectation that things will go wrong in a wide range of areas with a minimisation of the positive aspects of life)	
16	Emotional Inhibition (Lack of emotional expression and over controlled actions to avoid embarrassment, shame, disapproval)	Over vigilance and Inhibition (Excessive focus on inhibiting emotional expression and behaviour with the need to meet demanding internalised rules)
17	Unrelenting Standards (The need to strive for high expectations/ perfection often	

	to avoid criticism)
18	Punitiveness (The feeling that people should be punished if they make a mistake or do something wrong)

Appendix C:

Assessment Form for Existing Reviews

THRESHOLD CRITERIA				
CLARITY OF ISSUE PRESENTED	**YES (2 POINTS)**	**PARTLY (1 POINT)**	**NO (0 POINTS)**	**UNCLEAR**
Did the review address a clearly focused issue?				
Was the therapeutic intervention clearly defined?				
Were measurement tools validated and clear?				
STUDY DESIGN				
Did the review include the right type of study?				
Did the reviewers address the question being asked?				
DETAILED QUESTIONS				
INCLUSION OF STUDIES	**YES**	**PARTLY**	**NO**	**UNCLEAR**
Was a variety of bibliographic databases used?				
Was there a follow-up from reference lists?				
Was there personal contact with experts?				
Was there a search for unpublished studies?				
Did the reviewers search for non-English-language studies?				
QUALITY OF INCLUDED STUDIES				
Was a pre-determined strategy used to define which studies were included?				

Was a scoring system used?				
Was more than one assessor used?				
MEASUREMENT AND RESULTS				
Was a confidence interval reported?				
Was a p-value reported where confidence intervals are unavailable?				
Was the presentation of results appropriate?				
Were the results significant?				
APPLICABILITY OF FINDINGS				
Was the setting for research representative of UK environments used for therapeutic practice?				
Can the results be applied to the UK population?				
Is the review different from your population in ways that would produce different results?				

TOTAL QUALITY ASSESSMENT SCORE (Out of 38):

Appendix D:

Search Terms and Syntax

EMBASE CLASSIC + EMBASE

1. (psychotherap* or talking therap* or cognitive behaviour* therap* or cognitive behavior* therap*).mp. [mp=title, abstract, heading word, table of contents, key concepts]
2. schema*.mp. [mp=title, abstract, heading word, table of contents, key concepts]
3. (schema* adj5 (intervention or treatment or therapy)).mp. [mp=title, abstract, heading word, table of contents, key concepts]
4. early maladaptive schema*.mp. [mp=title, abstract, heading word, table of contents, key concepts]
5. schema mod*.mp. [mp=title, abstract, heading word, table of contents, key concepts]
6. young schema questionnaire*.mp. [mp=title, abstract, heading word, table of contents, key concepts]
7. (schema adj2 (questionnaire* or interview* or psychometric*)).mp. [mp=title, abstract, heading word, table of contents, key concepts]
8. (patient* or client* or service user*).mp. [mp=title, abstract, heading word, table of contents, key concepts]
9. (outpatient* or communit*).mp. [mp=title, abstract, heading word, table of contents, key concepts]

10. (inpatient* or detain* or prison* or convict* or offen* or clinical population* or section* or hospital* or ((secure or forensic) adj2 (hospital* or facilit* or unit*))).mp. [mp=title, abstract, heading word, table of contents, key concepts]
11. (psychiatry or (psychiatric adj2 (population* or setting* or sample*))).mp. [mp=title, abstract, heading word, table of contents, key concepts]
12. (mental health or personality disorder* or PD).mp. [mp=title, abstract, heading word, table of contents, key concepts]
13. (psychological adj2 (symptom* or complaint* or health or dysfunction* or difficult*)).mp. [mp=title, abstract, heading word, table of contents, key concepts]
14. (rehabilitation or relaps*).mp. [mp=title, abstract, heading word, table of contents, key concepts]
15. (compar* or effective* or evaluat* or cost benefit* or efficac* or assess* or differen* or outcome*).mp. [mp=title, abstract, heading word, table of contents, key concepts]
16. 1 or 2 or 3 or 4 or 5 or 6 or 7
17. 2 or 3 or 4 or 5 or 6 or 7
18. 1 and 17
19. 8 or 9 or 10 or 11 or 12 or 13 or 14
20. 15 and 17 and 19
21. 15 and 18 and 19
22. limit 21 to (human and english language and disordered populations and treatment & prevention and adulthood <18+ years> and "300 adulthood <age 18 yrs and older>" and human)

23. limit 20 to (human and english language and disordered populations and treatment & prevention and adulthood <18+ years> and "300 adulthood <age 18 yrs and older>" and human)

MEDLINE

1. (psychotherap* or talking therap* or cognitive behaviour* therap* or cognitive behavior* therap*).mp. [mp=title, abstract, heading word, table of contents, key concepts]
2. schema*.mp. [mp=title, abstract, heading word, table of contents, key concepts]
3. (schema* adj5 (intervention or treatment or therapy)).mp. [mp=title, abstract, heading word, table of contents, key concepts]
4. early maladaptive schema*.mp. [mp=title, abstract, heading word, table of contents, key concepts]
5. schema mod*.mp. [mp=title, abstract, heading word, table of contents, key concepts]
6. young schema questionnaire*.mp. [mp=title, abstract, heading word, table of contents, key concepts]
7. (schema adj2 (questionnaire* or interview* or psychometric*)).mp. [mp=title, abstract, heading word, table of contents, key concepts]
8. (patient* or client* or service user*).mp. [mp=title, abstract, heading word, table of contents, key concepts]
9. (outpatient* or communit*).mp. [mp=title, abstract, heading word, table of contents, key concepts]

10. (inpatient* or detain* or prison* or convict* or offen* or clinical population* or section* or hospital* or ((secure or forensic) adj2 (hospital* or facilit* or unit*))).mp. [mp=title, abstract, heading word, table of contents, key concepts]
11. (psychiatry or (psychiatric adj2 (population* or setting* or sample*))).mp. [mp=title, abstract, heading word, table of contents, key concepts]
12. (mental health or personality disorder* or PD).mp. [mp=title, abstract, heading word, table of contents, key concepts]
13. (psychological adj2 (symptom* or complaint* or health or dysfunction* or difficult*)).mp. [mp=title, abstract, heading word, table of contents, key concepts]
14. (rehabilitation or relaps*).mp. [mp=title, abstract, heading word, table of contents, key concepts]
15. (compar* or effective* or evaluat* or cost benefit* or efficac* or assess* or differen* or outcome*).mp. [mp=title, abstract, heading word, table of contents, key concepts]
16. 1 or 2 or 3 or 4 or 5 or 6 or 7
17. 2 or 3 or 4 or 5 or 6 or 7
18. 1 and 17
19. 8 or 9 or 10 or 11 or 12 or 13 or 14
20. 15 and 17 and 19
21. 15 and 18 and 19

22. limit 21 to (human and english language and disordered populations and treatment & prevention and adulthood <18+ years> and "300 adulthood <age 18 yrs and older>" and human)
23. limit 20 to (human and english language and disordered populations and treatment & prevention and adulthood <18+ years> and "300 adulthood <age 18 yrs and older>" and human)

PsycINFO AND PsychARTICLES

1. (psychotherap* or talking therap* or cognitive behaviour* therap* or cognitive behavior* therap*).mp. [mp=title, abstract, heading word, table of contents, key concepts]
2. schema*.mp. [mp=title, abstract, heading word, table of contents, key concepts]
3. (schema* adj5 (intervention or treatment or therapy)).mp. [mp=title, abstract, heading word, table of contents, key concepts]
4. early maladaptive schema*.mp. [mp=title, abstract, heading word, table of contents, key concepts]
5. schema mod*.mp. [mp=title, abstract, heading word, table of contents, key concepts]
6. young schema questionnaire*.mp. [mp=title, abstract, heading word, table of contents, key concepts]
7. (schema adj2 (questionnaire* or interview* or psychometric*)).mp. [mp=title, abstract, heading word, table of contents, key concepts]

8. (patient* or client* or service user*).mp. [mp=title, abstract, heading word, table of contents, key concepts]
9. (outpatient* or communit*).mp. [mp=title, abstract, heading word, table of contents, key concepts]
10. (inpatient* or detain* or prison* or convict* or offen* or clinical population* or section* or hospital* or ((secure or forensic) adj2 (hospital* or facilit* or unit*))).mp. [mp=title, abstract, heading word, table of contents, key concepts]
11. (psychiatry or (psychiatric adj2 (population* or setting* or sample*))).mp. [mp=title, abstract, heading word, table of contents, key concepts]
12. (mental health or personality disorder* or PD).mp. [mp=title, abstract, heading word, table of contents, key concepts]
13. (psychological adj2 (symptom* or complaint* or health or dysfunction* or difficult*)).mp. [mp=title, abstract, heading word, table of contents, key concepts]
14. (rehabilitation or relaps*).mp. [mp=title, abstract, heading word, table of contents, key concepts]
15. (compar* or effective* or evaluat* or cost benefit* or efficac* or assess* or differen* or outcome*).mp. [mp=title, abstract, heading word, table of contents, key concepts]
16. 1 or 2 or 3 or 4 or 5 or 6 or 7
17. 2 or 3 or 4 or 5 or 6 or 7
18. 1 and 17
19. 8 or 9 or 10 or 11 or 12 or 13 or 14

20. 15 and 17 and 19
21. 15 and 18 and 19
22. limit 21 to (human and english language and disordered populations and treatment & prevention and adulthood <18+ years> and "300 adulthood <age 18 yrs and older>" and human)
23. limit 20 to (human and english language and disordered populations and treatment & prevention and adulthood <18+ years> and "300 adulthood <age 18 yrs and older>" and human)

Web of Science (Journals)

1. (schema*) OR (schema therap*) OR (schema intervention*) OR (schema treatment*) OR (young schema questionnaire*) OR (schema interview*) OR (schema questionnaire*) OR (schema psychometric*) OR (early maladaptive schema*) OR (schema mod*).

AND

2. (patient*) OR (client*) OR (service user*) OR (outpatient*) OR (communit*) OR (inpatient*) OR (detain*) OR (prison*) OR (convict*) OR (clinical population*) OR (section*) OR (secure hospital*) OR (secure facilit*) OR (secure unit*) OR (forensic) OR (offender*) OR (psychiatry) OR (psychiatric population*) OR (psychiatric sample*) OR (psychiatric setting*) OR (mental health) OR (mental illness) OR (personality disorder) OR (PD) OR (psychological symptom*) OR (psychological difficult*) OR (psychological dysfunction*) OR (rehabilitation) OR (relapse*).

AND

3. (compar*) OR (effective*) OR (evaluat*) OR (cost benefit*) OR (efficac*) OR (assess*) OR (differen*).

Appendix E:

Inclusion/ Exclusion Criteria

	Inclusion	Exclusion
Population	Adults aged 18 and over Clinical population including full range of psychological symptom complaints Inpatients and Outpatients	Children and adolescents aged 17 and under.
Intervention	Schema-focused therapy Dual focused therapy Schema modal work	Integrated therapy disallowing the potential for schema to be assessed independently.
Comparator	Alternative psychotherapies Medication Treatment as usual Studies without comparators will also be included	N/A
Outcomes	Existence and severity of symptom complaints, diagnostic criteria, validated assessment tools measuring symptom severity.	Cost effectiveness
Study design	Randomised Control Trials Quasi-experimental Cohort Observational studies without control	Opinion papers, book reviews, commentaries, editorials, non-English papers.

Inclusion Criteria Protocol

Author(s): **Date:** **Country of Origin:**	

	Criteria	Yes	No	Unclear
Population	▪ Does the population include adults 18 and over only? ▪ Is there a clear diagnosis of a psychological symptom complaint?			
Intervention	▪ Has the population engaged in schema focused therapy, schema mode work or dual focused schema therapy? ▪ Is the intervention solely focused on schema and not integrated with other forms of			

	therapy?			
Comparator	▪ Is there a control or comparison group? ▪ If the answer is no to the above question, are there pre and post measures?			
Outcomes	Are there validated assessment tools measuring symptom severity and diagnostic criteria?			
Study design	Does the study include, RCT's, Quasi-experimental, cohort, or a pre and post study design?			

Is this study to be included?	
Reason for exclusion	

Appendix F:

Data Extraction Form

GENERAL INFORMATION

Date of data extraction: Author(s): Date: Title: Source (e.g. Journal) Country of Origin	

SPECIFIC INFORMATION

Aims & Objectives of study	
Population Characteristics Target population (describe) Inclusion criteria Exclusion criteria Recruitement procedures used Characteristics of participants:	

o Total Number at start of intervention: o Average Age: o Age range: o Gender: o Diagnosis:	

Methodological Quality of Study

Please tick one of the following;

RCT	Quasi-Experimental	Cohort	Case Control	Cross Sectional

Intervention Setting (e.g. community, inpatient):	

Conditions:

Condition	Intervention	Duration of Intervention	Delivery style (group, 1:1)	Discpiline of Faciliator	Training of Facilitator
A					
B					

C					
D					

Outcome Measures

What pre and post measures were conducted?

	Measurement tool	Concept measured	Validity of measure
1			
2			
3			

4			
5			
6			
7			
8			

Length of follow up	

Condition	No. of particpants enrolled	No. of participants included in analysis
A		
B		
C		
D		

Analysis

Statistical techniques employed Were confounding variables considered? Overall attrition rates Was attrition adequetely managed?	

Condition	Measurement tool	Pre-measure result	Post measure result
A			
B			

C			
D			

Overall study quality	good reasonable poor

Appendix G:

Quality Assessment Form for Experimental Studies

Study Number:	
Study Author(s):	

QUESTION	YES (2 POINTS)	PARTLY (1 POINT)	NO (0 POINTS)	UNCLEAR
THRESHOLD CRITERIA				
CLARITY OF ISSUE PRESENTED				
Did the study address a clearly focused issue?				
Was the sample clearly only individuals with psychological difficulties				
Were control/ comparison groups clearly defined?				
Was the therapeutic intervention clearly defined?				
Were measurement tools validated and clear?				
STUDY DESIGN				
PLEASE CIRCLE DESIGN USED	RCT	QUASI-EXPERIEMENTAL		
Was this the right research approach for the question being asked?				
Has the study addressed the question being asked?				
DETAILED QUESTIONS				
SELECTION BIAS AND INTERVENTION ALLOCATION	**YES**	**PARTLY**	**NO**	**UNCLEAR**
Was the sample representative of the defined population?				
Was a sufficient sample size used?				
Was there sufficient information about the demographic background factors of the sample?				

Were any potential confounding variables controlled for?				
Was allocation to groups appropriate?				
Were groups the same at entry?				
ATTRITION BIAS				
Were all participants followed up?				
Were all participants outcomes analysed within groups they were initially allocated?				
MEASUREMENT AND OUTCOME BIAS				
Was the outcome measure validated?				
Were the assessment instrument(s) for outcome (psychometrics/questionnaire) standardised?				
Was the outcome assessed in the same way across groups?				
Were participants reviewed at the same time period?				
SAMPLE SIZE AND CONCLUSIONS DRAWN				
Was there a power calculation stating number of participants required to ensure that findings are				
Was the statistical analysis used correct?				
RESULTS				
Are the results significant?				
Is it precise enough to make a decision?				
Have limitations been discussed?				
APPLICABILITY OF FINDINGS				
Can results be applied to clinical population?				
Was the setting for research representative of UK environments used for therapeutic practice?				
Can the results be applied to the UK population?				

TOTAL QUALITY ASSESSMENT SCORE (Out of 54):

Appendix H:

Quality Assessment Form for Observational Studies without Controls

Study Number:	
Study Author(s):	

QUESTION	YES (2 POINTS)	PARTLY (1 POINT)	NO (0 POINTS)	UNCLEAR
THRESHOLD CRITERIA				
CLARITY OF ISSUE PRESENTED				
Did the study address a clearly focused issue?				
Was the sample clearly only individuals evidencing psychopathology				
Was the therapeutic intervention clearly defined?				
Were measurement tools validated and clear?				
STUDY DESIGN				
Was this the right research approach for the question being asked?				
Has the study addressed the question being asked?				
DETAILED QUESTIONS				
SELECTION BIAS	**YES**	**PARTLY**	**NO**	**UNCLEAR**
Was the cohort representative of the defined population?				
Was a sufficient sample size used?				
Was there sufficient information about the demographic background factors of the sample?				
Were any potential confounding variables controlled for?				

ATTRITION BIAS				
Were all participants followed up?				
MEASUREMENT AND OUTCOME BIAS				
Was the outcome measure validated?				
Were the assessment instrument(s) for outcome (psychometrics/questionnaire) standardised?				
Was the intervention assessed over an appropriate length of time?				
SAMPLE SIZE AND CONCLUSIONS DRAWN				
Were outcomes clearly presented?				
Was the statistical analysis used correct?				
RESULTS				
Are the results significant?				
Is it precise enough to make a decision?				
Have limitations been discussed?				
APPLICABILITY OF FINDINGS				
Can results be applied to clinical population?				
Was the setting for research representative of UK environments used for therapeutic practice?				
Can the results be applied to the UK population?				

TOTAL QUALITY ASSESSMENT SCORE (Out of 44) :

Appendix I:
Excluded Studies

	Authors	Date	Title	Reason For Exclusion
1.	Arntz and Weertman	1999	Treatment of childhood memories; theory and practice	Integrated therapy
2.	Ball, Mitchell, Malhi, Skillecom and Smith	2003	Schema-focused cognitive therapy for bipolar disorder: reducing vulnerability to relapse through attitudinal change	Systematic review
3.	Beckly and Gordan	2010	Schema Therapy in a high secure setting (not yet published)	Book chapter
4.	Coon	1994	Cognitive behavioural interventions with avoidant personality: A single case	Unobtainable
5.	Dickhaut and Arntz,	2010	Individual and group schema therapy combined	Outcomes not yet available. Cost effectiveness also used as an outcome measure
6.	Dolan and Bishay	1996	The effectiveness of cognitive therapy in the treatment of non psychotic morbid jealousy	Unobtainable
7.	George, Thornton, Touyz, Waller and	2004	Motivational enhancement and schema-focused cognitive	Unobtainable

	Beumont		behaviour therapy in the treatment of chronic eating disorders	
8.	Giesen-Bloo, Bamelis and Hermes	2007	De Effectiviteit van Schema-Focused Therapy en Transference-Focused Psychotherapy voor cliënten met een Borderline Persoonlijkheidsstoornis op Sociaal Gedrag, en de invloed van Trauma op Sociaal Gedrag (Bachelorthesis)	Non English
9.	Hoffart and Sexton	2002	The role of optimism in the process of schema focused cognitive therapy of personality problems	Integrated therapy
10.	Hoffart, Versland and Sexton	2002	Self understanding, empathy, guided discovery, and schema belief in schema focused cognitive therapy of personality problems: A process-outcome study	Integrated therapy
11.	Kienast T. Foerster	2008	Psychotherapy of personality disorders and concomitant substance dependence	Review
12.	Nadort et al.	2009	Three preparatory studies for promoting implementation of outpatient schema therapy for borderline personality disorder in general mental	No treatment implementation to date

			health care	
13.	Nadort et al.	2009	Implementation of outpatient schema therapy for borderline personality disorder: Study design	Study design-no implementation
14.	Siddle, Turkington and Dudley	1997	Cognitive behaviour therapy in a case of organic hallucinosis	CBT highlights need for schema therapy. No implementation.
15.	Spinhoven, Giesen-Bloo, Van Dyck and Arntz	2008	Can assessors and therapists predict the outcome of long-term psychotherapy in borderline personality disorder?	Predictive outcome assessed
16.	Spinhoven, Giesen-Bloo, van Dyck, Kooiman and Arntz	2007	The therapeutic alliance in schema-focused therapy and transference focused psychotherapy for borderline personality disorder	Treatment effect reported by Giesen-Bloo (2006), included in review
17.	Van Asselt, Dirksen, Arntz and Severens	2008	Difficulties in calculating productivity costs: work disability associated with borderline personality disorder	Main outcome measure related to cost effectiveness

18.	Weertman and Arntz	2007	Effectiveness of treatment of childhood memories in cognitive therapy for personality disorders; a controlled study contrasting methods focusing on the present and methods focusing on childhood memories	Integrated therapy/ assessment
19.	Welburn, Dagg, Coristine and Pontefract	2000	Schematic change as a result of an intensive group-therapy day treatment program	CBT programme used, not schema therapy

Appendix J:

INFORMED CONSENT FORM

A Qualitative Study of Schema Functioning Amongst Female Forensic Mental Health Patients

Participant reference number allocated:

Name of Researcher:

Please initial box

- I confirm that I have read and understand the information sheet for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
- I understand my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
- I understand that data collected during the study will remain anonymous, but overall outcomes, may be looked at by supervisors of the project, individuals from Raphael Healthcare, from regulatory authorities or from the NHS Trusts, where it is relevant to my taking part in this research. I give permission for these individuals to have access to research outcomes in addition to these being publicised at conferences, on databases or through journal articles. ☐
- I agree to take part in the above study. ☐

_____

Name of participant Date Signature

_____

Name of person taking consent Date Signature

If illiterate OR do not have access to pens

I have witnessed the accurate reading of the consent form to the potential participant, and the individual has had the opportunity to ask questions. I confirm that the individual has given consent freely.

_____

Name of person witnessing consent Date Signature

(When completed: 1 for participant; 1 for researcher site file; 1 (original) to be kept in medical notes.)

ADDITIONAL INFORMATION SHEET

Ref Number:	
Research Project	**A Qualitative Study of Schema Functioning Amongst Female Forensic Mental Health Patients**

Please take the time to complete the following details. Information provided will remain anonymous and confidential.

Age: _____

Ethnic Origin (Please tick):

Asian

☐ Bangladeshi

☐ Indian

☐ Pakistani

☐ Any Other Asian Background (specify if you wish)

……..

Black

☐ African

☐ Caribbean

☐ Any Other Black Background (specify if you wish)

…….

Chinese

☐ Asian and White

☐ Any Other Chinese Background (specify if you wish)

……..

Mixed Ethnic Background

☐ Black African and White

☐ Black Caribbean and White

☐ Any Other Mixed Ethnic Background (specify if you wish)

……

White

☐ White background (specify if you wish)

……

Any Other Ethnic Background

☐ Any Other Ethnic Background (specify if you wish)

……

Psychiatric diagnoses: _____

Reason for residency:

Is this due to a current index offence?

☐ Yes ☐ No

If yes, what was the nature of your offence?

☐ Offence against person ☐ Offence against property

☐ Other miscellaneous (e.g. possession of drugs, possession of weapons)

If no, was the reason for transfer due to;

☐ Risk to others ☐ Risk to self ☐ Other

Thank you for taking part

Appendix K:

Interview Schedule

Interviewer guidance*: The interview schedule is due to be followed in the order as detailed below. Additional prompts are indicated for each question to enable thorough exploration and discussion. It is recognised however that some participants may require further probes to obtain information and clarify meaning if generic statements are given or jargon terms used. Such probes may include "what do you mean by...?", "can you explain…?", "can you tell me more…?", "does this apply to anyone/ anything else?" and "why…?". Please note that the secondary probes for each question labelled (a) tends to ask "What have been the most likely reasons for this feeling to occur/ come up for you?". The word* <u>feeling</u> *is italicised as it is considered that such thoughts or feelings may come up without the expected event actually happening. In order to ensure there is clarity regarding what is said throughout interview, information may be recapped upon before proceeding on to next question.*

Introduction: Within the next few moments I am hoping to start asking you questions about specific life patterns that people may develop, that can create difficulties for those that hold them and can often be repeated throughout a person's lifetime. These difficult life patterns are often called schemas, which a person tends to accept without question. For each schema I will ask if you have experienced them and ask questions around this, however I am aware that not all schemas will be relevant for you. If this is the case we can move on to the next one. During the interview I will be recording what is said and I expect it to last for approximately one hour. There will be eighteen subsections in total. If at anytime you wish to take a break, or withdraw from the interview, please feel free to let me know and we will stop the recording. If you later wish to continue, then we may resume at an agreed time. Any questions before we start?

1. Have you ever felt that you have to be the best, whereby second best wouldn't be good enough?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?
    i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?
    ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?
b. What words would you use to describe how you have felt at these times?
    i) *Prompt*: What emotions in particular?
c. How have you responded to this/ what did you do?
    i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?
    ii) *Prompt*: What has this led to?
d. What has that (actions) done for you?

2. Has it ever been hard to fit in with others?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?
    i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?
    ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?
b. What words would you use to describe how you have felt at these times?
    i) *Prompt*: What emotions in particular?
c. How have you responded to this/ what did you do?

i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?

ii) *Prompt*: What has this led to?

d. What has that (actions) done for you?

3. Have you ever felt that people were going to leave you or not be there for you?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?

i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?

ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?

b. What words would you use to describe how you have felt at these times?

i) *Prompt*: What emotions in particular?

c. How have you responded to this/ what did you do?

i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?

ii) *Prompt*: What has this led to?

d. What has that (actions) done for you?

4. Have you ever felt as though people may lie, cheat or hurt you in some way?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?

i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?

ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?

b. What words would you use to describe how you have felt at these times?

i) *Prompt*: What emotions in particular?

c. How have you responded to this/ what did you do?

i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?

ii) *Prompt*: What has this led to?

d. What has that (actions) done for you?

5. Have people supported you emotionally? Have there been times when you have expected this <u>wouldn't</u> happen?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?

i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?

ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?

b. What words would you use to describe how you have felt at these times?

i) *Prompt*: What emotions in particular?

c. How have you responded to this/ what did you do?

i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?

ii) *Prompt*: What has this led to?

d. What has that (actions) done for you?

6. Have you ever found yourself wanting to do a lot of things for others, maybe at the expense of meeting your own needs?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?
    i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?
    ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?
b. What words would you use to describe how you have felt at these times?
    i) *Prompt*: What emotions in particular?
c. How have you responded to this/ what did you do?
    i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?
    ii) *Prompt*: What has this led to?
d. What has that (actions) done for you?

7. Have you ever felt as though there is something wrong with you, which may affect other parts of your life?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?
    i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?
    ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?
b. What words would you use to describe how you have felt at these times?
    i) *Prompt*: What emotions in particular?

c. How have you responded to this/ what did you do?

    i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?

    ii) *Prompt*: What has this led to?

d. What has that (actions) done for you?

8. Have you ever felt that you couldn't survive on your own?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?

    i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?

    ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?

b. What words would you use to describe how you have felt at these times?

    i) *Prompt*: What emotions in particular?

c. How have you responded to this/ what did you do?

    i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?

    ii) *Prompt*: What has this led to?

d. What has that (actions) done for you?

9. Have you ever felt that the worst is likely happen at any moment?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?

i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?

ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?

b. What words would you use to describe how you have felt at these times?

i) *Prompt*: What emotions in particular?

c. How have you responded to this/ what did you do?

i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?

ii) *Prompt*: What has this led to?

d. What has that (actions) done for you?

10. Have you ever felt so connected to someone that you couldn't be who you wanted to be otherwise it might upset them?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?

i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?

ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?

b. What words would you use to describe how you have felt at these times?

i) *Prompt*: What emotions in particular?

c. How have you responded to this/ what did you do?

i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?

ii) *Prompt*: What has this led to?

d. What has that (actions) done for you?

11. Have you ever found it difficult to show/ tell people how you feel?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?
    i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?
    ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?
b. What words would you use to describe how you have felt at these times?
    i) *Prompt*: What emotions in particular?
c. How have you responded to this/ what did you do?
    i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?
    ii) *Prompt*: What has this led to?
d. What has that (actions) done for you?

12. Have you ever felt less likely to succeed as compared to others?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?
    i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?
    ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?
b. What words would you use to describe how you have felt at these times?
    i) *Prompt*: What emotions in particular?

c. How have you responded to this/ what did you do?
    i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?
    ii) *Prompt*: What has this led to?
d. What has that (actions) done for you?

13. Have you felt as though you deserve to be treated differently to others (in a good way)?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?
    i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?
    ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?
b. What words would you use to describe how you have felt at these times?
    i) *Prompt*: What emotions in particular?
c. How have you responded to this/ what did you do?
    i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?
    ii) *Prompt*: What has this led to?
d. What has that (actions) done for you?

14. Have you ever had difficulty in stopping any urges, impulses or emotions you may have had?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?

i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?

ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?

b. What words would you use to describe how you have felt at these times?

i) *Prompt*: What emotions in particular?

c. How have you responded to this/ what did you do?

i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?

ii) *Prompt*: What has this led to?

d. What has that (actions) done for you?

15. Have you ever felt you must do things for others even if you don't want to?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?

i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?

ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?

b. What words would you use to describe how you have felt at these times?

i) *Prompt*: What emotions in particular?

c. How have you responded to this/ what did you do?

i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?

ii) *Prompt*: What has this led to?

d. What has that (actions) done for you?

16. Have you ever felt that everything will go wrong no matter what?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?
    i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?
    ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?
b. What words would you use to describe how you have felt at these times?
    i) *Prompt*: What emotions in particular?
c. How have you responded to this/ what did you do?
    i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?
    ii) *Prompt*: What has this led to?
d. What has that (actions) done for you?

17. Have you ever considered that if someone has done something wrong that there should be consequences for their actions or that they should be punished in some way?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?
    i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?
    ii) *Prompt:* Does this apply to anyone in particular? How did you feel about the people/ person this related to? / How did you feel about yourself?
b. What words would you use to describe how you have felt at these times?
    i) *Prompt*: What emotions in particular?

c. How have you responded to this/ what did you do?
    i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?
    ii) *Prompt*: What has this led to?
d. What has that (actions) done for you?

18. Have you ever felt the need to look for recognition or attention from others?

a. What have been the most likely reasons for this *feeling* to occur/ come up for you (examples)?
    i) *Prompt*: What were your thoughts at this time? What was going through your mind? What were you saying to yourself in your head?
    ii) *Prompt:* How did you feel about the people/ person this related to? / How did you feel about yourself?
b. What words would you use to describe how you have felt at these times?
    i) *Prompt*: What emotions in particular?
c. How have you responded to this/ what did you do?
    i) *Prompt*: Tried to keep a distance or avoid/ go along with it/ make efforts to fight against it?
    ii) *Prompt*: What has this led to?
d. What has that (actions) done for you?

Closing statements: We have now reached the end of the interview. I would just like to say thank you for participating. What I will do now is stop the recording and we can discuss how you have found this experience and whether you feel any additional support is required following this. You will also be able to ask any questions you may have. I appreciate your time.

Appendix L:

Example transcript

J1. **I**: **So the first question is wondering if you have ever felt that you have to be the best, whereby second best just wouldn't be good enough?**

J2. R: Yes

J3. I: What's the most likely thing to bring that up for you

J4. R: Well I'm a twin so being the best mattered, second best wasn't good enough.

J5. I: Was that in terms of anything in particular?

J6. R: Sport mainly and academic

J7. I: So when that comes up for you is there anything that would go through your head at those times?

J8. R: I always thought my mum and dad didn't love me and that they loved my sister more.

J9. R: And if I didn't come first it would make it even worse

J10. I: What would it mean if you were to be the best and come first, what would that mean for you?

J11. R: It would be happy for me

J12. I: When this is coming up for you, how does it leave you feeling?

J13. R: Angry

J14. I: Where does that anger come in? What is that about?

J15. R: Not sure.

J16. R: I've had anger for a lot of years.

J17. I: Is that directed anywhere that anger?

J18. R: Yes, something else.

J19.I: Are you able to say what that is?

J20.R: Myself and others

J21.I: So what would you do at those times?

J22.R: I used to self-harm.

J23.R: Take drink and drugs.

J24.R: But now I just bottle it all up.

J25.R: Still don't release it anywhere

J26.R: I'm a lot better with it now though.

J27.R: I can control my temper now.

J28.R: Before I would flip over little things

J29.I: And you say that would tend to come out in ways such as drink, drugs and self-harming?

J30.R: Yes.

J31.I: What would the drinking do for you?

J32.R: Make me dangerous

J33.I: In what way?

J34.R: Violent and arson

J35.I; What would they do for you?

J36.R: It's like a release

J37.I; Both of them?

J38.R: Yes

J39.I: And what about the self-harming, what function does that serve?

J40.R: It's like a release as well.

J41.I: Do all those act quite similar for you then?

J42.R: Yes

J43.I; But now you say you are able to keep control it a lot more, but still not going anywhere

J44.R: Yes

J45.I: So is there any other way you do cope with it?

J46.R: I try and talk to myself now and talk myself through it.

J47.R: Work out the best possible solution

J48.I: Do you find that helpful?

J49.R: Yes

J50.I: Why?

J51.R: Because it saves me bottling it all up.

J52.R: And I talk to my psychologist about it.

J53.R: Don't really talk to the staff anymore just the psychologist.

J54.I: When it is coming up for you, how might you come across to others? Anything they might notice?

J55.R: My mood can go down.

J56.R: Become withdrawn

J57.R: Isolate myself

J58.I; Anything else?

J59.R: Not that I can think of.

J60.I: **Okay. Have you ever found it hard to fit in with others?**

J61.R: Yes

J62.I: What have been most likely reasons?

J63.R: I'm a bit of a loner really, always have been

J64.I: Anything that brings it up for you? More intense?

J65.R: Find people annoying

J66.I: Anything in particular they do that you find annoying?

J67.R: If they don't understand me.

J68.R: It can kick in straight away.

J69.I: So in terms of this any other thoughts or feelings come up for you?

J70.R: Haven't got much confidence in myself

J71.I: So what impact does that have?

J72.R: Gets me angry

J73.I: Why is it anger that you start to feel?

J74.R: Because I feel useless, thick and stupid.

J75.I: How do you manage that?

J76.R: Try and think what my psychologist has told me.

J77.I: Okay, and would you do anything?

J78.R: If I'm angry I go into my room.

J79.I: What does that do for you?

J80.R: It's like my security blanket for me when I go there, calms me down.

J81.I: Takes you away from others?

J82.R: Yes.

J83.R: Anything else you do?

J84.R: No.

J85.I: Okay. Have you ever felt that people were going to leave you or not be there for you?

J86.R: Yes

J87.I: What are the most likely reasons for this to come up for you?

J88.R: My family

J89.I: Are there things that might be going on that would make it come up?

J90.R: If I haven't seen them for a while I worry, because they disowned me for 6 years.

J91.R: And I have been in contact for 2 years now but I still worry that they won't contact me even though they are doing.

J92.R; It's getting better every time but I still feel they will.

J93.I: Do you have any thoughts about them, when you think they aren't going to come back?

J94.R: I want to hurt them when I think like that

J95.I: What would that do for you?

J96.R: Short term it would make me feel better.

J97.R: Long term it would make me feel worse.

J98.R: I know all this.

J99.I: Why is it you feel like you would want to hurt them?

J100. R: Because they hurt me.

J101. I: What do you feel at this time in yourself

J102. R: angry, upset, scared

J103. I: in terms of wanting to hurt them, sometimes I feel good about it, sometimes ai feel bad about it.

J104. R: So what kind of things do you do or what has it lead to before?

J105. R: I was going to kill them, I got a knife and everything ready to do it with.

J106. I: Anything take place?

J107. R: No I got locked up and stopped before it happened.

J108. I: In terms of you having that knife ready, was that a good or bad feeling for you?

J109. R: At the time it was a good feeling.

J110. I; Any other things you have done at the times this has come up for you?

J111. R: Arson

J112. I: And what does that do for you?

J113. R: I feel like I'm in control when I do arson.

J114. I: Anything else?

J115. R: Gets rid of my anger.

J116. I: How might you come across to others at those times?

J117. R: Normal, no different.

J118. I: How would you describe yourself when things are normal?

J119. R: I can act as though everything is alright, like I haven't got any problems and nobody knows.

J120. I: I've kept hidden.

J121. R: Yes.

J122. I: No. Okay. Have you ever felt as though people may lie, cheat or hurt you in some way?

J123. R: Yes

J124. I: Again what are the most likely reasons for this to come up for you at times?

J125. R: I think a lot of people lie to me

J126. R: I don't trust people

J127. I; Is there anything in particular people might do to trigger that off? Or suggest they are lying?

J128. R: Err…….(pause), I don't know, I just don't trust them.

J129. I: Any other thoughts about those people that you expect might lie?

J130. R: No

J131. I: What about in terms of yourself?

J132. R: I don't lie

J133. I: I mean in terms of feelings you have about yourself at those times?

J134. R: I get angry about it.

J135. R: And then I start beating myself up about getting angry about it.

J136. I: So what do you do?

J137. R: I just agree with it because I can't be doing with it.

J138. R: Well I don't agree I just leave it.

J139. I: And what does that do for you?

J140. R: If they shut up and go away it makes me feel better, safer, because I got rid of them.

J141. R: But if they don't shut up and go away I just switch off and don't listen to them.

J142. I: And what does that switching off do for you?

J143. R: Erm…..(pause), don't know

J144. I: That's ok you don't have to have the answers to everything.

J145. I: if you are chatting to someone and you think they are lying, would they notice anything different about you?

J146. R: No.

J147. I: No changes in how you come across?

J148. R: No.

J149. I: Okay. Do you feel like people have supported you emotionally through your life?

J150. R: Yes.

J151. I: What are the most likely things to trigger that off?

J152. R: Family

J153. I: Anything in particular they might do that would bring it up?

J154. R: Not so much now, but in the past there was.

J155. R: They hurt me, physically, emotionally and in other ways.

J156. R: They didn't care.

J157. I: Any particular thoughts you would have about your family?

J158. R: Want to hurt them.

J159. I: Is it different from the question before?

J160. R: No not really, want to hurt them because they hurt me.

J161. I: Any particular thoughts about yourself at those times?

J162. R: Yes, I think I'm a bad person.

J163. I: How does that leave you feeling?

J164. R: Depressed, angry, sad, anxious.

J165. I: what would you do with that if you have those feelings there and expecting people don't care.

J166. R: I don't know anymore.

J167. I: Does this still come up for you?

J168. R: Not very often.

J169. I: In general how you have dealt with it in the past? Or how have you come across?

J170. R: (pause). I've self-harmed,

J171. R: Set fires

J172. R: Drunk

J173. R: Took drugs

J174. R: Anything to blot it out.

J175. I: Do all those thing serve slightly different functions or the same?

J176. R: Yes

J177. I: So the self-harming

J178. R: Releasing anger

J179. R: Physical scars instead of mental scars

J180. I: Is that a good thing?

J181. R: Not now, it was at the time but I regret it now.

J182. R: But at the time it was one of the only things I could do.

J183. I: And what about setting fires?

J184. R: A release as well.

J185. I: Any other outcome for you?

J186. R: Locked up in prison for it.

J187. I: Drinking?

J188. R: Blot things out, that's the drink and drugs.

J189. I: Anything else you mentioned?

J190. R: Violence.

J191. I: Ok what did that do?

J192. R: That's where my anger came out.

J193. R: And it did.

J194. R: Only violent when I was on drink and drugs, not when I'm off them.

J195. I: Would that be to the people involved or not?

J196. R: No, it would be people not involved.

J197. I: Okay. Have you ever found yourself wanting to do a lot of things for others, maybe at the expense of meeting your own needs?

J198. R: Yes.

J199. I: I want to please other people.

J200. R: Anything that brings that up for you?

J201. R: Family again, wanting to please them all the time.

J202. I: And for what reasons?

J203. R: Because I was always in competition with my sisters.

J204. I: And if you did please them what would that mean?

J205. R: Means I wouldn't get beat up.

J206. I: Ok does it mean that you feel like you have to or you want to do these things for people?

J207. R: I want to.

J208. I: Any particular thoughts about yourself or family at those times when wanting to please them?

J209. R: Just wished they would love me.

J210. I: Any thoughts about yourself that this brings up?

J211. R: Thought people didn't like me, thought they hated me.

J212. I: So how might you be feeling?

J213. R: Lonely, sad, depressed, angry.

J214. I: So what kind of things might you do when your wanting to do things for others?

J215. R: Don't want to talk about it (short in tone of voice).

J216. I: Ok, you want to carry on with the rest of this question or go onto next one, or stop?

J217. R: Next one.

J218. I: Okay. Have you ever felt at all that there is something wrong with you at times, which may affect other parts of your life?

J219. R: I'm dyslexic and that affected me growing up.

J220. I: So what kind of thoughts might be going through your head at those times then?

J221. R: That I was thick and stupid because it was what people called me.

J222. I: Would that bring up thoughts regarding them?

J223. R: No.

J224. I: Just how you were feeling about yourself?

J225. R: Yes.

J226. R: Any particular emotions that brings up?

J227. I: No.

J228. I: So how would you respond to that, what would you do?

J229. R: Isolate myself.

J230. I: Is that physically or in other ways?

J231. R: Physically.

J232. R: Come across as quiet.

J233. I: And what does that do for you, isolating and keeping quiet?

J234. R: (Long pause)…, it used to upset me.

J235. R: I wanted friends like my sister had, but I couldn't face them in case they called me thick and stupid.

J236. I: So wanting to interact but finding it too difficult to do?

J237. R: Yes

J238. I: What impact did that have on you then?

J239. R: (Pause)….. at the time it didn't have any impact but long term it has

J240. I: In what way?

J241. R: Well now, …… (pause) when I went to do voluntary work and I did something wrong, all the memories came back to me.

J242. R: And then I wanted to burn the place down, because I felt like they were getting on at me like the way they used to when I was a kid.

J243. I: so that had stayed with you?

J244. R: Yes.

J245. I: Is there anything else you do at these times, when feeling defective?

J246. R: Just do fires.

J247. I: And what does that do in this situation?

J248. R: I take the control.

J249. R: As much as fires are out of control I feel like I've got control of it.

J250. R: And I don't have much control, or I didn't used to have much control in my life.

J251. I: In what way do you have control of it?

J252. R: I'm the one that starts it, I'm the one that can do something about it but I don't.

J253. I: I can just be me.

J254. I: Anything else?

J255. R: No

J256. I: Anything that people might notice about you?

J257. R: No

J258. I: Have you ever felt as though you couldn't survive on your own? Needing support from others?

J259. R: No.

J260. I: Not relevant for you?

J261. R: No.

J262. I: Have you ever felt as though the worst is likely to happen at any moment?

J263. R: No, not really.

J264. I: You tend to get that expectation or feeling coming up?

J265. R: No.

J266. I: Have you ever felt so connected to someone that you felt you couldn't be who you wanted to be, otherwise it might upset them?

J267. R: No.

J268. I: Okay. Have you ever found it difficult to show or tell people how you feel?

J269. R: Yes

J270. I: What have been the most likely reason for that to come up for you?

J271. R: I don't show my anger, keep it all inside.

J272. I: is there anything which makes it more difficult at times to show anger?

J273. R: I don't like confrontation.

J274. I: Is that in terms of if you expect confrontation from saying something?

J275. R: Yes.

J276. I: At that time what kind of things might be going through your head?

J277. R: Depends what it is really.

J278. I: Any particular thoughts about yourself at those times?

J279. R: Yes I get angry at myself then for not being able to express how I feel.

J280. I: And what about other people around you?

J281. R: I get angry at them as well. I used to want to stab them.

J282. R: I used to get stabbing images quite a lot but I have worked through that and I don't get the stabbing images anymore.

J283. I: So would you get them if you were finding it difficult to talk to someone?

J284. R: Yes

J285. I: How does that link in then, why is that?

J286. R: Because I've stabbed somebody in the past when I was angry, and I always get picture of that in my head.

J287. I: So when these thoughts are coming up for you, are there any other things you might be feeling?

J288. R: It's sometimes when I'm upset and sometimes when I'm angry.

J289. I: Is that feeling upset and angry and you find that hard to say to someone, or is it feeling upset and angry because you can't show how you feel?

J290. R: A bit of both really.

J291. I: What kind of things might you do at those times then?

J292. R: Usually walk away from the situation, go and do something else to take my mind off it.

J293. I: And does that work for you?

J294. R: Yes

J295. I: How might you come across to others at those times, might they notice anything about you?

J296. R: No.

J297. I: Just that you might come away?

J298. R: Yes

J299. I: Would you be involved with other people to distract you or on your own?

J300. R: On my own

J301. I: Have you ever felt less likely to succeed as compared to others?

J302. R: Yes, my sister.

J303. I: Are there particular situations where this may come about?

J304. R: As I was growing up, always felt like I was in competition with her.

J305. I: Is that in anything specific?

J306. R: Everything really

J307. I: Okay. So what kind of things might have been going through your head when this comes up?

J308. R: Jealous of her.

J309. I: In what way?

J310. R: That she had more friends than me, did better at sports than me, and our family were big sports people so it was quite important to be good at sport and she was better than I was.

J311. I: How would you be feeling about yourself at those times?

J312. R: Used to get upset and angry.

J313. I: Where was that anger directed?

J314. R: Towards my mum and my sister.

J315. I: Mum and sister. Okay. For what reason was it to both of those?

J316. R: My mum used to beat me and I was jealous of sister, I felt like they loved her but didn't love me.

J317. I: How would you cope with that at those times then?

J318. R: Used to commit arson when I felt this way or in competition with her.

J319. I: What would that do for you?

J320. R: Like a release. Felt like I was in control.

J321. I: Release of what?

J322. R: Tension, the anger

J323. I: Is there anything in particular people would notice about you at those times, how you might come across?

J324. R: No, don't think so.

J325. R: I hid it very well.

J326. R: They didn't know I was doing arson, I've been doing arsons all my life and they didn't know until I was 21.

J327. I: What age did you start?

J328. R: When I was 5

J329. I: Something you would do on your own?

J330. R: Yes always on my own.

J331. I: And that's a tension release for you?

J332. R: Yes, get it all out, express how I'm feeling.

J333. I: Have you ever felt as though you deserve certain things, or should be treated differently to others, like maybe in a good way?

J334. R: No.

J335. I: Okay. Have you ever had any difficulty stopping any urges, impulses or emotions that you might have had?

J336. R: Yes.

J337. I: What is that in relation to?

J338. R: Sometimes the fires are impulsive and the stabbing was impulsive.

J339. I: When that comes about for you are there particular things that might be going through your head at those times?

J340. R: Just wanted to hurt people, when I was stabbing them.

J341. I: And what reason would that be for?

J342. R: They might have upset me or something.

J343. I: They have upset you so you want to hurt them, like you mentioned before?

J344. R: Yes.

J345. I: And the arson?

J346. R: That's different really, because that was more of a release for me rather than wanting to hurt anyone, something I just felt I really needed to do, hard to stop.

J347. I: What about any thoughts about yourself at those times?

J348. R: Self-harming; something I wanted to do and would do.

J349. R: Cutting myself.

J350. I: And how would you feel about yourself at those times?

J351. R: Just feel like I was worthless.

J352. I: Are there any other emotions that link to any of these scenarios that come up?

J353. R: No.

J354. I: Have you ever felt as though things may go wrong, no matter what?

J355. R: No.

J356. I: Okay. Have you ever felt as though you must do things for others even if you don't want to?

J357. R: Yes.

J358. I: What have been the most likely reasons for this to come up?

J359. R: I like to please people. And I don't like to upset them. Because I don't like confrontation if they get upset.

J360. R: I will do anything for an easy life.

J361. I: And this is different from wanting to do something and having to do something?

J362. R: Yes

J363. I: Anything for an easy life?

J364. R: Yes.

J365. I: What do you feel would happen if you wasn't to do that?

J366. R: I feel like I would lose control.

J367. I: In what way?

J368. R: If I got angry with them. If I didn't agree with what they were saying.

J369. I: In terms of them asking you to do something, and you're not wanting to do that how would you feel?

J370. R: Angry

J371. I: So that anger is still there?

J372. R: Yes

J373. I: What makes that different then? You mention if you don't do things you feel like you might lose control but if you go along and do it any way, you're still angry?

J374. R: But more in control

J375. I: How does that work?

J376. R: I don't know it just does, it just avoids the confrontation.

J377. I: Ok, so is it around that then that makes the difference. Still angry but there won't be confrontation and the less likely to lose control

J378. R: yes

J379. I: Are there particular thoughts you might be having about yourself or those others involved at those times?

J380. R: Might want to hurt them.

J381. R: In the past I wanted to hurt myself.

J382. R: But now if someone hurts me I might want to hurt them.

J383. R: But I resist the urges now.

J384. I: How do you resist the urges now?

J385. R: I think about the consequences

J386. I: And that's made a difference for you?

J387. R: Yes.

J388. I: Before when it was more difficult to resist the urges what would you used to do?

J389. R: Arson.

J390. R: Want to harm them but do arson instead.

J391. I: Is the arson away from others or to impact on the people involved?

J392. R: No not to harm anyone, just off on my own, just a way of releasing that anger and tension.

J393. I: Have you ever considered that if someone has done something wrong, that there should be consequences for their actions or be punished in some way?

J394. R: Yes.

J395. I: Seems to have come up in things we have talked about already, but what might be the most likely reasons for this to come up for you?

J396. R: I don't know.

J397. I: Is there an example you can think of?

J398. R: No.

J399. I: Okay just thinking in general terms then, what kind of things might be running through your head at those times?

J400. R: If they weren't punished for something they had done then yes, maybe I should do something.

J401. I: Take it in to your own hands?

J402. R: Yes.

J403. I: In any way in particular?

J404. R: No, try and avoid situations like that if possible.

J405. I: Are there any other thoughts you might get about yourself or others involved.

J406. R: No.

J407. I: How might you be feeling?

J408. R: Probably angry.

J409. I: So what would you do with that?

J410. R: Don't really know.

J411. I: Particular actions you might take? Or have done?

J412. R: Yes I have taken action before, I've been violent, but don't wish to say to say any more about it.

J413. I: Okay, so sometimes might act on it but more recently hasn't been the case?

J414. R: Yes.

J415. I: When you have acted on it what purpose has that served?

J416. R: It's been a release for me and to show them how I'm feeling. Nothing else really.

J417. I: Alright, this is the last question. Have you ever felt the need to look for recognition or attention from others?

J418. R: No.

J419. I: You don't find that's a need for you or comes up for you?

J420. R: I did in the past but not now.

J421. I: Okay. Although that's not the case now, in the past what kind of things would bring that up for you?

J422. R: The jealousy again, with my sister and the competition.

J423. I: is there anything you would do to seek that approval?

J424. R: Can't remember

J425. I: Or is there anything other people might have noticed about how you came across?

J426. R: Used to get in trouble a lot at school.

J427. I: Was that purposeful, in terms of this?

J428. R: Yes

J429. I: What kind of things did you do?

J430. R: I was just disruptive and things like that.

J431. I: In what way?

J432. R: I used to set fire alarms off a lot.

J433. R: I used to mess about in lessons.

J434. R: I used to smoke.

J435. R: It's like negative attention really.

J436. I: And would that serve the purpose you wanted?

J437. R: I used to get told off.

J438. R: And I would get upset.

J439. R: But it didn't seem to stop me.

J440. I: How come?

J441. R: Don't know.

J442. I: But this isn't something that comes up for you now?

J443. R: No.

J444. I: Okay, well that's the last of our questions so thank you for your time. Think we will leave it there.

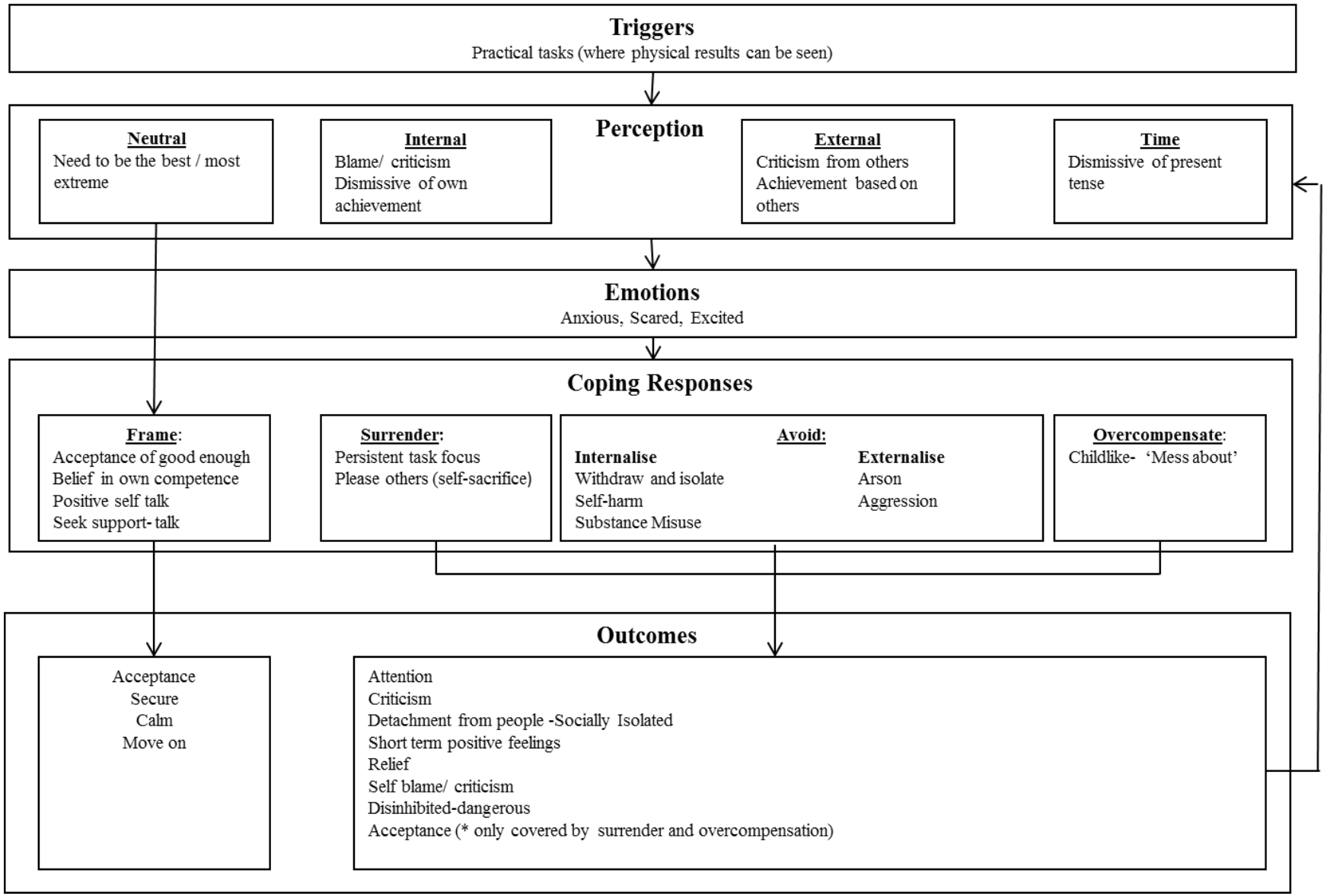
- **Recording Terminated.**

Appendix M:

Template Analysis

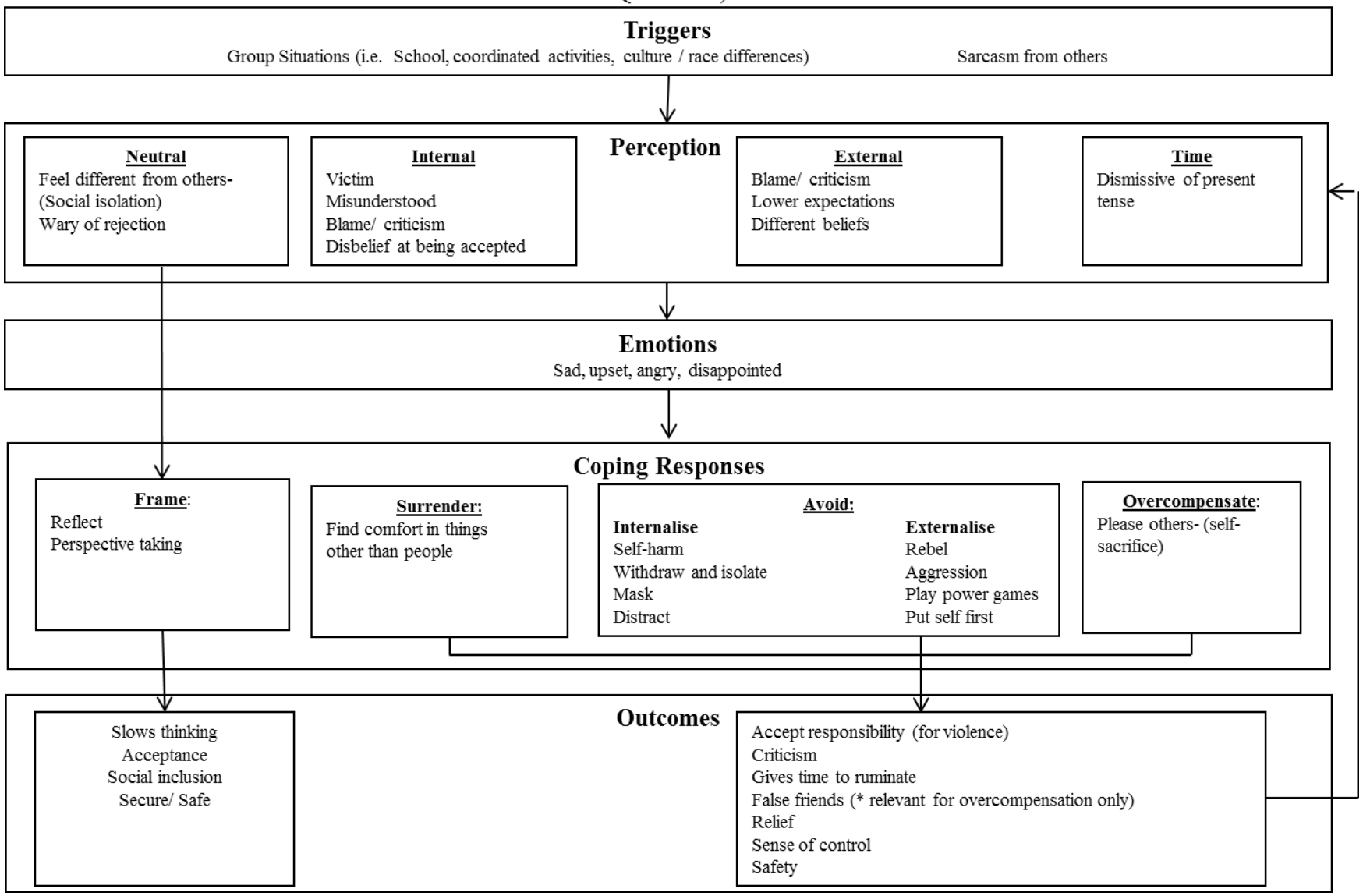
Unrelenting Standards

The need to strive for high expectations/ perfection (Young et al., 2003) (Please see Appendix L Question 1)



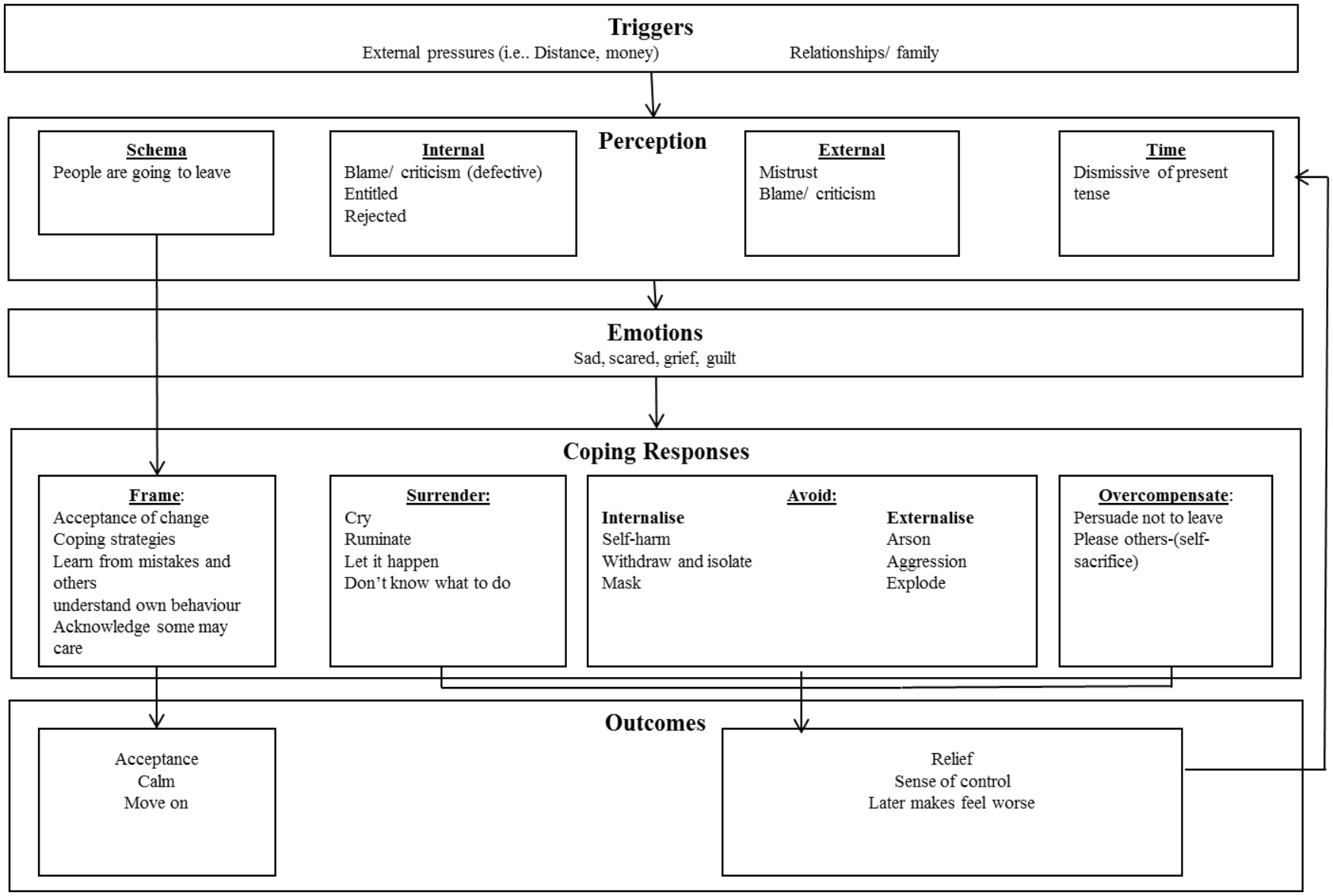
Social Isolation

Belief that one is different from others and often feels on the outside of groups (Young et al., 2003) (Please see Appendix L Question 2)



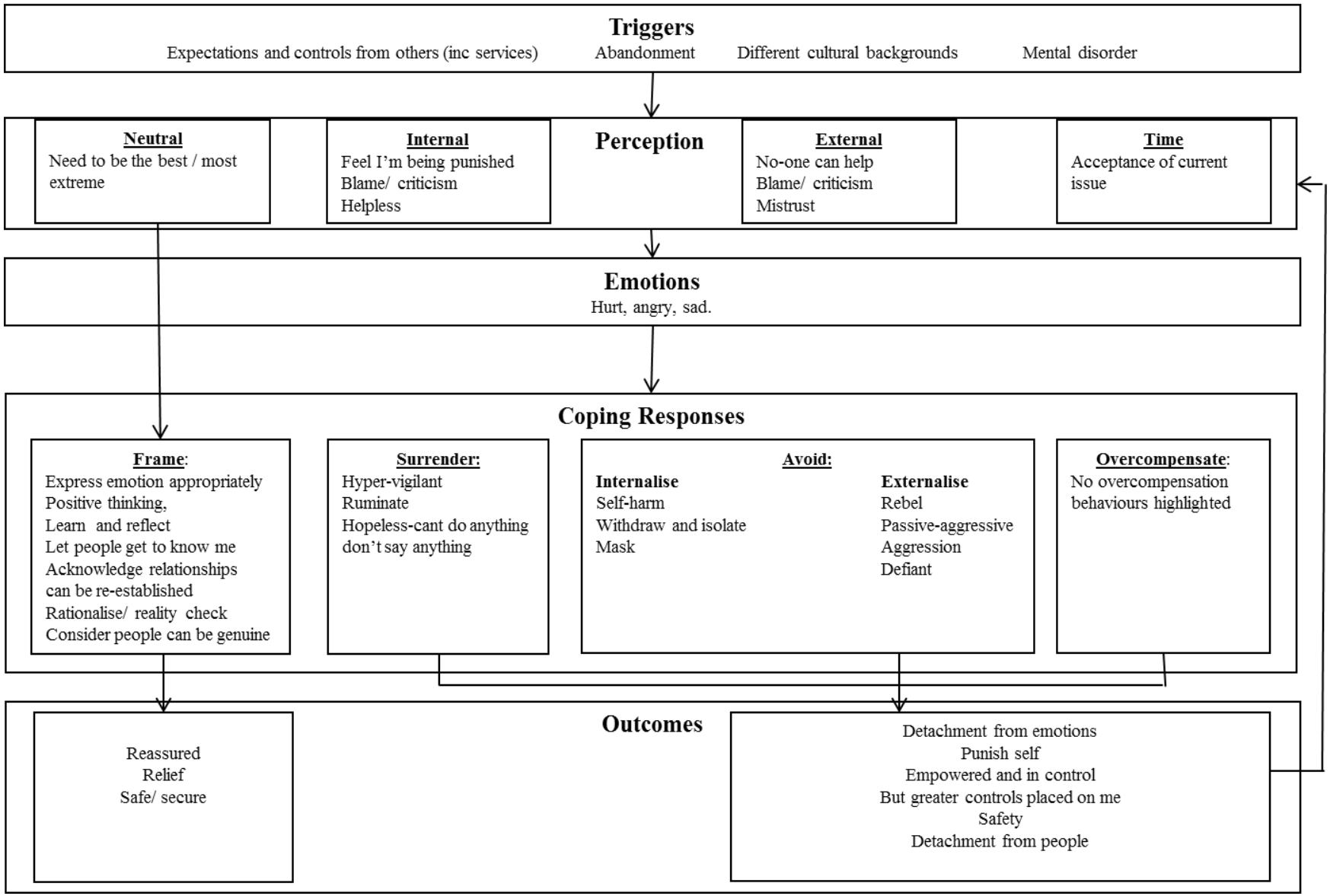
Abandonment

Expectation that others will leave or be unable to provide support (Young et al., 2003) (Please see Appendix L Question 3)



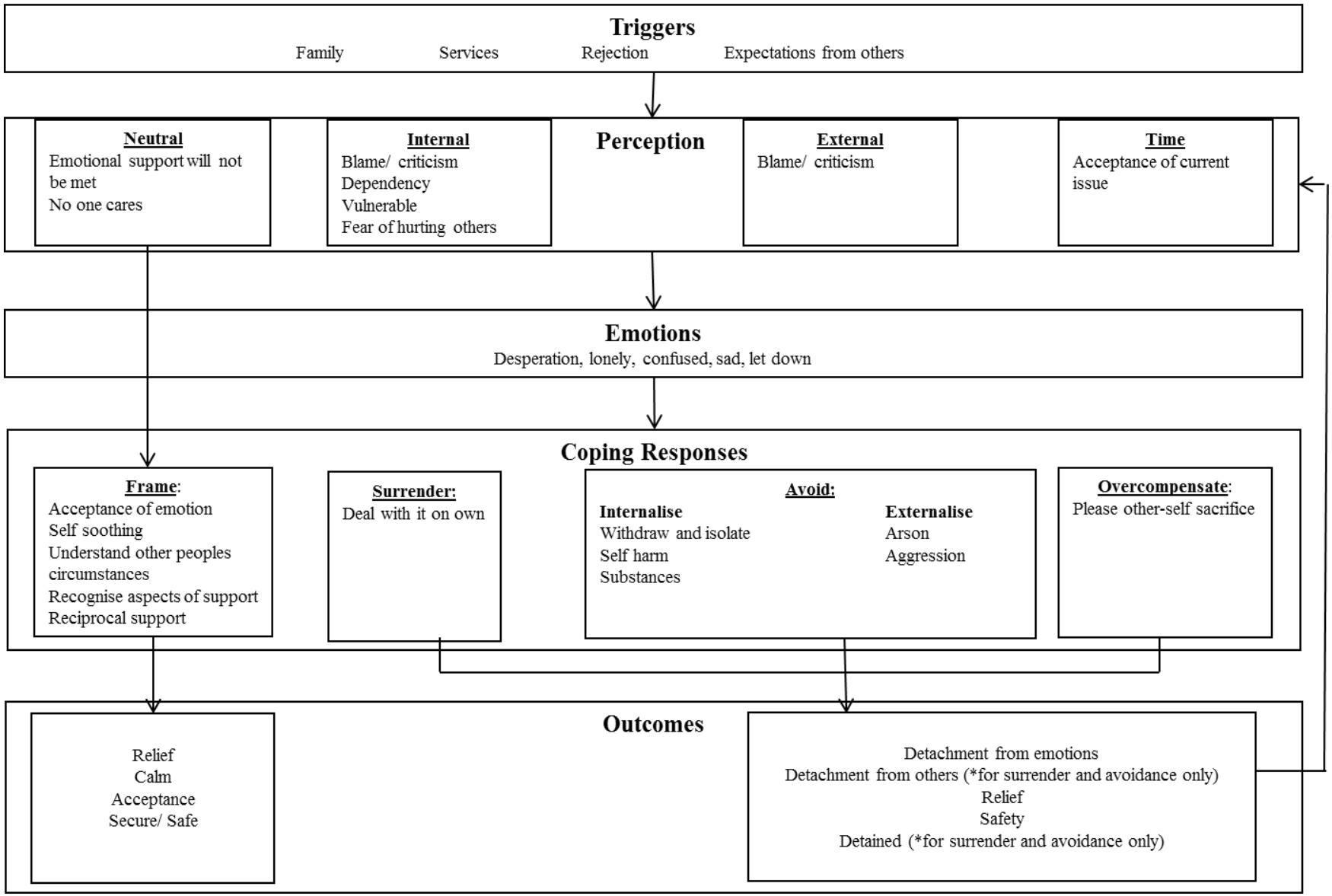
Mistrust

(Consider people will harm, lie or cheat them in some way (Young et al., 2003) (Please see Appendix L Question 4)



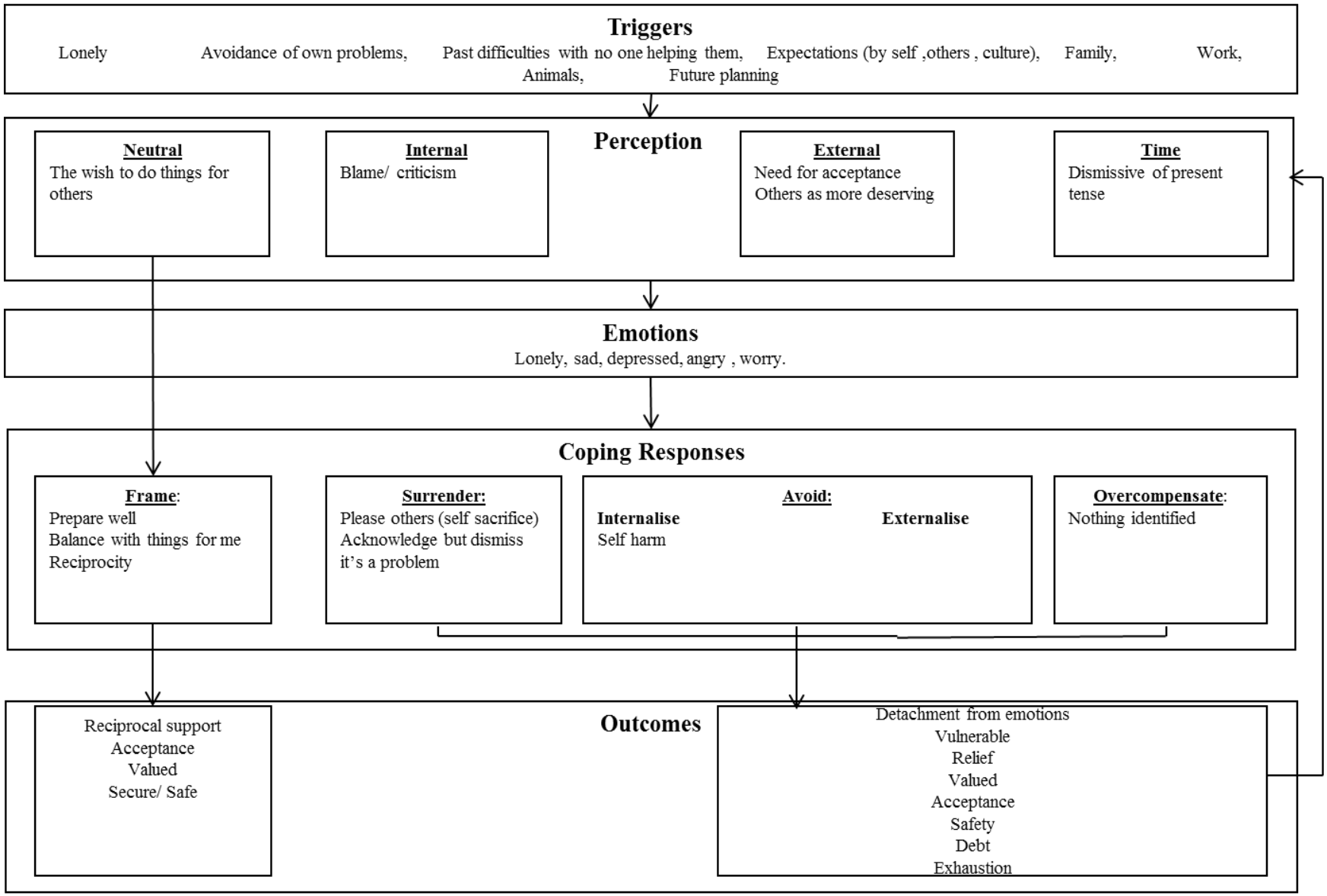
Emotional Deprivation

Belief that the need for emotional support will not be met by others (Young et al., 2003) (Please see Appendix L Question 5)



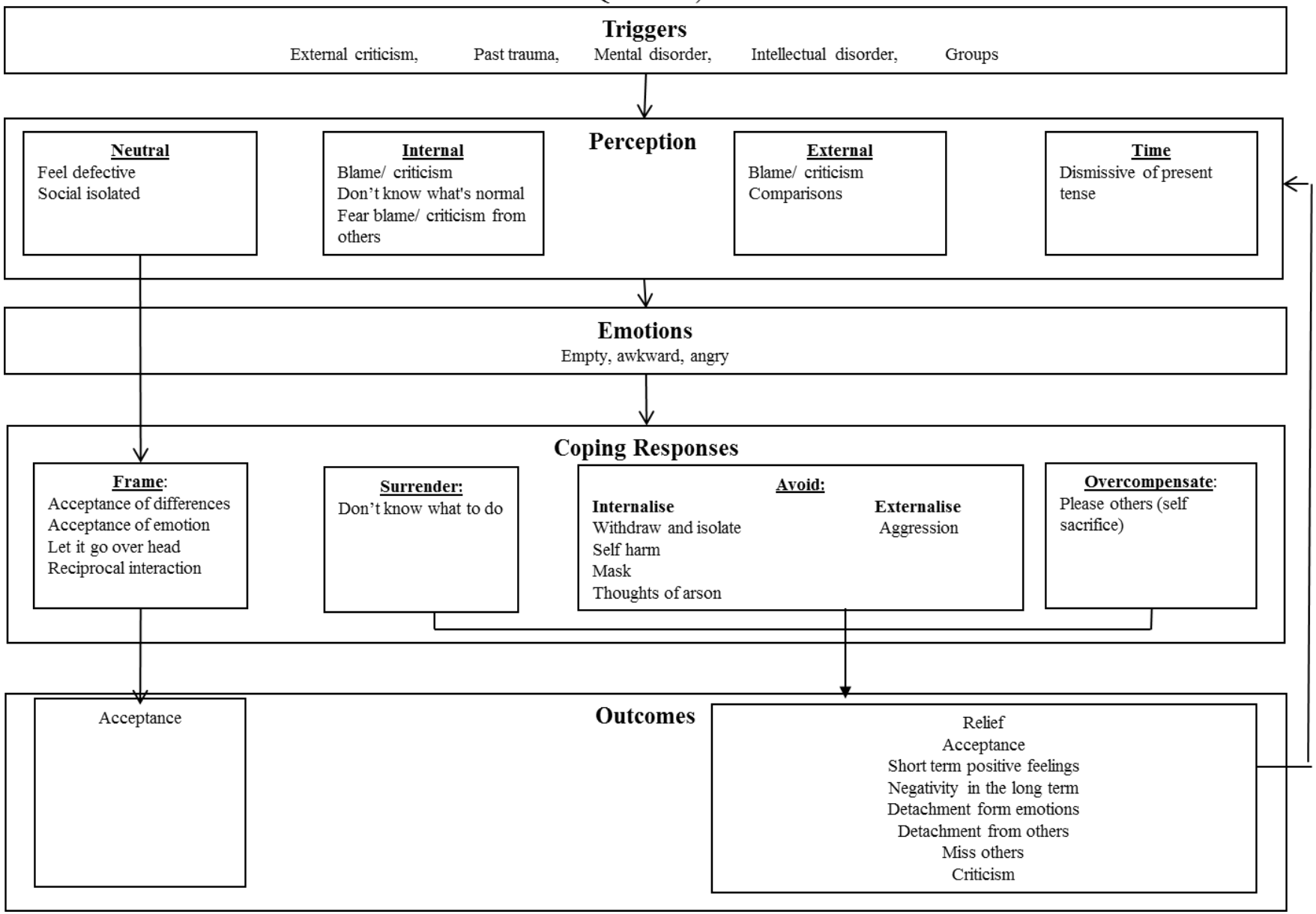
Self Sacrifice

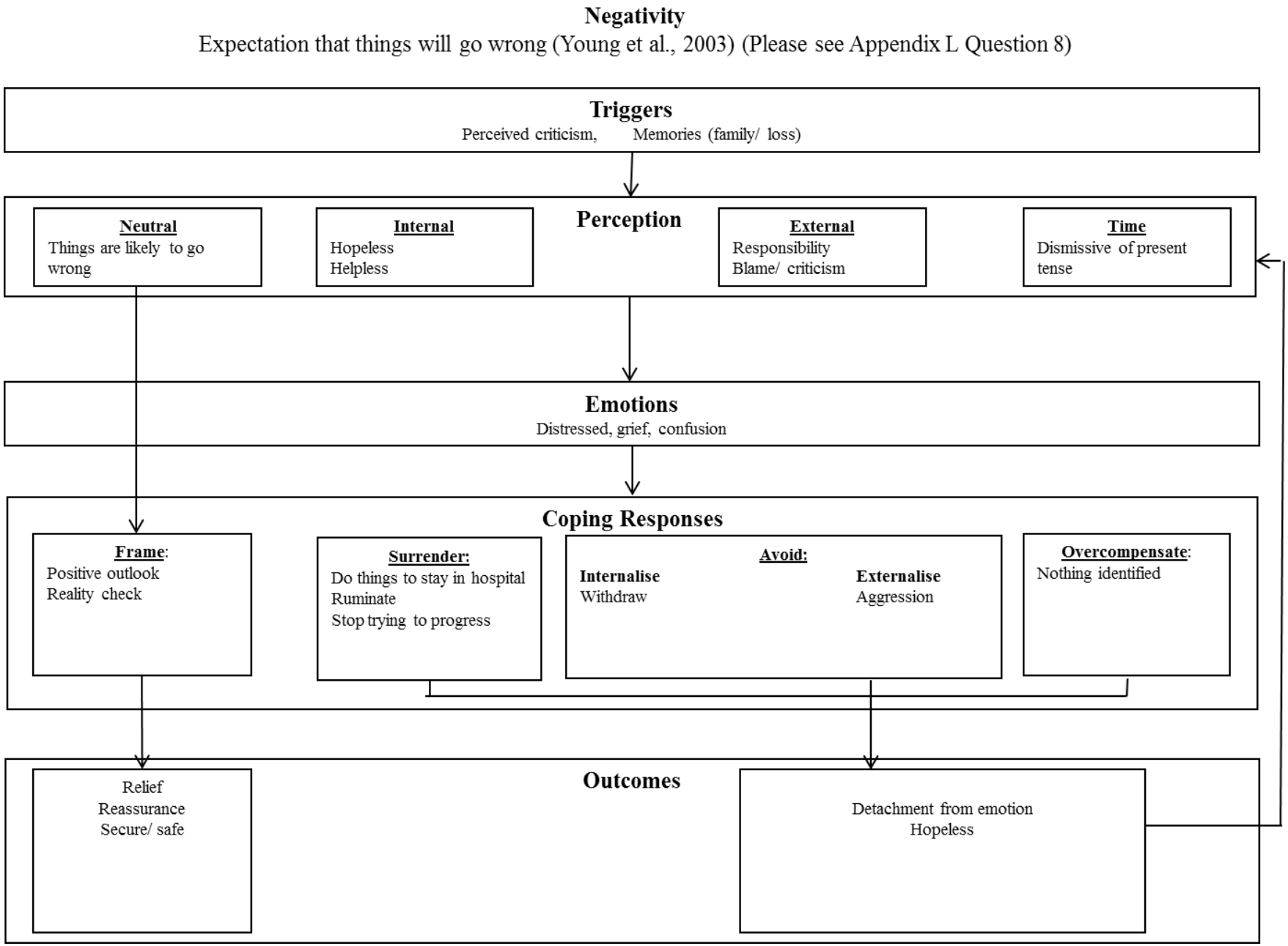
Voluntarily doing things for others (Young et al., 2003) (Please see Appendix L Question 6)



Defectiveness

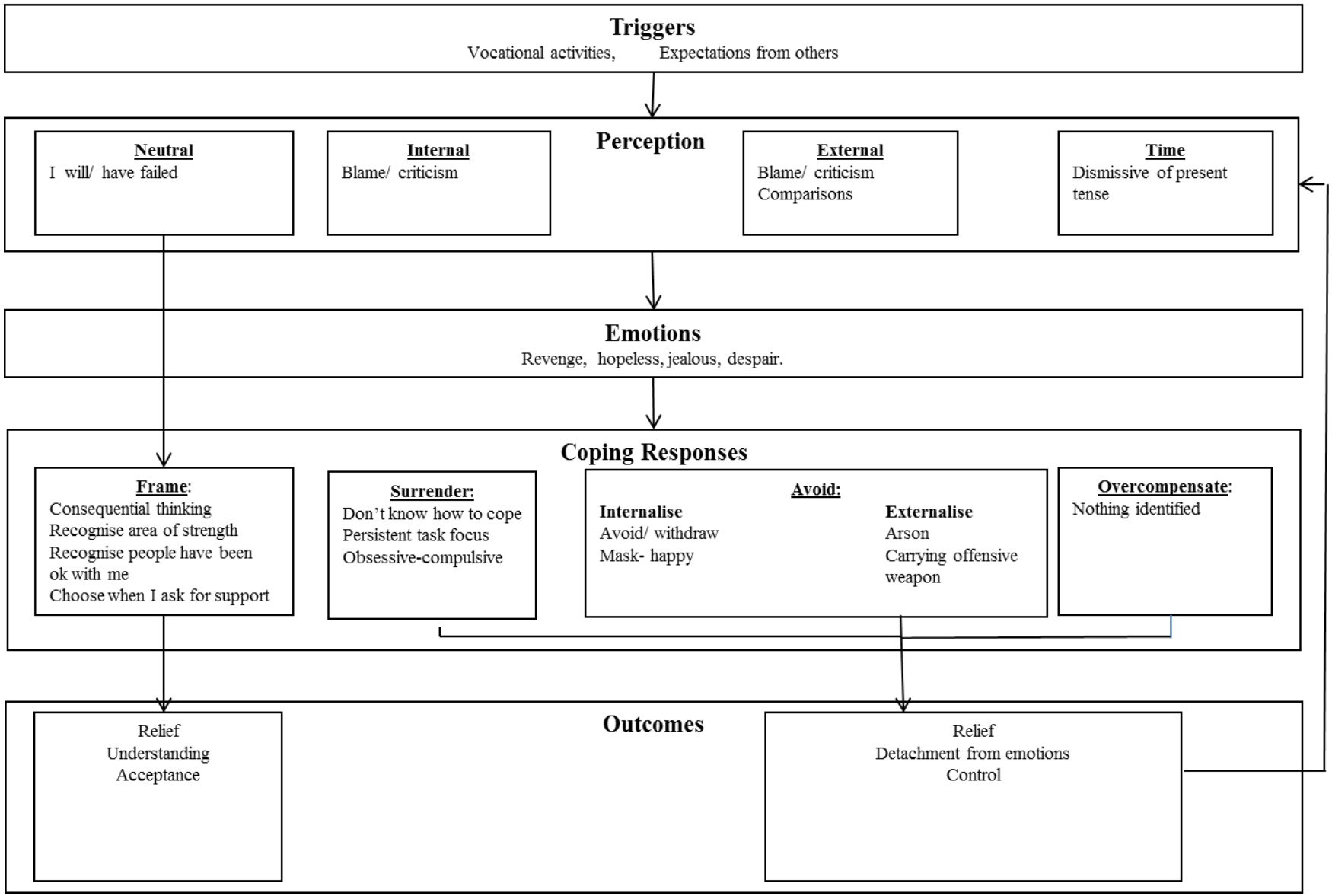
The feeling that there is something inherently wrong and defective about them (Young et al., 2003) (Please see Appendix L Question 7)




Negativity
Expectation that things will go wrong (Young et al., 2003) (Please see Appendix L Question 8)
Triggers
Perceived criticism, Memories (family/ loss)
Perception
Neutral
Things are likely to go wrong
Internal
Hopeless
Helpless
External
Responsibility
Blame/ criticism
Time
Dismissive of present tense
Emotions
Distressed, grief, confusion
Coping Responses
Frame:
Positive outlook
Reality check
Surrender:
Do things to stay in hospital
Ruminate
Stop trying to progress
Avoid:
Internalise
Withdraw
Externalise
Aggression
Overcompensate:
Nothing identified
Outcomes
Relief
Reassurance
Secure/ safe
Detachment from emotion
Hopeless

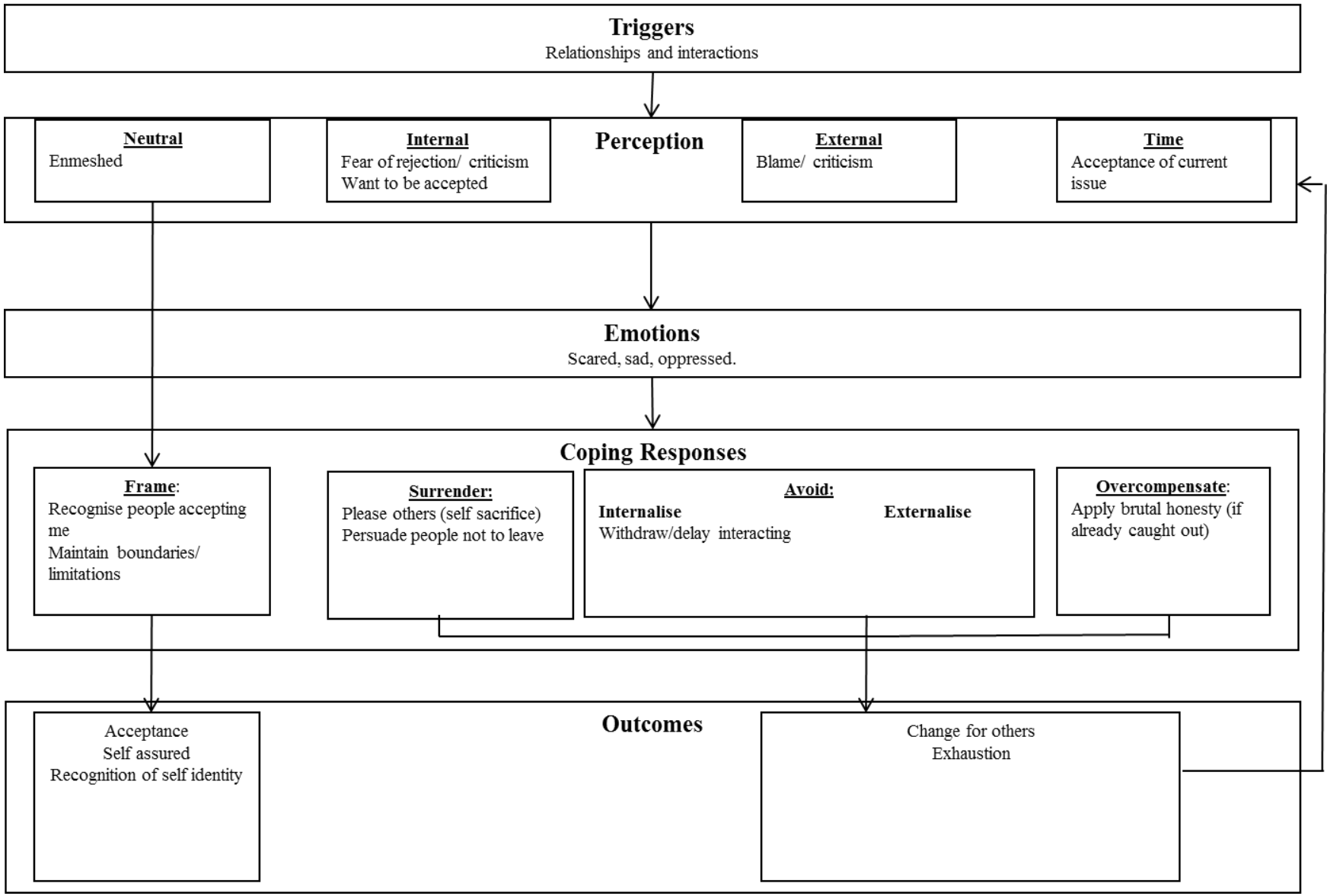
Failure

Expectation of failure or that one has failed (Young et al., 2003) (Please see Appendix L Question 9)



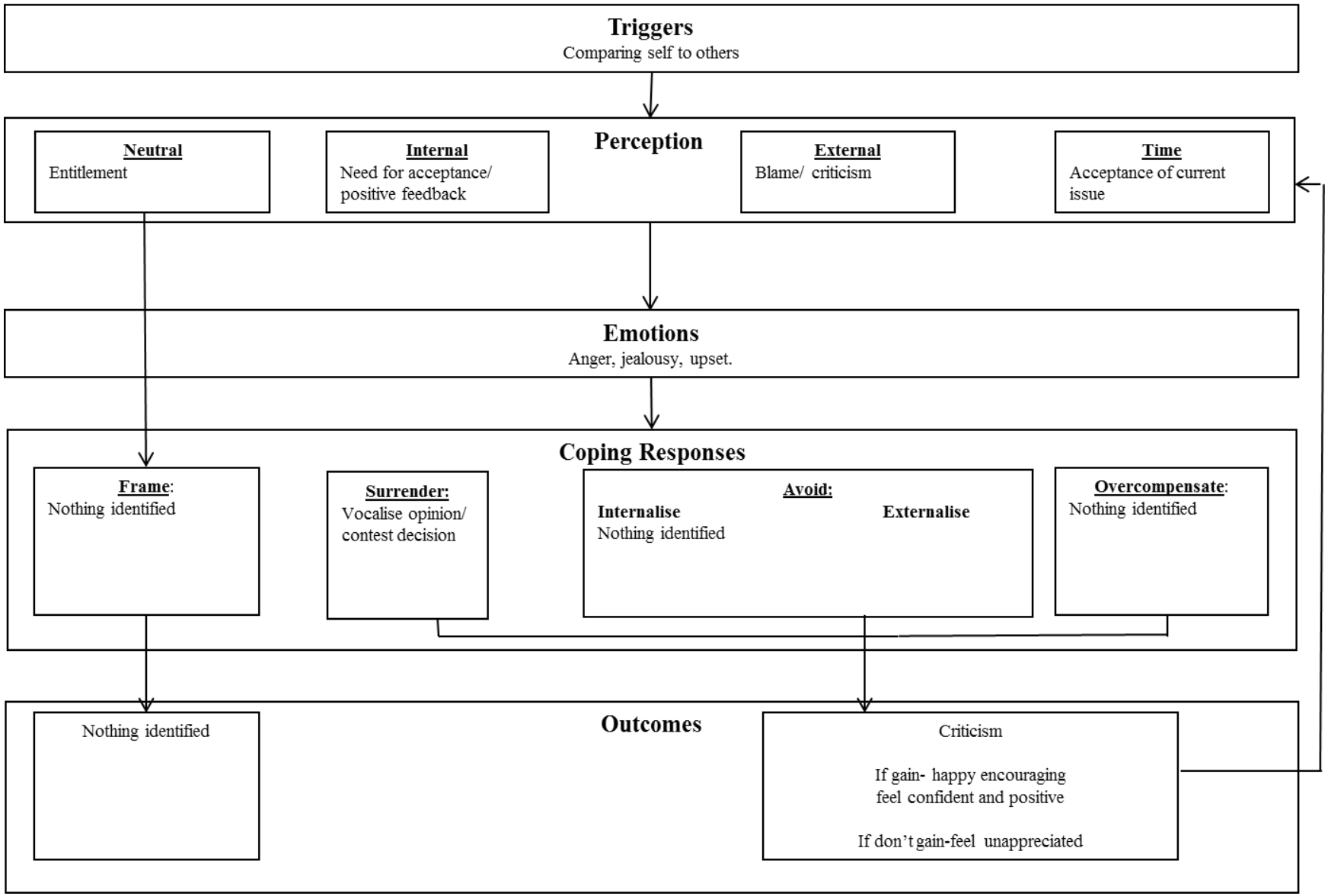
Enmeshment

Development of an over-attachment to others, with uncertain self identity (Young et al., 2003) (Please see Appendix L Question 10)



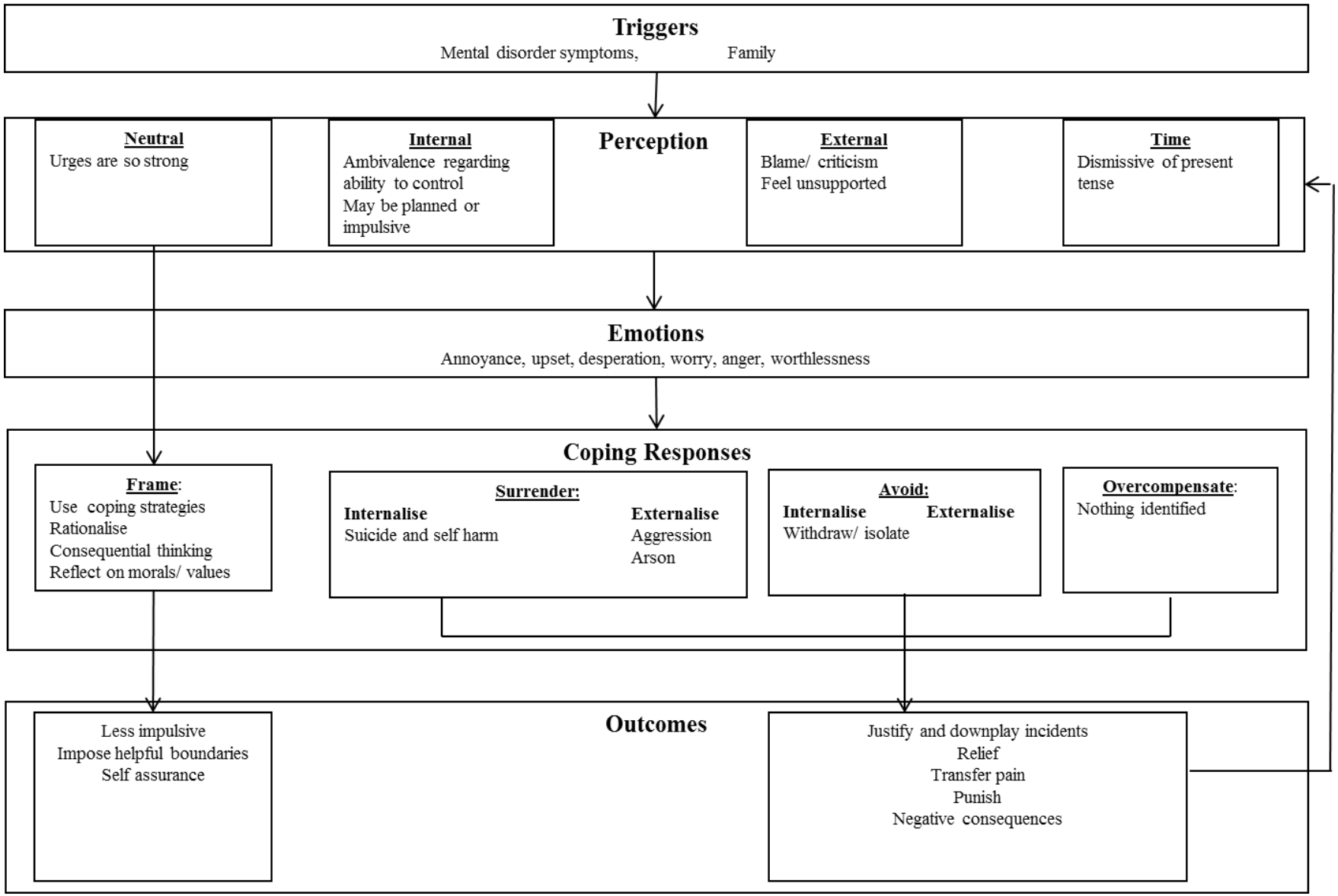
Entitlement

Expectation that aspects of desire should be granted (Young et al., 2003) (Please see Appendix L Question 11)



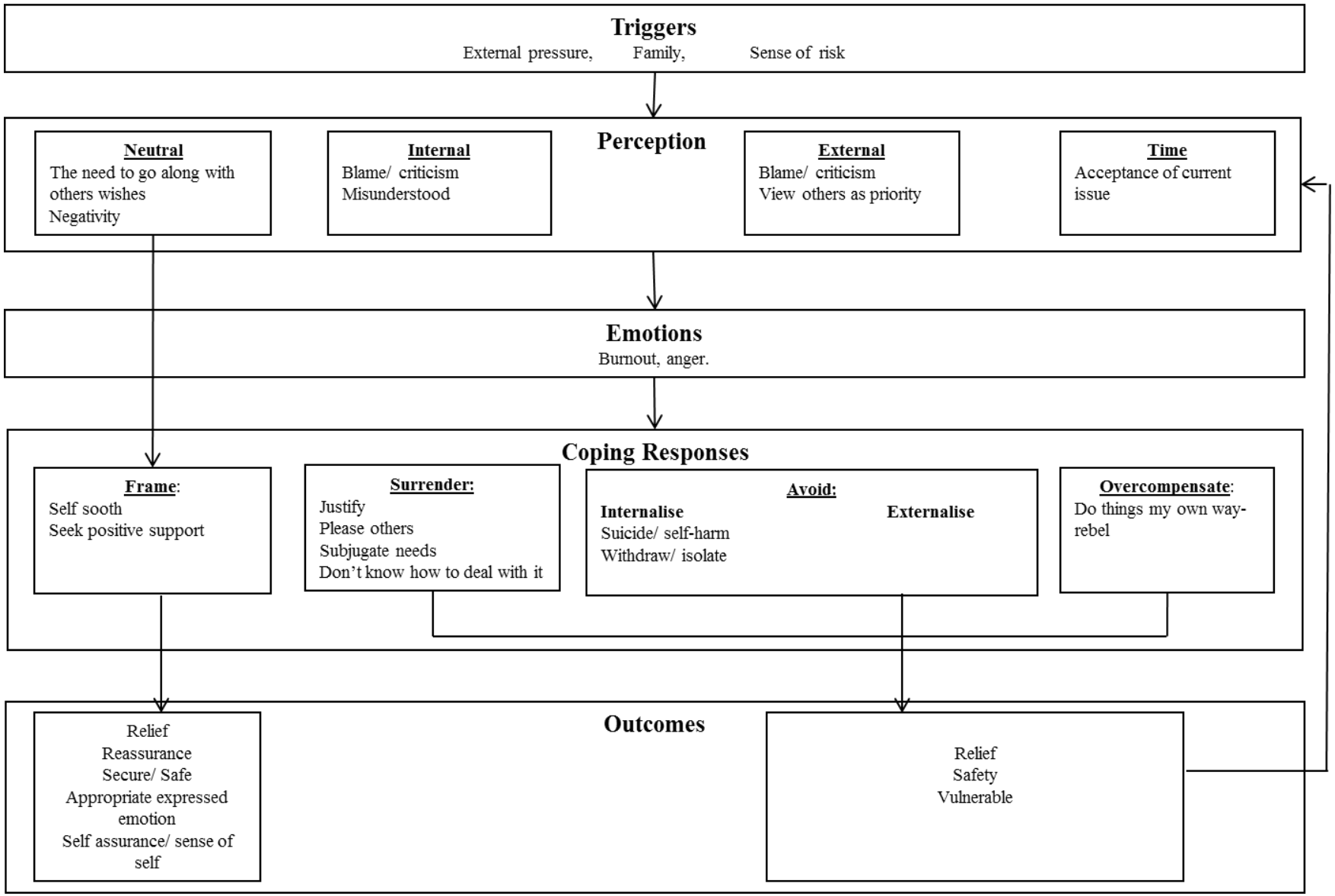
Insufficient Self-Control

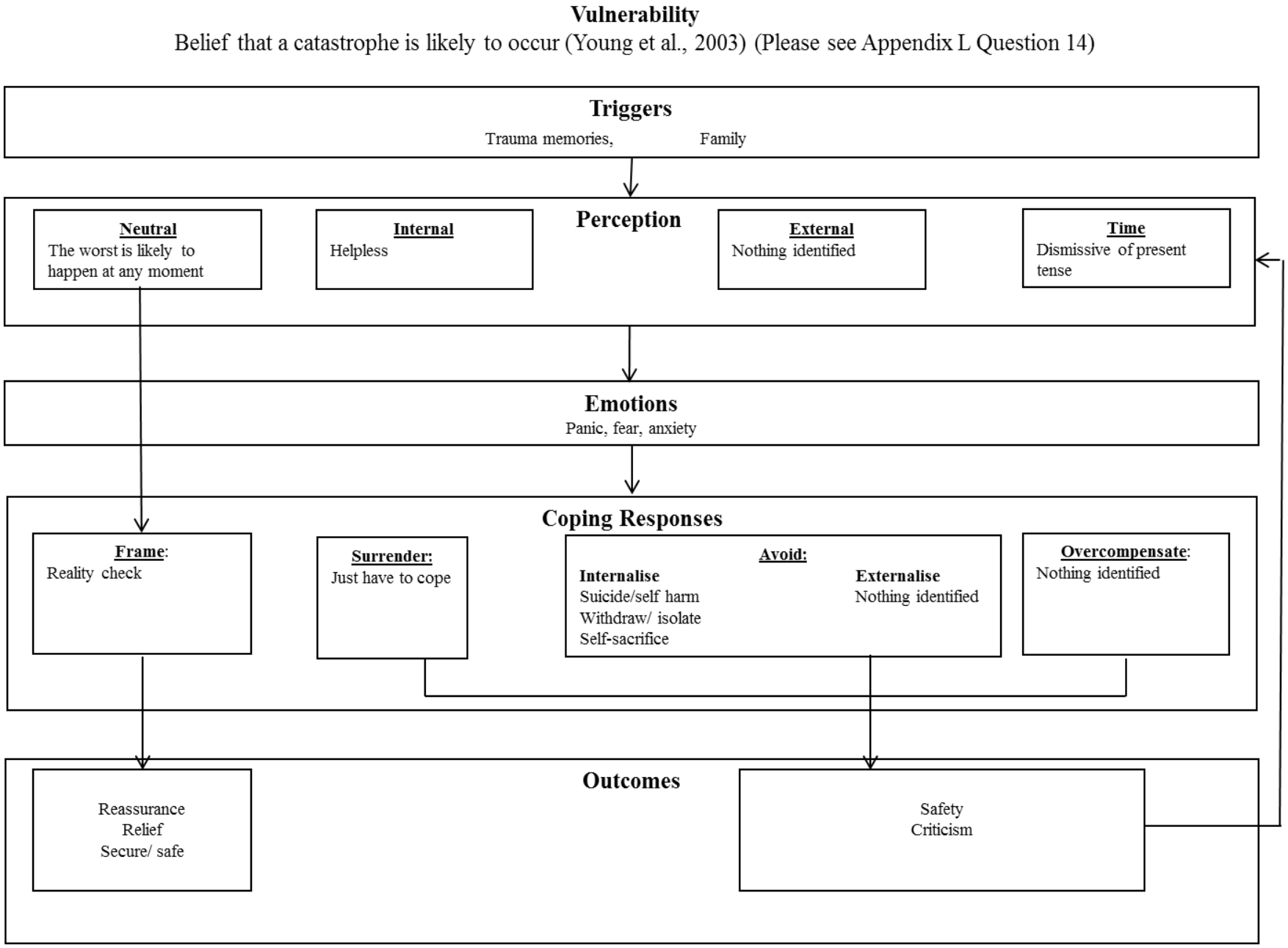
Difficulty exercising restraint over actions, urges, or emotions (Young et al., 2003) (Please see Appendix L Question 12)



Subjugation

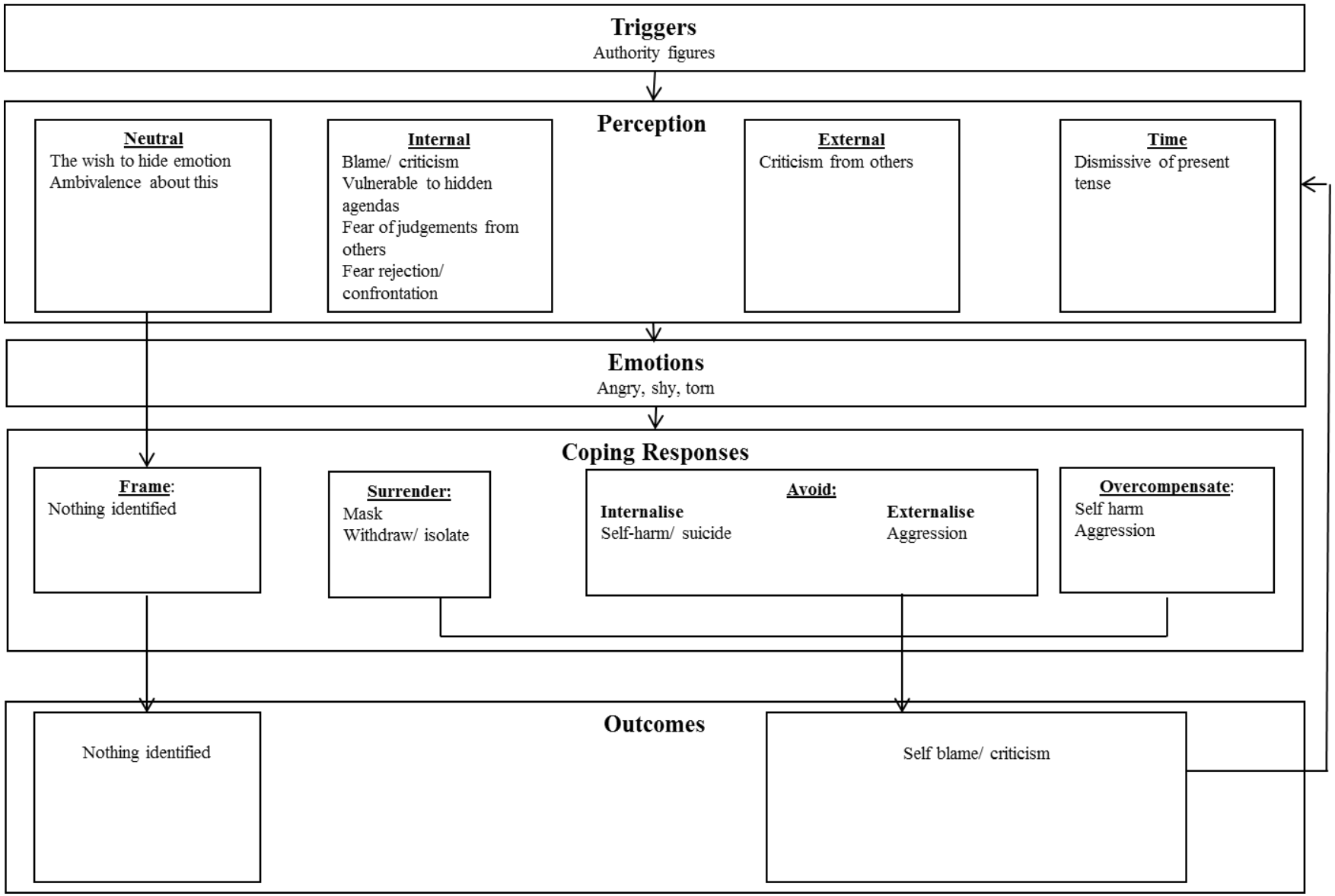
Feeling forced or coerced to submit to the demands of others (Young et al., 2003) (Please see Appendix L Question 13)




Vulnerability
Belief that a catastrophe is likely to occur (Young et al., 2003) (Please see Appendix L Question 14)
Triggers
Trauma memories, Family
Perception
Neutral
The worst is likely to happen at any moment
Internal
Helpless
External
Nothing identified
Time
Dismissive of present tense
Emotions
Panic, fear, anxiety
Coping Responses
Frame:
Reality check
Surrender:
Just have to cope
Avoid:
Internalise
Suicide/self harm
Withdraw/ isolate
Self-sacrifice
Externalise
Nothing identified
Overcompensate:
Nothing identified
Outcomes
Reassurance
Relief
Secure/ safe
Safety
Criticism

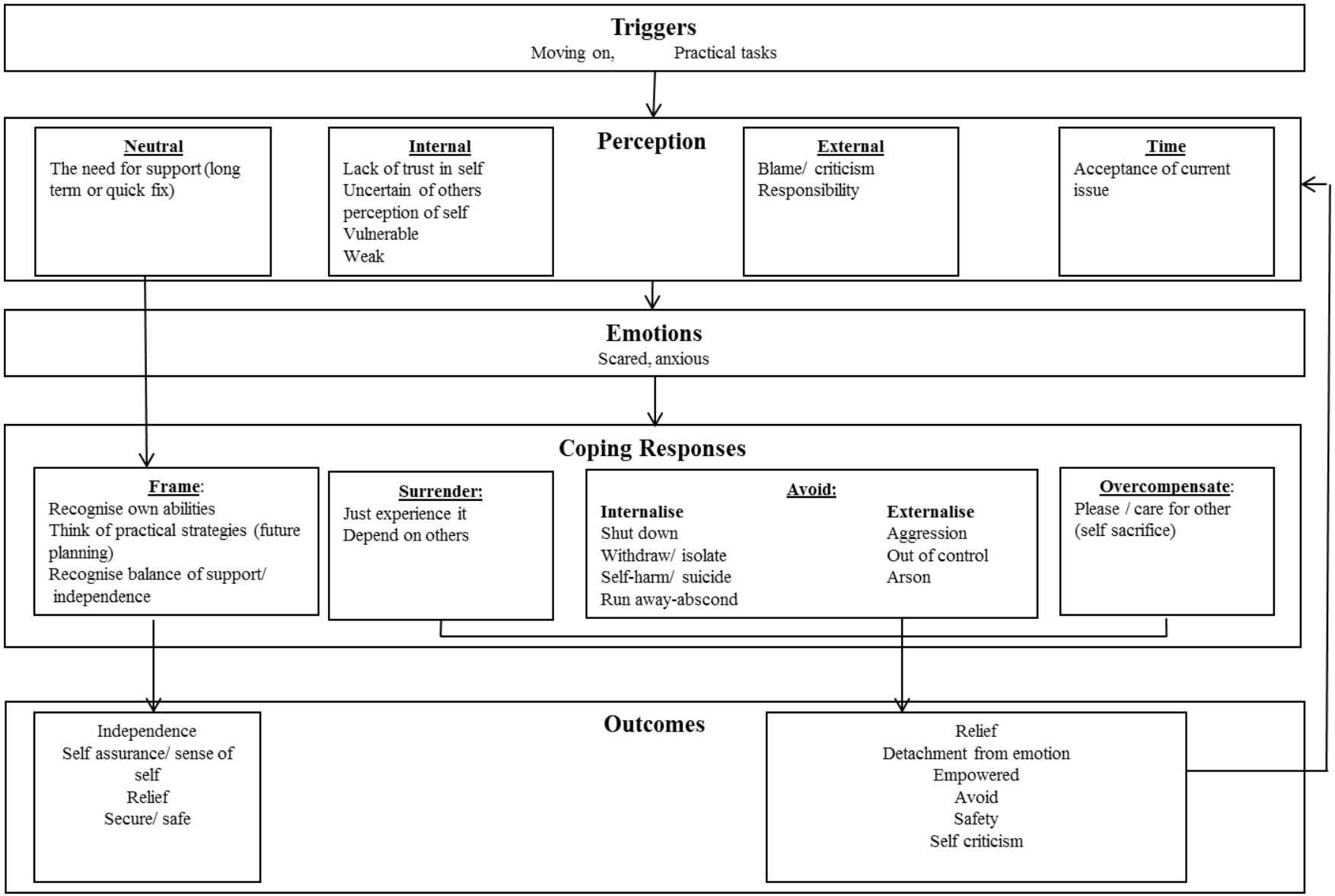
Emotion Inhibition

Limited expression of emotion (Young et al., 2003) (Please see Appendix L Question 15)



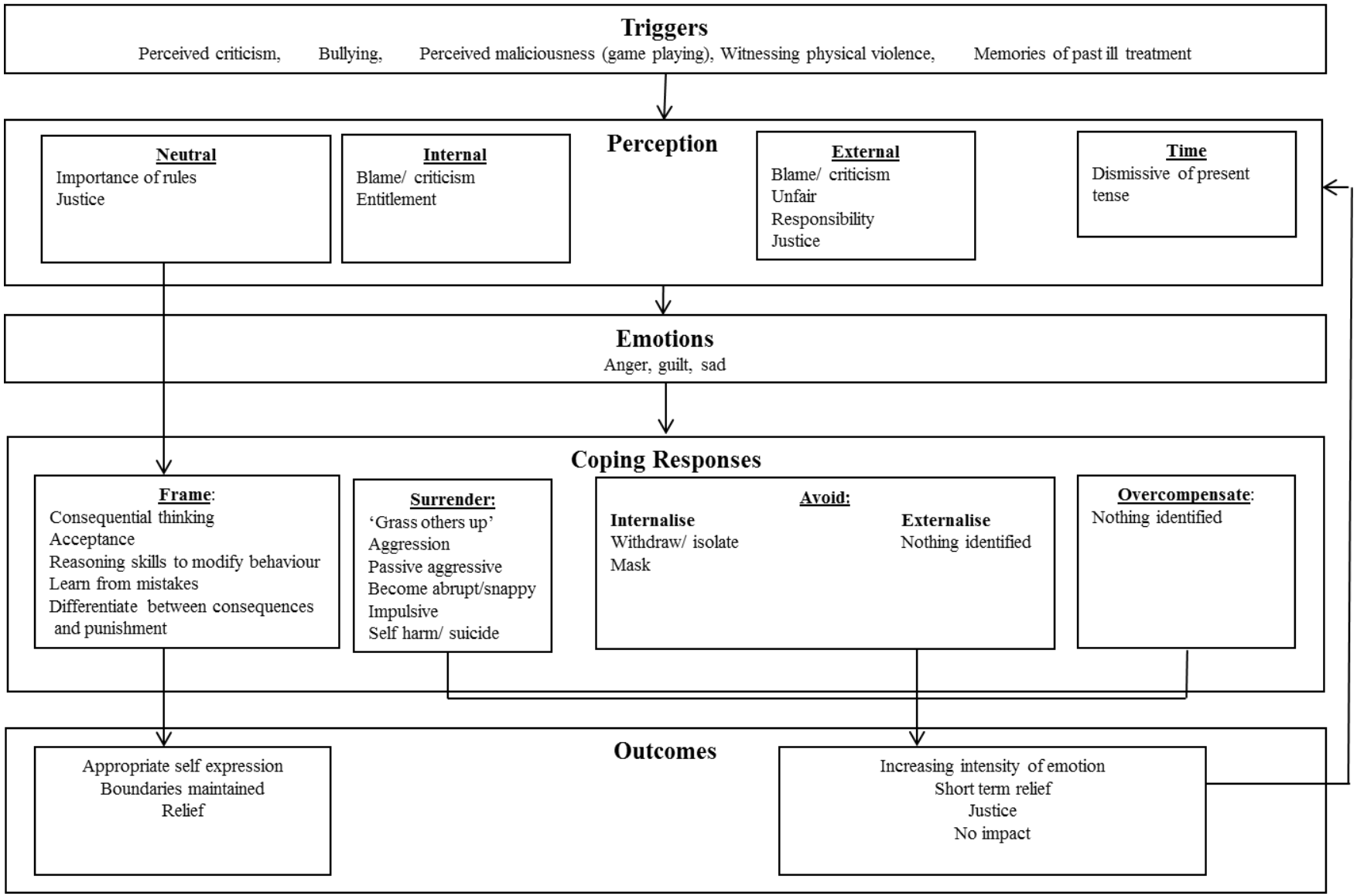
Dependency

The feeling that one requires considerable support from others (Young et al., 2003) (Please see Appendix L Question 16)



Punitiveness

The sense that people should be punished if they do something wrong (Young et al., 2003) (Please see Appendix L Question 17)



Approval Seeking

The need for recognition from others (Young et al., 2003) (Please see Appendix L Question 18)