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Closing the Suitcase: Forensic Service Users’ Experiences of Imagery in Schema Therapy

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Abstract

Schema therapy was developed as a treatment for chronic and entrenched psychological difficulties, and has progressed to be used as an offence focused intervention that addresses dynamic risk factors. This thesis investigated the lived experiences of people with diagnoses of personality disorder who had offended and who had used the technique of imagery in schema therapy. This was explored because although the literature around schema therapy demonstrates some support for the effectiveness of schema therapy holistically, the individual components of this therapy have not been explored. Interpretative Phenomenological Analysis is felt to be an appropriate methodology to address this gap in the literature as it explored imagery from the perspective of those who had experienced it and also acknowledged the researcher’s influence in co-constructing the understanding of the experience. This methodology allowed for a starting point of knowledge by beginning to develop an understanding of this area which could potentially inform future research. Semistructured interviews were conducted with six people diagnosed with Personality Disorder, who had offended and who had used imagery in schema therapy. Their experiences were explored using Interpretative Phenomenological Analysis. Throughout analysis a metaphor of life as a journey on which one carries carry emotional baggage resonated and themes were named accordingly. An overarching theme of the life journey (as temporal) enveloped three superordinate themes of opening the suitcase (revisiting trauma), unpacking and ordering the contents (therapeutic processes), and closing the suitcase (therapeutic outcomes). The super-ordinate theme of opening the suitcase incorporated a subordinate theme of reconnecting with the childhood self which overlapped with the super-ordinate theme of unpacking and ordering the contents. The super-ordinate theme of unpacking and ordering the contents included three subordinate themes, 1) emotional control (i.e. attempts to control emotions isolate people from others, but losing control of emotions during imagery leads to interpersonal connectedness with the therapist), 2) moving on versus being stuck in the past and 3) the therapeutic relationship as characterized by trust, and meeting needs. The second of these subordinate
themes was felt to overlap with the super-ordinate theme of closing the suitcase. The super-ordinate theme of closing the suitcase was felt to contain two subordinate themes of healing the fractured self and applying what has been learned. All three super-ordinate themes were penetrated by another theme; distancing from the trauma (protection from emotional pain). This theme was felt to be embedded within descriptions of revisiting the trauma, re-connecting with the childhood self, emotional control, the therapeutic relationship, healing the fractured self and applying what has been learned. Two other minor themes were also identified relating to use of professional language and avoidance. It was concluded that for the six participants in this study, imagery was described as a process that enabled them to close the suitcase and put it away without fear that its contents would be unintentionally disgorged. These results represent the first qualitative exploration of people’s lived experiences of imagery in schema therapy. The results add to the literature around both schema therapy and imagery separately. Although these results are not generalisable, they may be transferable to other groups that have topographically similar experiences and therefore they offer a new way to understand imagery in schema therapy.
Statement of Contribution

In completion of this thesis the majority of responsibility pertaining to project design, applying for ethical approval, writing the review of the literature, recruiting participants, conducting interviews, transcribing data, analysing the data and writing up has lain with the trainee clinical psychologist. Advice regarding the project design, literature review, recruitment of participants, analysis of data and write up was given by the clinical research supervisor, Dr. Kerry Beckley. Advice regarding design, applying for ethical approval, writing the literature review, analysing data and writing up has also been given by the academic research supervisor Dr. David Dawson. Assistance with transcription was also given by Kerry Reynolds.

Regarding recruitment of participants and conducting interviews, the assistance of staff at the Personality Disorder Directorate of Rampton Hospital was invaluable. Special thanks go to Dr. Sue Evershed, Dr. Louise Sainsbury, Mellissa Collingburn and Kerry Reynolds for their help in the practicalities of completing this.

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Closing the Suitcase: Forensic Service Users’ Experiences of Imagery in Schema Therapy

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Abstract

Experiences of six people diagnosed with Personality Disorder, who had offended and who had used imagery in schema therapy were explored using Interpretative Phenomenological Analysis. Throughout analysis a metaphor of life as a journey on which one carries carry emotional baggage resonated and themes were named accordingly. An overarching theme of the life journey (characterised by a non-linear temporality linked to memories of traumatic events) enveloped three super-ordinate themes of opening the suitcase (revisiting trauma), ordering the contents (therapeutic processes), and closing the suitcase (therapeutic outcomes). Another theme, distancing from the trauma (protection from emotional pain) was found to penetrate and run through the super-ordinate themes. It was concluded that for the six participants in this study, imagery was described as a process that enabled them to close the case and put it away without fear that its contents would be unintentionally disgorged. Although these results are not generalisable, they may be transferable and therefore they offer a new way to understand imagery in schema therapy.

Keywords: emotions / emotion work; hermeneutics; interpretative phenomenological analysis (IPA); interviews, semistructured; lived experience; phenomenology; psychology; qualitative analysis; trauma; trust.
Schema therapy is an integrative therapy that combines techniques from cognitive-behavioral, attachment, psychodynamic, and emotion-focused traditions (Young, 1990). The name derives from the therapy’s focus on Early Maladaptive Schemas (EMS); the idea that people hold unhelpful frameworks relating to themselves, others and the world around them based on early negative or traumatic experiences. The theory holds that people develop strategies for dealing with these in their everyday life by surrendering to them, avoiding them or overcompensating for them. These coping strategies are adaptive in early environments but might become maladaptive in later life. Therapy to heal EMS and replace maladaptive coping strategies is suggested through the use of four core mechanisms; limited re-parenting\(^1\), experiential techniques (e.g. imagery and dialogue work), cognitive restructuring and education, and behavioral pattern breaking.

Schema therapy was initially found to be effective in treating people with diagnoses of borderline personality disorder (BPD) as compared to transference focused psychotherapy (Giesen-Bloo, et al., 2006) and treatment as usual (Farrell, Shaw and Webber, 2009). Schema therapy has also been studied with regard to its effectiveness in forensic settings (e.g. Bernstein, Arntz and de Vos, 2007). This is a logical extension in treatment application given the suggested prevalence of those with diagnoses of personality disorder in forensic populations. These range from ten times greater than in the general population (Fazel & Danesh, 2002) to 86.8% of forensic patients (Timmerman and Emmelkamp, 2001).\(^2\)

As early trauma is considered to play a part in the development of personality disorders (e.g. Richardson, 2005), consideration of incidence of trauma within forensic populations seems pertinent. As it appears there are no prevalence studies for the specific population studied here, related areas have been discussed. These have been

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\(^{1}\) This is a technique in schema therapy whereby the therapist adopts a parental role by providing boundaries that were not given in childhood and meeting previously unmet childhood needs.

\(^{2}\) Additional background information on schema therapy, including critique of these studies can be found in section 1.1.1, extended background.
suggested to be 31% in sexual offenders, as compared to only 3% of a control sample (Groth, 1979), 24% of male and female adolescent offenders (Burton, Foy, Bwanausi, Johnson & Moore, 2005) and 37% of female adolescent offenders (Dixon, Howie & Starling, 2005). Bernstein, Arntz and de Vos (2007), examined the effectiveness of schema therapy in forensic populations and concluded it could be used in these without the need for major changes. In contrast to this, Tarrier et al. (2010) conducted the first randomized control trial of schema therapy in a forensic setting and concluded that it could not be recommended for this population. However, within this study, therapists delivering schema therapy did not achieve ratings indicating competence. This calls into question the generalisability of the results to therapy conducted by more competent therapists. The study was also limited by a very small sample size and a large attrition rate. In combination with an intention to treat method of analysis, the reliability of the results is questionable.

The literature above provides some evidence for the effectiveness of schema therapy overall, however this therapy is made up of component parts and the focus of this study relates to one of these; namely imagery.\(^3\)

Imagery can be defined as “a picture in the head…imagery is a cognitive process that operates as if one had a mental picture that was an analogue of a real world scene. The image is not necessarily treated as a reproduction of an earlier event but as a construction, a synthesis” (Reber & Reber, 2001, p.341). Imagery is one of several techniques used in schema therapy. It was chosen as the focus of this study because it is considered central within schema therapy, and the first author’s experience of using the technique suggested it was powerful. Further there is no existing literature relating to this technique. Within schema therapy, imagery is used to re-script remembered events.

\(^3\) Additional background information on schema therapy in forensic settings, including critique of these studies can be found in section 1.1.2, extended background.
This involves setting up an imagined safe place and moving on to imaginal exposure to the traumatic memory. After this the memory is re-scripted to include seeing oneself as an adult in that situation, confronting the perpetrator of abuse, gaining a sense of mastery over the situation, and rescuing and protecting the childhood self. To date the role of imagery has not been examined in regard to schema therapy. Although the use of imagery in schema therapy differs from the way imagery is used in other techniques, all are related by the use of mental images to re-experience events. The effectiveness of imagery in other psychotherapeutic approaches has been studied and demonstrated for specific disorders. Imagery techniques have been shown to be effective in cognitive treatments for Post Traumatic Stress Disorder (Holmes, Arntz & Smucker, 2007), in exposure and response prevention (McKay et al., 1997), in eye movement desensitization and reprocessing (Schneider, Hofmann, Rost & Shapiro, 2007) and in dialectical behavior therapy (Safer, Telch, & Agras, 2001) among others.\(^4\)

The literature above provides a brief overview of the research surrounding the effectiveness of imagery techniques. The majority of studies relate to groups of people who have experienced trauma, and because this is highlighted in the development of both diagnosis of personality disorder and EMS it seems reasonable to suggest that the literature is generalisable to this area.

There are several proposed explanations for the processes underlying imagery in psychological therapy. Behaviorism suggests conditioned stress responses are treated by exposure and response prevention, which might be conducted distally via imagery (e.g. Vaughan & Tarrier, 1992). The dual representation model of memory (Brewin, 2001) proposes that the type of memory encoded during a trauma is inhibited by inability to attend to events at the time and therefore might be un-representative of the event itself; however a more accurate representation of events is stored in a non-verbal

\(^4\) Additional background information on imagery can be found in section 1.1.1, extended paper.
memory and that can be accessed via imagery. Emotional processing theory (e.g.
Meadows & Foa, 1992 as cited in Folette, Ruzek and Abueg, 1998) suggests emotional reactions to trauma are survival instincts which can be evoked without the need for physical re-experiencing via imagery.

In conclusion, the literature demonstrates some empirical support for the effectiveness of schema therapy holistically, with people diagnosed with BPD and within forensic populations. Nevertheless not all of the components of schema therapy have been explored individually. With specific regard to imagery, the evidence appears to have been drawn from other psychotherapeutic approaches. There is some evidence to suggest that imagery is an effective treatment method, although this is an area that would benefit from additional research, but there is also dissenting opinion regarding the mechanisms which underlie the technique. In short there appear to be gaps in the literature around schema therapy, and the technique of imagery. Although imagery in schema therapy is considered to be an essential adjunct to cognitive and behavioral techniques that works through emotions, the experience of this has not been explored. It seems appropriate to begin addressing the gaps in the literature by employing qualitative methods, to explore the experiences of people who have used this technique. Therefore this study aims to help understand the subjective experience of imagery and to shed light on the processes involved in it. It aims to provide a starting point of knowledge from which future ideas for research into this area may be developed. This could lead to hypotheses that could influence future research in this area, and will add to the understanding of imagery as a technique and potentially as an essential part of schema therapy.
Methodology

Design

Interpretative Phenomenological Analysis (IPA; Smith, Jarman & Osborn, 1999) is an appropriate methodology to address the aforementioned gap in the literature as it explores imagery from the perspectives of those who have experienced it. This allows for a rich in-depth understanding of the subjective experience of undertaking imagery which opens up the area and facilitates the way we make sense of the technique and its uses. This provides a starting point of knowledge from which future research into the area might be informed. The research was conducted at a single NHS site.  

Epistemological Position

The methodology of IPA is underpinned by the philosophical ideas of phenomenology “a philosophical doctrine that advocates that the scientific study of immediate experience be the basis of psychology”, (Reber, 1995, p.564) and hermeneutics “interpretative procedures or the scientific study of such” (Reber, 1995, p.335). Phenomenology might be said to have its origins in the works of Husserl, Heidegger, Merleau-Ponty and Satre. It emphasizes the importance of how people make sense of their experiences and their ability to convey this to others. Hermeneutics could also be said to have been influenced by Heidegger, but has been expanded by the thinking of Gadamer. Within IPA, hermeneutics is emphasized in the acknowledgement that participants interpret their lived experiences and also that the researcher interprets participants’ accounts of this. IPA also focuses on the ideographic (“relating to or dealing with the concrete, the individual, the unique” Reber, 1995, p.356). These philosophical points underpin the epistemological stance taken in this study. That stance, critical realism, proposes that certain external objects might convey a shared understanding of truth; however that things that produce sensations in people (e.g.

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5 For additional details on design see section 2.1.1, extended methodology.
experiences) will not have this quality. Within this epistemological position, different truths are held by people based on their experiences and all versions are equally applicable. Critical realism also incorporates the ideas of phenomenology and hermeneutics and is allied with an ideographic approach.  

*Participants and Sample Size*

Participants were recruited from a service specializing in treating people with diagnoses of Personality Disorder at a High Secure Hospital, in the United Kingdom, because this service uses schema therapy as a primary intervention. It was therefore a sample of convenience as this location allowed a suitable pool of participants who had shared the experience of imagery in schema therapy to be identified. Forensic elements were not of direct interest in this study (beyond environmental and contextual considerations) and therefore were not explored. Six men were identified who met inclusion and exclusion criteria (for demographic information see table 1 below) and these were invited to participate to allow for comparison of super-ordinate themes across cases without detracting from the richness of individual interviews. Participants had undertaken imagery with a number of different therapists; however this was felt to reflect a homogenous sample as they had all experienced imagery in schema therapy. The choice of a small sample size was closely tied to the methodology and influenced by its theoretical and epistemological underpinnings; IPA espouses a case-by-case, ideographic approach with emphasis on the richness of qualitative data rather than on quantity of participants.

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6 For more on epistemology see extended methodology section 2.3.1 for Husserl, Heidegger, Merleau-Ponty & Satre, section 2.3.2 for Heidegger & Gadamer and section 2.3.4 for critical realism
Table 1. Demographic information of participants

<table>
<thead>
<tr>
<th>Age at time of participation</th>
<th>Ethnic Background</th>
<th>Clinical Background: Diagnosis</th>
<th>Forensic Background: Index Offence</th>
<th>Stage of Treatment: Yrs since admission at time of participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>54</td>
<td>White-British</td>
<td>PD &amp; Depression</td>
<td>Manslaughter with diminished responsibility</td>
<td>6 yrs</td>
</tr>
<tr>
<td>48</td>
<td>White-British</td>
<td>PD &amp; Paranoid Schizophrenia</td>
<td>Attempted Murder</td>
<td>10 yrs</td>
</tr>
<tr>
<td>29</td>
<td>Caribbean</td>
<td>PD &amp; Paranoid Schizophrenia</td>
<td>Rape x 3 &amp; false imprisonment</td>
<td>6 yrs</td>
</tr>
<tr>
<td>41</td>
<td>White-British</td>
<td>PD</td>
<td>Manslaughter with diminished responsibility</td>
<td>3 yrs</td>
</tr>
<tr>
<td>50</td>
<td>White-British</td>
<td>PD</td>
<td>Wounding with intent, kidnapping &amp; AOAABH</td>
<td>17 yrs</td>
</tr>
<tr>
<td>42</td>
<td>White-British</td>
<td>PD &amp; Schizophrenia</td>
<td>AOAABH, arson &amp; wounding</td>
<td>4 years</td>
</tr>
</tbody>
</table>

**Inclusion and Exclusion Criteria**

Inclusion criteria were forensic in-patients over the age of 18 who had undergone imagery in schema therapy within the service. Participants were excluded if they were deemed to lack capacity to consent to the study. These criteria were employed to ensure the research aims could be met, without unnecessary exclusion. To ensure criteria were met, potential participants were identified (according to inclusion criteria) by clinicians working with them. The exclusion criterion was checked by asking Responsible Clinicians to confirm capacity to consent to the research.⁷

Consideration was given to dual classification including mental illness and mental impairment and also to verbal ability. It was deemed however that if people had sufficient ability to engage in a complex verbally-based therapy then they would also be able to engage in the IPA methodology of the research. Further influences on capacity to consent (such as acquiescence and implicit coercion⁸) were also considered. Where

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⁷ For participant selection & exclusion criteria see extended methodology section 2.1.2.
⁸ This was a psychological study pertaining to a psychological technique, and demonstrating psychological progress is related to moving to lower secure settings. Therefore, participants may have been invested in participating and presenting schema therapy in a positive light.
these influences could have been exacerbated through current stressful life events, participants were excluded. For those included in the study, where possible, steps were taken to minimize the impact of these influences by making explicit that the researcher was not allied to the clinical team, stressing that the reporting of negative experiences was as beneficial as positive ones, using open-ended, non-leading questions and explaining that all data would be collated and anonymised.

**Materials**

A semistructured interview schedule was developed (see Appendix V for interview schedule) relating to the use of imagery in schema therapy. The interview schedule consisted of open ended discussion points to allow participants to report what they felt were the most important factors regarding their experiences.9

**Reliability and Validity**

The concept of reliability is not easily applied to IPA because of the ideographic and interpretative emphases of the methodology. However, reliability and validity can be assessed by checking themes are tied to the transcript data, via audit and transparency. In this study an audit trail and independent audit of themes were used. Validity was evaluated using Yardley’s criteria for assessing qualitative research (Yardley, 2000). These criteria have been recommended for IPA studies because of the broad variety of options available for assessing validity and the theory neutral orientation of the criteria (Smith, Flowers & Larkin, 2009). Yardley proposes four criteria: sensitivity to context; commitment and rigor; transparency and coherence; and impact and importance.

Attempts were made to ensure sensitivity to the context through an ideographic focus, establishment of rapport with clinicians from the service where participants were identified, an understanding of the therapeutic techniques used, and generation of an

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9 For more about the interview schedule see section 2.1.3 and for apparatus & transcription see section 2.1.4; extended methodology.
interview schedule that allowed an empathic interaction where the participant was the expert because of their experiences. Such considerations may also constitute evidence for commitment. Regarding rigor, the methodology attempted to purposively select a homogenous group (i.e. people who had experienced the same thing) and who were therefore uniquely able to provide insights into the research question. However similarity of experience does not convey true homogeneity and the concept of homogeneity itself is one for philosophical debate, because a shared experience does not necessarily convey a uniformity of composition or character. Transparency has been attempted through use of an audit trail relating to the steps involved in the study and via the researcher’s reflective diary. Impact and importance are explored in the discussion.\textsuperscript{10}

Procedure

Fig.1. (below) shows a diagrammatic representation of the research procedure. The first stage, identifying potential participants, has been described above. Clinicians working with potential participants were asked to provide them with the information sheet for the study (see Appendix III for information sheet), following which they were given a week to make an informed choice regarding participation.

Once participants were identified, a date for interviews was set and details of these were sent via clinicians. Interviews took place at the service site, in a setting which allowed for both privacy and security considerations to be met. Only the first author and the participant were present, to minimize the possibility of response bias due to presence of clinical team members. At the beginning of each interview participants were given the opportunity to ask questions, following which they signed a consent form (see Appendix IV for consent form). Semi-structured interviews, based on the schedule and lasting approximately 60-90 minutes then commenced. Participants were

\textsuperscript{10} For more discussion on reliability and validity see extended methodology, sections 2.1.5, 2.1.6 and 2.2.2
asked to describe their overall experiences of schema therapy, their experiences of the imagery component, and to discuss this within the context of the other techniques used in schema therapy. The first author kept a reflective diary before and after interviews highlighting her thoughts, feelings and reactions, to enable reflection regarding the impact of these on analysis. Recordings were kept in a secure location until interviews were transcribed, after which they were erased.

**Fig.1. Diagram of research procedure**

![Research Procedure Diagram]

**Ethical Approval**

Ethical approval was gained both from the local University ethics committee and the local NHS Research Ethics Service. Approval was also gained from the local NHS
Trust research governance officer (research and development department) and the Research Unit in the service.

**Analysis**

Interviews were transcribed and analyzed manually using IPA (Smith et al., 1999), one-at-a-time starting with the interview the first author felt was most engaging. In IPA, analysis is conducted through use of the double hermeneutic; that is the researcher makes sense of the participant making sense of their experience. In this way analysis provides a co-constructed account of the experience. Data was analyzed by the first author: a 33 year old woman who has previously worked in forensic services. Because of this, the first author held fore-conceptions (or beliefs based on life experience) relating to forensic service users, schema therapy and the technique of imagery. It was accepted that during analysis, data would be understood in the light of fore-conceptions. By engaging with the transcripts awareness of relevant fore-constructions was gained so they could be put aside (or ‘bracketed’\(^{11}\)), and so analysis reflected the experiences of participants rather than the fore-conceptions of the researcher. An example of this was the first author’s fore-conception that sometimes people in forensic settings attempted to present themselves in a positive light and that this might be exaggerated in high secure settings. The first part of this fore-conception was identified prior to the study; however the second part (related to level of security) became apparent during engagement with transcripts. This understanding allowed the data to be examined with awareness of this as a possible bias, and where it was found it was derived from the data and acknowledged as an interpretation. Bracketing fore-conceptions is believed to reduce bias in analysis; however it is not possible to achieve total objectivity in a qualitative study, nor is this desirable in IPA. This process ensured that the analysis did not merely

\(^{11}\) Bracketing is a term commonly used in IPA that refers to the process of attempting to identify ones pre-conceptions and ideas about a subject and then ensuring that they do not skew analysis of data.
find what was expected (based on fore-conceptions), rather that the fore-conceptions that remained within the analysis helped ensure analysis was interpretative and co-constructed.

Analysis was begun by reading each transcript repeatedly, in conjunction with the first author’s reflective diary to highlight potential interpretative biases. Notes were made on the transcript regarding use of language, emphasis and semantics, with an explicit phenomenological focus. Notes describing the content were added and interpretative noting followed. These aided interpretations of meanings ascribed to events and how participants made sense of their experience. Super-ordinate and subordinate themes within each transcript were then developed from the exploratory notes and reflexivity rather than verbatim content. Themes were devised from patterns that emerged from the exploratory notes and reflected both the participant’s words and the first author’s interpretations. Once emergent themes were identified, connections between these were explored to develop a structure that allowed identification of the perceived most interesting or important themes. Once this procedure was completed for each individual transcript, themes were examined across all transcripts. This involved making links between themes and identifying which ones were super-ordinate within idiosyncratic experiences and which ones were super-ordinate across cases. Themes developed throughout the analysis rather than having been determined in advance. Each theme was explicitly explained and supported by verbatim quotes from the interviews.

**Results**

At the initial stage of analysis multiple emergent themes were found, however these were then subsumed via polarization, contextualization and function into three overlapping super-ordinate themes, one over-arching theme and one penetrating theme.
which was found to run through the other themes\textsuperscript{13}. The first super-ordinate theme described revisiting the trauma and overlapped with the second theme of therapeutic processes. The second super-ordinate theme overlapped with the third which represented therapeutic outcomes. The penetrating theme (linked to emotional pain) was substantially present in each of the three overlapping, super-ordinate themes. The over-arching theme (of a temporal but non-linear life journey characterized by feeling repeatedly pulled back into the past by trauma memories) enveloped the three super-ordinate themes and the penetrating theme (see fig.2. below for schematic representation of themes).

One participant employed a metaphor of emotional baggage as a suitcase which, during schema therapy is unpacked, rearranged and repacked so that the contents (emotional difficulties) no longer disgorge and surprise the owner. This metaphor resonated with the first author, and has been applied to the themes within this analysis, although this is not intended to prioritize the account of this participant over accounts of others. Indeed, echoes of this metaphor were found in all accounts. Some participants spoke of a journey, others of emotional baggage, and many spoke about understanding and ordering their difficulties. It is the first author’s interpretation that the metaphor of a journey with a suitcase of emotional baggage encapsulates the main sense making that was conveyed across the majority of accounts.

\textsuperscript{12} A penetrating theme is a theme that was found within the data that penetrated and ran through all other super and subordinate themes.

\textsuperscript{13} For discussion of earlier themes see extended results, section 3.1.
The schematic representation above shows that an overarching theme regarding the life journey (characterized by an experience of non-linear temporality linked to trauma memories) enveloped all other themes that emerged from the data. Within this concept of the life journey, three super-ordinate themes were identified. These have been named in keeping with the metaphor of the life journey with a suitcase of emotional baggage as 1) opening the suitcase (or revisiting the trauma), 2) unpacking and ordering the contents (or the process of therapy), 3) repacking and closing the suitcase (or therapeutic outcomes). These three themes were also penetrated by another theme of distancing from the trauma (or protection from emotional pain in relationships), which evolved over time throughout all other themes. These themes will be discussed separately in more detail.
The Journey

This overarching theme was present in all other themes in references toward time generally and specifically feeling as though it took a non-linear course. Within the theme of opening the suitcase it was conveyed in context of going back to another time and place as the quote below from Finn\textsuperscript{14} demonstrates:

Imagery its, I’ve done it twice in here that I know of. Once was with the psychologist on a one to one and it was, put me, me back in a situation years ago and being there, if you know what I mean. Its erm, you’re there sort of thing. You know what I mean? It’s odd but you’re there.

Finn speaks about experiencing something that happened years ago in the present. He stresses that during this experience he felt he was in that experience rather than remembering it, as though he was journeying back to another time and place. He also begins by speaking about himself in the first person, but changes to describing the experience in the third person. It was interpreted that this alteration reflected an attempt to share this experience and make the temporal element more accessible.

In the theme of unpacking and ordering the contents, the journey was represented in reference to the development of the therapeutic relationship. This is exemplified in the quote below from Brynn\textsuperscript{10}:

I had certain trust issues, so I, I had to work through that first to trust people and be open to people, especially [principal therapist], well mainly [principal therapist] really, I’ve worked with him for a good 5 years now, which is a long time... You’ve got to trust your therapist, there are good therapists, there are bad therapists, we all know that, do you know what I mean, but I think, it, it’s a trust, it’s a trust issue, and it’s a willingness to say, you know what, I know this is

\textsuperscript{14} Pseudonyms have been assigned to participants to preserve their confidentiality and anonymity.
going to be difficult, but it needs to be done, it needs to be said and, and it’s quite an, quite an acceptance, that you know what actually, you’re going to have the take that leap.

Brynn describes trust within the therapeutic relationship as developing over time. He explains that he felt a difficulty trusting anybody, but over a long period of time he built a trusting relationship with his therapist by accepting that bestowing trust was necessary to facilitate his progression. His description of this was interpreted to reflect temporal shifts in the process of giving trust to another person. Brynn’s mention of good and bad therapists was taken to reflect an ongoing difficulty in trusting which was in direct contrast to his assertion that he trusted his primary therapist.

Within the theme of repacking and closing the suitcase, the life journey was also thought to be represented in descriptions of readiness for change. This theme captures participants’ descriptions of applying what they have learned and making changes. Their descriptions of this appeared to reflect a process of change that vacillated throughout their journey. The quote below from Conner\(^{10}\) highlights this:

[My therapist] gave me a poem and it was about finding the, the road that you want to go down in life ...you might find it hard and you might fall in that hole in the road, but you can get back out and go and try another route and that’s what I'm doing here. I'm starting to, I sometimes fall in that hole in the road. A few days ago I was in that hole in the road a few days, but I climbed back out again and you find a new way around and you think what about this road, and then you can just, you know, find a new way, start going down a new route and see where it leads me. But this time, you know, there’s a few rocks and you get over, but at the end of the day it’s straight and narrow and that’s what gets it done.
Conner describes a fluctuation in his ability to put changes into practice. He seems to have a desire to change, but his capacity to apply this wavers over time in accordance with obstacles that arise. Conner’s use of a metaphor of a hole in the road was interpreted to be reflective of a painful fall as a result of going astray. Conner’s tone of voice became low when he spoke about this and his posture appeared submissive whilst his body language seemed subdued. In conjunction with his words (and the wider context of this quote) this conjured up images for the first author of plunging into darkness from having been in the light and was taken to represent a state of being lost, stuck and alone following a state of complacency regarding progress. This appears to go to the heart of the difficulty for Conner, as such fluctuations in the way he sees himself and his ability to cope with life’s obstacles reflects his schemas and the way they affect his behavior. It was interpreted that Conner was explaining a route of moving forward and backward in relation to making changes in his life and behavior, but that the setbacks were temporary rather than lasting.

In summary, the life journey was felt to envelop all themes that emerged from the data. This was symbolized by multiple references to progression through time and therefore was felt to reflect a journey. This encompassed allusions toward returning to traumatic times, developing trust within the therapeutic relationship as a process that vacillates over time and to temporal fluctuations regarding attempts to alter patterns of behavior.

Opening the Suitcase

Within the encompassing theme of the journey, three super-ordinate themes were identified. The first of these was conceptualized as opening the suitcase or revisiting the trauma. This theme was found in all interviews and is highlighted by the quote below from Eoghan:

"..."
Going back to the safe place and then dealing with your problems as an adult, what happened in your childhood and erm, in a safe way. Even though the feelings and emotions are still there, it’s quite good to do it in a safe environment, you get a better understanding of it.

Eoghan’s quote exemplifies the difference between re-visiting the experience and reliving it. The notion of reliving implies having the experience in the same way it was experienced the first time, yet Eoghan describes going back to the experience as an adult not reliving it as a child. Similarly, it does not seem appropriate to describe the experience as re-traumatizing as although mention is made of feeling the pain from the event, Eoghan highlights that this is done in a safe way. The experience was interpreted as one of re-visiting rather than reliving for several reasons. There was a conscious choice to ‘go back’, and the description of understanding childhood problems better as an adult implied that some elements of the event had changed over time (thus linking back to the overarching theme of the life journey). Also the event was not physically re-experienced and therefore does not fit with re-experiencing. This was elucidated in the quote below from Brynn:

It was about going back to painful or difficult events (pause) and basically replaying them now, now that you know, now you know certain things, do you know what I mean, and replay it and making sense of it, that’s, make, make sense of, you know, things that have happened or, you know, situations you was in or things you went through.

This however might not have been the experience for all participants. Aadil’s words suggest that in some cases opening the suitcase can be a re-traumatizing experience, “It just, er, takes you back to being that vulnerable child. And er, no, I’ve
lived through that stuff once; I don’t want to do it again.” In conjunction with highlighting re-traumatization, Aadil’s words might also reflect an attempt to distance himself from the emotional pain, a theme that was found to penetrate and run through the three super-ordinate themes. Also the experience was not described simply as a process of remembering the original event although there was an acknowledgement of conscious memory at the start of the experience. The quote below from Finn clarifies the experience:

> It’s not a memory it put, puts you there...it’s like being there, yes, whatever you’re doing, it’s like being there, you, it’s not, it’s like memory but it’s, you’re there, it’s the only way I can explain it to you, you’re there, you put yourself there, you’re, somebody asks you a question, you answer the question as though you’re there. (Pause) Not what you’d ask, answer now, but would have answered or said in that situation.

This super-ordinate theme also incorporated the notion of reconnecting with the childhood self. This theme was evident even among those who found the re-visiting traumatic. Aadil stated “… when I’ve done imagery, I’m back to being that little six, seven year old little lad, you know what I mean?” This was also echoed in the words of Daniel “The way I was when I was a little boy, and I was there, I got it back.” Conner’s words also reverberate with this theme, but attempt to explain it more fully:

> With imagery, what it does, it, it, it, the emotion will change, I might become the angry child or the vulnerable adult, in, in imagery...crying my eyes out as a kid for help and the angry adult now is a man who is trying to understand what that child needs and what, that, that child needs to mature and the child needs to be able to develop and, and change.
Conner seems to be describing a connection with the childhood self which links temporally back to adulthood but also with the way he responds as an adult to his childhood feelings of vulnerability being triggered. He appears to describe attempting to meet his childhood needs as an adult to facilitate change, although this is a source of emotional pain. This could be said to link into a process of distancing from the emotional pain, similarly to the quote from Aadil above. Conner speaks about crying and feeling vulnerable as a child, but angry as an adult as a form of protection for his childhood self. It was interpreted that the description of adult anger related to the childhood pain is an attempt to distance himself from the emotional pain that he felt in childhood and also from things that could cause him to feel emotional pain as an adult. His distancing from emotional pain refers back to the temporal theme of the life journey which overarches all other themes by describing a fluctuating relationship with his emotions through his life. It also links via temporality to the super-ordinate theme by describing the pain associated with reconnecting with the childhood self through the experience of revisiting the trauma.

Unpacking and Ordering the Contents of the Suitcase

The second super-ordinate theme appeared to describe the process of therapy. This was interpreted to arise from descriptions relating to three subordinate themes; 1) emotional control (i.e. attempts to control emotions isolate people from others, but losing control over emotions during imagery leads to interpersonal connectedness with the therapist), 2) moving on versus being stuck in the past and 3) the therapeutic relationship as characterized by trust, and meeting needs. The first and last of these subordinate themes contain overlap between this super-ordinate theme and the penetrating theme of distancing from emotional pain. The middle subordinate theme (moving on versus being

15 For comments on use of professional language see extended results, section 3.2.1.
stuck in the past) highlights an overlap between revisiting the trauma and unpacking and ordering the contents.

The first subordinate theme is highlighted by this quote from Daniel “I like to be in control of myself...but...you can’t do everything by yourself, you need...help” and by the quote below from Brynn:

It’s just like right well, that’s where that came from and obviously I’ve used that schema throughout my life, that mistrust/abuse, keep people at a distance, because if you keep them at a distance they can’t hurt you... and it got to the point where [my therapist] could ask me anything, you know the deepest, darkest secrets that I have and, and take me there with imagery, imagery work and, and work through them. It’s not, imagery is hard, it is really hard and it’s quite erm, it’s quite draining, after the session you feel quite, quite exhausted, not, not physically, you know like mentally tired, like you’ve been put through the wringer.

Brynn and Daniel both admit to trying to keep others at a distance but acknowledge that over time and through the experience of imagery they came to connect with and trust their therapists. Within this subordinate theme, they both appear to be discussing ways to detach and protect themselves from the emotional pain that resulted from working using imagery. This was interpreted to reflect the penetrating theme of distancing and also to refer to a development of connectedness over time, relating to the overarching theme of the life journey. The loss of control in imagery is exemplified by a quote from Daniel “It [the experience of being in the image] just takes over”.

The life journey and distancing were also present in the second subordinate theme of moving on versus being stuck in the past. It was interpreted that participants referred to their childhood experiences as a template for current relationships. This can be seen in this quote from Daniel “You’re automatically oh they’ll get up and leave and
that takes you back to what your parents did”. The theme is highlighted by the quote from Aadil below:

I try not to think of specific things that have happened in my past. You know what I mean? I think, I think about the vulnerable child and it’s weird because I think of him as a separate person to me, you know what I mean? He’s like a, a, like someone I want to help. I want him to feel better.

Aadil seems to be talking about a feeling of being separate from his childhood self but implying that he would like to move on from this. This super-ordinate theme also overlaps with the first theme of revisiting the trauma (or opening the suitcase) as the beginning of Aadil’s quote about trying not to think of things from his past was interpreted as avoidance of revisiting traumatic events and the emotional pain that this could cause.\(^{16}\) It was also interpreted that the two themes would overlap as talking about moving on from the past would involve revisiting and reconnecting with past events. An example of this can be seen in Brynn’s quote:

I think there would have been a lot of things unaddressed for me [if I had not done imagery], erm, that maybe and, you know, that I couldn’t have dealt with, and I suppose like that always leads to risk doesn’t it, if you like, it could lead to risk, erm, and potential re-offending, you know because it’s things that haven’t been dealt with as a child and you haven’t looked at things in a different way, you haven’t done the work around surrounding the offences and why you had the offence and why you feel and think the way you do and you’re, you’re not addressing your core problems are you, your just brushing over them and your just dealing with the offence, rather than really led up to the offence.

\(^{16}\) For discussion of the theme of avoidance see extended results, section 3.2.2.
In this passage Brynn talks about what he believes would have happened if he had not undertaken imagery. Brynn talked about goals that he said would not have been met if he had not done the work. It was interpreted Brynn was implying, that because he had undertaken the work he had achieved these goals. Within this framework Brynn talks about addressing core issues from childhood that were not dealt with at the time. He links these to risk and relates unaddressed issues to the development of offending behavior. It was interpreted that Brynn is suggesting that by revisiting his past, he was able to address his unmet needs and the core issues that arose from them through using imagery, and has therefore been able to move on from the hold that those issues previously held over him. This however might reflect a desire on Brynn’s part to represent himself in a positive light. In either event, Brynn’s account reflects the overarching theme of the life journey as it refers to the passage of time from childhood to the present. In his reference to understanding feelings Brynn’s words might also be interpreted to refer to a lessening of the distance between himself and his emotional pain and so reflect the penetrating theme of distancing. Brynn describes a process of making connections between reactions to core childhood events and his offending behavior. He describes addressing core problems (from childhood) as central to reducing risk, and therefore places importance on the process of therapy, or unpacking and ordering the contents of the suitcase.

The third subordinate theme, relating to the therapeutic relationship is evident in the quote below from Daniel:

I don’t mind crying in front of [my therapist], because if I’m going to get upset....And she knows, she can read me like a book....and I’ll tell her and then it’ll upset me a bit more, and then she’ll get me to a point where the upsetness goes away. And I start to feel calm and relaxed and that’s how I got to trust her.
Similarly, Conner said:

So I think it’s quite, really important that you have a good therapeutic relationship...because you need that bond, you need that bond, just like that bond that a mother and daughter or a mother and son has in the early stages. You need that bond there, although it’s a different bond it’s still serving the same purpose. It’s that rod for your back. That’s what the person is, he’s not going to come up and cuddle you and things like that, but at the same time he’s going to tell you exactly the way it is.

Both Daniel and Conner speak about the therapeutic relationship meeting their needs within therapy. Within both these quotes there is reference to the relationship developing over time thus exemplifying the overarching theme of the life journey. Incorporated within this however, Daniel speaks about his therapist containing his emotional pain in a healthy way, whereas Conner speaks about the relationship in terms of a bond and a relationship similar to that of being parented. Daniel’s reference to his therapist containing his pain appears to be in opposition to the use of distancing to reduce the impact of emotional pain and therefore reflects the penetrating theme of distancing. Daniel also points out the importance and development of trust. Overall both quotes highlight the process of therapy as temporal and painful but as a development whereby the therapeutic relationship meets the participants’ needs and this facilitates the sharing of experiences and the progress through therapy. Both Daniel and Conner describe the therapeutic relationship as crucial in the experience of unpacking and ordering the contents of the suitcase.
Repacking and Closing the Suitcase

This super-ordinate theme seemed to reflect therapeutic outcomes. Within this theme, two subordinate themes were identified relating to *healing the fractured self* and *applying what has been learned* to life. The quote below from Eoghan demonstrates the first of these:

> I am quite subjugated a lot and er, but now I don’t, now, I, I say, speak my mind and I stand up for myself, I’m a bit more, you know, bit more stronger like, you know what I mean so, gives you confidence as well, definitely gives you confidence, it does, it’s good.

Eoghan speaks about his confidence developing through therapy, possibly resulting in a change in his behavior. His use of language however calls this into question. His opening statement suggests that he is currently subjugated; however he goes on in the same sentence to contradict that by implying that in the present he is more assertive. This seems to reflect a core issue for Eoghan in that his personality is in flux, yet he wishes for it to be stable. Eoghan’s attempts to reduce the uncertainty around core traits of his personality appear to have led him to over-represent changes in his behavior.

Alternatively, this could be an example of an attempt to present himself in a positive light (as has been mentioned before for other participants). Despite this possibility, Eoghan still speaks of noticing changes in his interpersonal behavior. Similarly, Finn’s quote below speaks of a change in his sense of self because of the imagery work:

> I’m starting to er, I’m seeing things in a different light like, for me it’s helping me cope sort of, something that should have been done 30 years ago, it’s, (pause) it’s helped me, not forget, but, if, if this had been around 30 year ago or something like that in hospitals it, I don’t think I’d have been here now. It’s helping me er (pause), go through erm, a sort of grieving process that I should
have done 30 year ago but there was nobody about to help me and I didn’t know what to do and now it’s I say it’s painful but I know I’ve got to do it, but it really helps, it is helping me, erm, sort myself out I suppose, sort things out.

Finn speaks about his progress as a temporal process, thus reflecting the overarching theme of the journey. Finn also talks temporally about healing. He says that it was something he should have done in the past, and suggests that if he had been able to, then his life might have been different. It is possible however that Finn’s quote represents a desire to pass responsibility for the consequences of not making changes onto people he felt did not help him. If this was the case however, the reference to the life journey is still present. Both Eoghan’s and Finn’s quotes also incorporate references to emotional pain. Eoghan speaks about feeling stronger now and this was interpreted as meaning that at some point in the past he felt weaker. In conjunction with this Eoghan also spoke about being subjugated a lot, which was interpreted as his conveying his emotional pain and the difficulties that this has caused him. Finn speaks more explicitly about acknowledging the need to experience the pain to move forward. Also, Eoghan uses the word ‘stronger’ and says ‘it gives you confidence’, while Finn makes multiple references to imagery having helped him, therefore both quotes were interpreted as reflecting the penetrating theme of distancing, in a way that suggests distancing lessens over time because of the process of therapy and so represents a positive therapeutic outcome. Finn’s quote also demonstrates the overlap between the themes of unpacking and ordering (specifically the subordinate theme of moving on versus being stuck in the past) and of repacking and closing the suitcase (through the subordinate theme of healing the fractured self).

The second subordinate theme within repacking and ordering the case was interpreted to be applying what has been learned to life. This theme can be seen in the
following quote from Eoghan “it’s about using the stuff I’ve learnt here to understand ...
and then also checking mine [schemas] and why I feel the way I do and then talking
about that rather than arguing and it usually works”. Eoghan’s words seem to reflect a
feeling of success in applying the process of understanding his difficulties to his
relationships with others. Although interpreted as within the same theme, Conner’s
account (below) of applying his learning appears to reflect more difficulties:

The treatment is not the challenge for me, I see that as not a problem I can deal
with that, the challenge is living, I think that’s, that’s the challenge. I think
that’s the er, that’s the difficult part living, living is the hardest part. Doing the,
coursework and the legwork is not too bad, but putting it into practice is, is the
hardest part, and that’s, even now I find it difficult sometimes myself, living it is
the tough part for me.

In this statement Conner appears to be reflecting success in his attempts to apply his
learning, but also is counterbalancing this against the hard work involved in doing this.
He speaks about his success in applying techniques as transitory and something that
fluctuates over time. This again represents the overarching theme of the life journey
throughout the data. Conner also uses problem saturated language in the form of the
words ‘problem’, ‘difficult’, ‘hardest’ and ‘tough’. It was interpreted that through the
use of these words Conner was attempting to convey not only the motivation and hard
work involved in applying his knowledge but also trying to express the emotional pain
involved in acting this way. This seems representative of the penetrating theme of
distancing as reflective of a temporal process whereby distance is reduced or increased
according the circumstances the participant finds themselves in. Distancing is therefore
described as an interactive process between human beings and situations. Overall, the
theme of applying what has been learned can be encapsulated by the following quote
from Aadil, who acknowledges that progress has been made, but that therapeutic outcomes are something that will always require work, “I was so introverted you know what I mean, oh, I just isolated myself. I wouldn’t have been in this room now... I’ve just got to change my whole life”.

In summary then, the interviews could be said to be characterized by a narrative around life as a journey that emotional baggage is taken on and therapy as a journey within a journey where that baggage is opened, ordered, repacked and closed. The extension of this metaphor is that if the contents of the baggage (or suitcase) are not ordered then the case might spring open at any time, without action on the part of the owner, disgorging its contents, and this could cause problems. If, however the contents of the case are ordered and packed properly then the case can be closed and put away without fear that its contents will pour out and they may be noticed only when the owner desires to do this.

**Discussion**

These results represent the first qualitative exploration of people’s lived experiences of imagery in schema therapy. This study aimed to explore experiences of imagery in schema therapy (Young, 1990, 1999) in people diagnosed with personality disorders, who have offended. This was conducted because the use of imagery in schema therapy has not been specifically explored previously, and therefore the results add to the literature around both schema therapy and imagery.

The analysis was suggestive of positive results for participants and uncovered a number of key themes. First, an overarching theme regarding a *temporal life journey* which enveloped all other themes emerged. Within this, three super-ordinate themes were identified. These were named in keeping with the metaphor of a *life journey* with a suitcase of emotional baggage as: *opening the suitcase* (or revisiting the trauma); *unpacking and ordering the contents* (or the process of therapy); and *repacking and
closing the suitcase (or therapeutic outcomes). These three themes were also penetrated by another theme of distancing from the trauma (or protection from emotional pain in relationships).

The penetrating theme of distancing, or protection from emotional pain appears to support the literature around emotional processing as a therapeutic mechanism of imagery (Meadows & Foa, 1992 as cited in Folette et al., 1998). As mentioned earlier this suggests that reactions to trauma are survival instincts, and the results here imply that distancing from the emotional sequelae of trauma is a protective strategy employed by participants. Distancing is likely to happen in a number of ways. Cognitive and emotional distancing were highlighted in this study, however other mechanisms (e.g. physical distancing) may also be employed. Also in line with emotional processing, the themes discovered here suggest that physical re-experiencing was not necessary because revisiting the trauma through imagery allowed participants to reconnect with the childhood self’s experiences to work through these.

These results do not appear to support Brewin’s dual representation model of memory (Brewin, 2001) as an underlying mechanism of imagery because the experience of revisiting the trauma was specifically described as ‘not a memory’. Descriptions of this experience emphasized the nature of revisiting a time and place from the past, and having others from that time represented in the experience. Rather than just being a memory, participants spoke about going back to that time and experiencing it as a child but with the knowledge of the adult. This does not appear to reflect the process of passive memory as participants spoke of being able to question others during imagery and receive answers from them.

The results also appear to support the schema therapy literature. The superordinate theme of opening the suitcase (or revisiting the trauma) fits with schema therapy’s assertion that EMS (Young, 1990) are unhelpful frameworks relating to the
self, others and the world that originate from reactions to traumatic childhood experiences. Within this theme, the subordinate theme of reconnecting with the childhood self appeared to facilitate the process of correcting reactions to early experiences, which further supports the connection.

Moreover the results support ideas from behaviorism that suggest imagery serves as a process of in vivo exposure. Participants talked about being transported in a temporal sense, and they discussed revisiting rather than reliving elements of their early experiences from the position of a safe base. This was suggestive of exposure to feared situations coupled with response prevention (e.g. averting maladaptive coping strategies from EMS). The results however suggest that there is more to the process than merely exposure. Accounts portrayed the therapeutic relationship as meeting the unmet childhood needs of adult clients, which seemed to describe the idea of limited re-parenting in schema therapy\(^1\) (Young, 1990, 1999, Young, Klosko, & Weishaar, 2003). It appears limited re-parenting in conjunction with exposure, describes a therapeutic mechanism underlying imagery. Within behaviorism, this might be explained as the therapeutic relationship serving as a social reinforcer and encouraging pro-social, reciprocal responses through modelling.

The theme of unpacking and ordering the contents (or the process of therapy), was comprised of three subordinate themes: attempts to control emotions as isolative, but connectedness to others being facilitated through losing control in imagery; moving on versus being stuck in the past; and the therapeutic relationship as characterized by trust, and meeting needs. These appear to fit with schema theory where change is facilitated through the therapeutic relationship via limited re-parenting. Participants within this study described feeling that their therapists were providing what they needed during sessions, which could be interpreted as re-parenting, especially in light of
specific similes likening the bond of the therapeutic relationship to that of parent and child.

It is also of note, that given participants’ emphasis on the therapeutic relationship in imagery, that therapist skill could be an important factor related to this technique. As this was not mentioned within participant accounts it was not explicitly considered within this study. It would seem however, to be a relevant factor in light of what is known about the importance of non-specific factors in therapy (e.g. the therapeutic relationship), and the importance that participants placed upon this within their accounts of their experiences.

Although IPA is an ideographic approach and as such findings are difficult to generalize, they are transferable across contexts. The results of this study are relevant to facilitating the understanding of people who undertake imagery work in forensic settings. Applying these findings to other groups should be treated cautiously as they are co-constructed explanations of interviews with six people. That said however, clinicians using imagery as part of schema therapy in forensic settings might benefit from considering the themes that resulted from this study. Understanding that recipients of imagery in schema therapy experience a process like a journey could help them to facilitate imagery as long-term adjunct to the other components of therapy. It could also be beneficial for clinicians to appreciate that recipients’ ability to engage with this could fluctuate over time because re-visiting childhood trauma and experiencing emotional pain might be key aspects involved in imagery. Recipients might find reducing the distance between themselves and their emotions difficult at first; however working through the pain was associated with positive outcomes in this study. Although losing emotional control by engaging with imagery and re-visiting the trauma was described as painful, the act of relinquishing control was reported to facilitate interpersonal connectedness and the development of trust. The results suggest that this was essential
for facilitating progress through imagery. Sharing this information with recipients of imagery might help to alleviate concerns regarding engaging in the process.

Critique of the study from within its own epistemological position would suggest that the criteria for validity within an IPA study were achieved. However, as the epistemological position of the study holds that there are multiple truths and all are equally valid therefore it is difficult to critique the study from this standpoint. Therefore the following critique comes from a more positivist standpoint. IPA appears to employ a clinically allied paradigm in its emphasis on co-construction and the double hermeneutic. This allows the researcher to hear participants’ accounts and to attempt to make sense of these based on their own knowledge and understanding. In this way, this study allowed specific consideration of theory in clinical practice and added to understanding around how this can be applied. It also allowed for a rich, in-depth, detailed body of knowledge based on first-person accounts to be collected, which helped to open up thinking about the technique of imagery in schema therapy and provided a starting point for future research into the area. Although these accounts appeared to consistently describe the process involved in engaging with imagery in schema therapy, this study was based on the accounts of six participants, analyzed using IPA, and so co-constructed incorporating the first author’s interpretations. The strong interpretative emphasis within IPA also impacts on issues of reliability and validity in the study, in that, if replication occurred, different emergent themes might have been identified because of individual differences and fore-conceptions. Also IPA focuses on the perceptions of experiences but does not have the remit to examine the mitigating factors behind them, and it is possible that those factors influenced responses in a way that was not acknowledged by the double hermeneutic of the study. Another limitation could be said to relate to reflexivity. The first author kept a reflective diary throughout the research, and it was acknowledged that she brought certain fore-conceptions to the
study related to both participants and the therapy and technique being explored. Despite this, making fore-conceptions explicit was not felt to eradicate the possibility of bias in the results\textsuperscript{17}.

In addition to the stated limitations of the study it should also be noted that in writing this paper a bias towards a different methodology, namely Grounded Theory was noted. This was as a result of the process of undertaking the research and the results that emerged from it. IPA was initially chosen as a method because of a desire to open up the area and begin understanding imagery from the perspective of those who had undertaken it. Grounded Theory was considered as an alternative but at the start of the study it was felt that not enough was known about imagery in schema therapy to be able to track potential results to a theory. When the results emerged describing what appeared to be a process like a stage model it became apparent that a Grounded Theory methodology would have been appropriate; however this would not have been known if the initial IPA study had not been conducted. The results led me to consider how a Grounded Theory study could have added more to the literature and evidence base around both imagery and schema therapy and this in turn influenced the way the study was written.

Despite the above limitations the results of this study suggest directions for future research in the area. Participants in the study described a temporal sequence of events that they progressed through during imagery. Because this was an IPA study it is not possible to state whether such a process might be experienced more consistently by those undertaking imagery in schema therapy. Therefore a larger scale investigation using a quantitative methodology could help to elucidate the potential for a model which describes the stages involved in imagery. Moreover, the impact of experiential

\textsuperscript{17} For discussion around critique and limitations see extended discussion, section 4.1& for critical reflection see section 4.2.
techniques in therapy could be examined by using a quantitative design to compare schema therapy with cognitive-behavioral therapy via factor analysis. Additionally, anecdotal evidence from therapists conducting imagery in schema therapy suggests that (especially in therapists new to working with imagery) they might share some of the concerns voiced by recipients of imagery work. These were specifically identified as concerns around the consequences of people re-visiting trauma, experiencing their emotions and reconnecting with their childhood self. With this in mind, it could be useful to explore the experiences of therapists who have facilitated imagery from a phenomenological perspective to add to understanding of this technique and the evidence base of imagery in schema therapy. Furthermore, comparison between experiences of people undertaking imagery in secure forensic settings, and those engaging in community forensic settings, could help shed light on feelings of safety and containment during imagery, and the potential behavioral consequences of this.

In summary, although the results presented here only reflect interpretations of the accounts of six participants in a high secure hospital at one particular point in time, they offer an in-depth insight into the experiences of these participants, and provide another way of looking at the therapeutic technique of imagery in schema therapy. They allow us to understand the process that people may go through when engaging in imagery in Schema Therapy and that their ability to do this might fluctuate over time. They also highlight that people might find it difficult to reduce the distance between themselves and their emotional pain, but that although engaging with imagery requires losing emotional control and re-visiting the trauma which is painful; this facilitates the therapeutic relationship and aids the therapeutic process. Sharing this information could help both therapist and recipient alleviate concerns about engaging in the process.

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References


Extended Paper

1: Extended background

1.1.1: Extended Background: Schema Therapy

This study explored the experiences of people with diagnoses of Personality Disorder, who have committed offences and who have undergone Schema Therapy. In particular it investigated their experiences of one of the techniques used within this therapy; imagery. This technique is applied in many psychotherapeutic approaches, and there is some evidence for its effectiveness, however its role in Schema Therapy has not been studied. This study aimed to provide a starting point to filling this gap in the literature. The background to this study comes from the areas of schema therapy with people with borderline personality disorder (BPD), schema therapy in forensic settings, and the psychotherapeutic technique of imagery, incorporating effectiveness and the proposed mechanisms that underlie imagery. These will be discussed in turn.

Schema Therapy as proposed by Young (1990) was initially designed as a technique for “patients with entrenched, chronic psychological disorders who have heretofore been considered difficult to treat” (Young, Klosko & Weishaar 2003, p.1). It proposes that Early Maladaptive Schemas (EMS) were at the core of personality disorders and were the result of toxic childhood experiences (i.e. a result of ongoing patterns of injurious interactions with others which originated in childhood). He characterised them as having both cognitive and emotional content and theorised that maladaptive behaviours were a result of activation of such unhelpful schemas. He proposed that there were five areas of core emotional need, which if unmet, during childhood, lead to the development of maladaptive schemas, these were; 1) secure attachments to others, 2) autonomy, competence, and sense of identity, 3) freedom to express valid needs and emotions, 4) spontaneity and play and 5) realistic limits and self-control (Young, 1990). In all, 18 maladaptive schemas relating to the five domains of core emotional need were identified by Young (although the number has since been adapted in light of research into this area); these were believed
to exist below the levels of negative automatic thoughts and dysfunctional assumptions.

Giesen-Bloo, et al. (2006) conducted a randomised control trial (RCT) that compared Schema focused Therapy (SFT) and Transference Focused Psychotherapy (TFP) over a three-year period with people who had diagnoses of BPD. The comparison was chosen based on findings from an uncontrolled pilot study and clinicians’ experiences of treatments which were supported by open studies (Arntz, 1999, Clarkin et al., 2001, Nordahl & Nysaeter, 2005). Transference focused therapy was used as a comparison as earlier studies had demonstrated that these were more effective than control conditions (Linehan, Armstrong, Suarez, Allmon & Heard, 1991, Linehan, Heard & Armstrong, 1993, Perry, Banon & Ianni, 1999, Verheul et al., 2003 as cited in Giesen-Bloo, et al. 2006). The study found that participants undergoing Schema Therapy were less likely to drop-out of therapy, required fewer sessions to completion and reduced more on scores of BPD symptomology, psychopathology and personality pathology, whilst increasing more on quality of life scores. They also demonstrated more change in personality concepts (although the nature of these was not specified in the article). Overall, this study appeared robust, although it was a randomised control trial (RCT) which may be argued is not as appropriate in psychological research as in medical research (Prescott et al., 1999). Eighty-eight participants were involved in the study, although two (one from each group) were excluded from the analysis. One for eyesight difficulties which made assessment results unreliable and the other became unreachable following randomisation. Forty-four participants were assigned to the SFT group and forty-two to the TFP group. The relatively small sample size may indicate a potential limitation of the study, especially as the power calculation related to the study suggested that forty-five participants were required in each group to detect differences with a 2-sided significance of 5% and a power of 80%. Despite this limitation, this was the first RCT that provided evidence for the effectiveness of Schema Therapy with people with diagnoses of BPD. The results however do not generalise to other diagnoses of personality disorder.
Similarly van Asselt et al. (2008) found that Schema Therapy conveyed less societal costs and was more effective than Transference Focused Psychotherapy after twice weekly sessions across three years of therapy for patients with BPD. This was a study of cost-effectiveness which examined the outcomes of both treatments using the Borderline Personality Disorder Severity Index (version IV) and used quality adjusted life years to express this. It also looked at unit prices of economic costs involved in delivery of therapy. The authors acknowledged that the study was limited by relatively high dropout rates relating to the final assessments, and therefore a last observation carried forward (LOCF) method was employed to replace missing data. This method has implications that limit the strength of the overall findings as such use of data may skew means and this is especially true if LOCF is employed in longitudinal studies. Also, the study used an intention to treat approach which means that although participants may not have actually engaged in the treatment condition they were assigned to their data was analysed as if they did. In connection with the LOCF method the intention to treat approach further skews the data and calls into question the validity of the results. It is also of note that this study did not employ either a ‘care as usual’ or ‘natural course’ control group. Allowing for these limitations however, the results still indicate that Schema Therapy has cost-effectiveness benefits as compared to Transference Focused Psychotherapy.

These results are further strengthened by the findings of Farrell, Shaw and Webber (2009) who conducted a randomised control trial to test the effectiveness of adding a 30 session group trial of Schema Therapy to a ‘treatment as usual’ group for adult, women with BPD. This was compared to a ‘treatment as usual’ group. The results indicated that within the Schema Therapy group there were significant reductions in symptoms related to BPD as well as in overall severity of psychiatric symptoms. Global improvements in functioning were also found within the Schema Therapy group. Farrell et al., (2009) concluded that following the treatment period 94% of participants within the Schema Therapy condition no longer met criteria for diagnosis of BPD, as compared to 16% of the treatment as usual group. The major limitation of this study was sample size, as the Schema Therapy group consisted of 16
participants whilst the treatment as usual group consisted of 12 participants. This would have affected the strength of the statistical analysis used (analysis of co-variance) and therefore limits the reliability of the results. Despite this limitation however, this study adds to the increasing evidence base for the effectiveness of Schema Therapy with people who have diagnoses of BPD.

Whilst the concept of schemas has its origins within Cognitive Therapy, Schema Therapy is an integrated therapy that uses many different techniques. Young, et al. (2003) define a schema as “a pattern imposed on reality or experience to help individuals explain it, to mediate perception, and to guide their responses.” (p.6). What distinguishes Schema Therapy from standard Cognitive Behavioural Therapy is its emphasis on childhood development of problems, emotive techniques, the therapeutic relationship (and interpersonal relationships in general) and maladaptive coping strategies. Weertman and Arntz (2007) studied Schema Therapy's focus on early development of problems and compared this to therapy focused on current difficulties. Participants had matched diagnoses of Axis II disorders (according to the diagnostic and statistical manual – 4th edition), excluding diagnoses of borderline, schizotypal, schizoid, and anti-social personality disorders and also personality disorder not otherwise specified. Two groups were compared, one who received childhood focused therapy followed by therapy focused on current difficulties, and the other who received current focused therapy followed by childhood focused therapy. Each group's progress was monitored at baseline, following the first intervention and at the end of both interventions. They found that therapy focusing on childhood memories was at least as effective as therapy focusing on current events for people diagnosed with personality disorder. It is possible however, that therapists' level of experience affected the results (as the study showed improvement correlated with therapists' experience in cognitive therapy). Also as the therapy was lengthy (24 sessions in each condition) the amount of interaction between therapist and participant may have affected the outcomes. It is not possible to exclude this as a control group was not employed within the study. It is also important to note that the study did not show significant differences in improvement in either the current or childhood focused memory groups. It appeared to demonstrate that focus on either condition was
equally valid. The results therefore indicated the importance of working therapeutically with early memories as well as current difficulties when working with people with personality disorders.

1.1.2: Extended Background: Schema Therapy in Forensic Populations

Schema Therapy has also been suggested to be applicable in forensic populations. Timmerman and Emmelkamp (2001) studied a forensic inpatient population using the Diagnostic and Statistical Manual of Mental Disorders, third edition, revised (DSM-III-R), which may have skewed the results as offenders show anti-social behaviour and this is a diagnostic criterion for anti-social personality disorder. Also, the study found a high proportion of people diagnosed with 'personality disorder not otherwise specified', which is suggestive of difficulty in specifying the exact nature of people's problems and may possibly have represented cultural or social choices rather than actual psychological difficulties.

Evidence specifically relating historical abuse and trauma to Schema Therapy in forensic populations can be drawn from the work of Richardson (2005). This study used the Young Schema Questionnaire (YSQ), a structured interview tool which was developed to help highlight which EMS were activated in those interviewed, to study the prevalence of EMS in a sample of sexually abusive adolescents. The study found that results on the YSQ could differentiate between those offenders who had a history of childhood sexual abuse and those who did not. It demonstrated that offenders with a history of childhood abuse had a higher prevalence of EMS. These results show that Young's (1990, 1999) proposed schemas are present within this population and therefore schema therapy could potentially be used with this group.

Regarding prevalence of trauma in forensic populations, Groth's (1979) study focused on sexual offenders, therefore these results might not have been representative of wider forensic populations. More recent studies however, also suggest that trauma may be found in many groups of offenders. Dixon, Howie and Starling (2005) found 37% of female adolescent offenders met the criteria for Post Traumatic Stress Disorder (PTSD) and that childhood sexual abuse
was precipitant in 70% of cases. Comparable results were found in a group of male and female adolescent offenders. Burton, Foy, Bwanausi, Johnson and Moore (2005) found that 24% of their population met the criteria for PTSD. They concluded that this group was at high risk of exposure from multiple types of trauma. These studies illustrate the high percentages of historical abuse present in forensic populations.

The studies above (Dixon et al., 2005, Burton et al., 2005 and Richardson, 2005) provide further evidence for the applicability of Schema Therapy to forensic populations; however it is a caveat that these studies used adolescent samples and may not be generalisable to adult populations. Also, the first two studies mentioned above did not include a control group, whilst the final study did. It is difficult, therefore to make comparisons between the general population and the groups studied in this research. Despite the limitations however, these results suggest that Schema Therapy may be effectively used with forensic populations, as this group been shown to have a high incidence of personality disorder diagnoses, and such diagnoses have been linked to early childhood trauma, which are both areas that Schema Therapy was developed for and has been demonstrated to be effective in.

Schema Therapy later developed to incorporate the concept of Schema Modes (Kellogg and Young, 2006). These can be seen as relatively independent, organised states of thinking feeling and behaviour that an individual may alternate between. These may be linked to intense emotional states that were experienced as a child during traumatic events, and to maladaptive coping strategies. This model was tested on people with BPD by Arntz, Klokman and Sieswerda (2005). State and trait versions of a Schema Mode questionnaire were given to a group of women who were diagnosed with BPD, a group of women diagnosed with cluster C Personality Disorders and a matched control group of non-patients. A crossover design was employed to show participants filmed clips designated as either neutral or emotionally evocative (showing scenes of child abuse). They found that significantly higher rates of Schema Modes were found in the participants who had diagnoses of Personality Disorder, and also that these modes were more easily triggered in this group by
watching the emotional film clips. The study also showed that certain modes were more common in people diagnosed with personality Disorder, and that these tended to be categorised by a response of emotional detachment. This study was the first to test the model and therefore the results would be strengthened by replication. It could potentially be limited by its reliance on self report measures, which mean the findings were based on subjective data. The authors suggested that replication using observational measures in addition to the original design would strengthen the results, as Schema Modes are characterised by sudden and dramatic shifts which the patient may not be aware of. The suggestion from this model that people with un-integrated personalities are likely to switch rapidly between emotional states and their resultant coping strategies is the reason for the focus within Schema Therapy on the therapist-patient relationship. This focus pervades the three phases of therapy; bonding and emotional regulation, schema mode change (attempts to integrate different parts of an individual's personality), and development of autonomy (Kellogg & Young, 2006).

The key study in the area of the effectiveness of Schema therapy in forensic populations examined working with Schema Modes (Bernstein, Arntz & de Vos, 2007). As discussed earlier these are rapid shifts in thoughts feelings and behaviours that affect interpersonal relationships and which are related to emotional states experienced during traumatic childhood events. Young et al. (2003) proposed 11 Schema modes. Four were likened to childhood states; vulnerable child, angry child, impulsive child, and lonely child, three were linked with dysfunctional coping; detached protector, detached self-soother and compliant surrenderer, two were likened to parenting modes; punitive parent and demanding parent, and two were linked to over compensation; self-aggrandizer mode and bully and attack mode. Young et al. (2003) claimed that it was likely that these would be triggered by stressful or emotional life events and that people with EMS would rapidly switch between these modes. One of the aims of Schema therapy is to allow for the integration of these states which will lead to the eventual development of a healthy adult state. Bernstein et al. (2007) reviewed the original form of Schema therapy (based on the 11 schema modes) and concluded that it could be used with forensic populations without
the need for major changes. They suggested the addition of four new modes (angry protector mode, predator mode, conning and manipulative mode and over-controller mode) which were felt to better capture the emotional states of forensic patients and which were linked to overcompensation for EMS. These additions did not alter the practice of Schema therapy, but rather added to the theory behind it. The article was based on theoretical review and used clinical case study illustrations. As such it did not provide empirical evidence for its claims. Conclusions were still drawn however that Schema therapy was applicable to forensic populations.

Tarrier et al. (2010) conducted a randomised control trial comparing people who received schema therapy in conjunction with treatment as usual (ST) with those who received only treatment as usual (TAU) over a three year period. The results indicted no significant differences in reduction of symptoms between the groups and therefore the authors concluded that schema therapy could not be recommended for forensic settings. The conclusions of this study appear tenuous however as the study was limited in several ways.

One limitation was that the therapists delivering schema therapy did not achieve the evaluation rating required to demonstrate adequate levels of competence. This calls into question the validity of the schema therapy conducted in the study and therefore the generalisability to schema therapy conducted by therapists assessed as competent. Another limitation relates to the sample size. Initially the authors did not complete an a priori power calculation. They claimed that this was because “no expected effect size existed to enable a formal power calculation” (Tarrier et al. (2010) p.7), however it might have been possible to hypothesise a medium effect size and complete a power calculation accordingly. As no power calculation was conducted, the authors chose a sample size based on previous studies. Initially this was 63 participants, 34 in TAU and 29 in ST. Over the course of the study many participants were lost to drop out or transfer to other hospital settings and the analysis was eventually conducted on 49 participants, 24 in TAU and 25 in ST. Complete data appeared to be available for only 20 participants in TAU and a maximum of 15 in ST. As can be seen, it is difficult to ascertain which participant’s received what
treatment in which groups. This leads to confusion that calls into question the validity of the conclusions drawn from the results. Also the group sizes were relatively small and the analysis was likely to have been below the power required to confidently draw conclusions. Possibly compounding the last of these limitations, an intention to treat method was employed, therefore outcomes were analysed according to the randomisation procedure rather than treatment actually received, and therefore this may have affected the results. It is also of note that the authors conclude some significant improvements were found in the ST group and not in the TAU group. These related to impulsivity, regulation of anger, risk of violence and interpersonal style. The ST group also found improvements in all but one of the 15 measured schemas. These findings were discounted as possibly due to chance as multiple post hoc statistical tests were conducted on the outcomes without statistical adjustment being made for repeated testing. An alternative statistical analysis may have resulted in different conclusions.

Finally, the TAU group was found to have received more treatments (excluding schema therapy) than the ST group implying that schema therapy may be more cost-effective than treatment as usual as similar results were found with less intensity of services provided. In summary, due to the methodological difficulties the results of this study should be interpreted with caution. Although these findings found no difference between schema therapy and treatment as usual, they do not appear to be generalisable to other populations and therefore the conclusion that schema therapy cannot be recommended in forensic settings appears questionable.

The literature reviewed above has demonstrated some evidence for the effectiveness of Schema Therapy overall, however when broken down into its component parts, the evidence for these differs in levels of strength. Limited re-parenting might be said to be grounded in attachment theory, cognitive restructuring in Cognitive Theory and behavioural pattern breaking in Behavioural Theory. Experiential techniques however do not have such a well defined evidence base. Despite this, Young et al. (2003) state that “Experiential techniques have two aims (1) to trigger the emotions connected to Early
Maladaptive Schemas and (2) to reparent the patient in order to heal these emotions and partially meet the patients unmet childhood needs. For many of our patients, experiential techniques seem to produce the most profound change.” (p.110). The authors claim that the use of such techniques allows people to understand emotionally as well as intellectually that their schemas are unhelpful.

1.1.3: Extended Background: Imagery
There are several competing theories regarding the mechanisms that underlie experiential techniques and although they are used within many approaches in Clinical Psychology, it is still unclear how they work. Therefore it is felt that further research in this area would be beneficial. This study is concerned with one of the experiential techniques, namely imagery. Schema Therapy theorises that experiential techniques (e.g. imagery) allow the client to re-experience and re-script their childhood experiences (i.e. understand them in a different way), whilst allowing them to reconnect to and process the emotions and the sense of vulnerability that they originally felt at the time of those experiences. Schema Therapy therefore suggests that experiential techniques such as imagery and dialogues work at an emotional level. Such techniques are aimed at facilitating the expression of emotions such as anger and sadness regarding what happened to people when they were children. Crucially, these techniques allow for links to be made between childhood experiences and similar situations in the present which may be triggering maladaptive schemas and schema modes.

Within the area of Schema Therapy, this technique does not currently appear to have been researched specifically. Imagery however has been explored in other areas. Propst (1980) has demonstrated the effectiveness of religious imagery modification for a group of depressed patients. This study however, was based on an American population with specific religious beliefs. It is unclear whether the results would generalise to other cultures with different value systems. In 1995, Smucker, Dancu, Foa, and Niederee considered imagery re-scripting as a new treatment for post traumatic stress disorder (PTSD) for adult survivors of childhood sexual abuse. This study found the treatment model to be consistent with both Schema Theory and information processing models of PTSD. It was
largely based on theoretical discussions around the incorporation of imagery and cognitive re-scripting into Schema Therapy and PTSD models. The authors proposed that the imagery re-scripting process may help to effect change in maladaptive schemas through the ability to provide corrective information related to cognitive associations with the original traumatic event. Similarly, Krakow, et al. (2000) showed imagery rehearsal to be effective in reducing nightmare frequency in sexual assault survivors with PTSD. It is of note that over half the participants did not attend the follow up, so the sample size totalled 78 people (approximately half from the original control and intervention groups). Despite this, numbers remained even in both groups, and the study was a randomised control trial showing significant differences between groups. Further evidence for the effectiveness of imagery techniques can be found in the treatment of industrial accident victims suffering from PTSD (Grunnert, Smucker, Weis & Rusch, 2003). This study showed that imagery based cognitive restructuring was more effective than prolonged exposure (PE; an efficacious behavioural technique) as a treatment in these cases. The authors suggested that this was a result of the addition of an imagery based cognitive restructuring technique to the habituation process of the exposure. They suggested that overall, PE showed high dropout rates, cases of non-improvement and exacerbation of symptoms (perhaps due to employment of avoidance techniques). This study however was based on two detailed case examples and therefore cannot be said to be generalisable to others suffering from PTSD. Holmes, Arntz & Smucker (2007) also reviewed psychotherapeutic techniques related to the use of imagery. These were found to include imaginal exposure, systematic desensitisation, imagery restructuring of traumatic memories, and of fantasy images (i.e. negative images without clear autobiographical memories), and imagery restructuring of underlying schematic beliefs. The review concluded that although there seemed to be a renewed recent interest in these techniques and in the use of imagery within different treatment approaches, this appeared to be based on a clinical belief that there was a direct link between use of imagery and emotional connection on the part of the patient (Holmes et al., 2007). This belief does not appear to be grounded within literature, as there is relatively little research that has examined the
relationship between imagery and emotions, and at the time of the review this was even less.

It is also of note that imagery re-scripting processes have long been used within Cognitive Behavioural Therapy and have recently received renewed interest. This interest appears to centre on the assessment and treatment of intrusive images. A review of imagery re-scripting in Cognitive Behaviour Therapy (Holmes et al., 2007) which looked at treatment techniques and outcomes found support for the effectiveness of imagery replacement (e.g. transforming existing negative mental images into more benign images), across a range of difficulties including Suicidality, Obsessive Compulsive Disorder, Bulimia Nervosa, Social Phobia, Personality Disorder, Trauma, Phobias, Depression, Psychosis, Agoraphobia, Body Dysmorphic Disorder, and Substance Cravings. The evidence for the effectiveness of imagery in many of the disorders mentioned was based on single published articles and therefore the validity of their claims would benefit from strengthening by replication.

Many psychological theories offer suggestions regarding what may underlie the process of imagery. One such explanation comes from the field of Behaviourism. Under this paradigm, current experiences of early trauma may be explained in terms of Mowrer’s two-factor learning theory (Mowrer, 1960). This model suggests classical and operant conditioning may explain the development of trauma in terms of a highly stressful event (i.e. early trauma) eliciting a stress reaction, which occurs in the presence of other neutral stimuli. These neutral stimuli can become paired with the trauma and come to elicit stress reactions themselves (outside of the context of traumatic experiences). The survivor consequently behaves in ways that allow avoidance of such stimuli, and if this results in perceived positive outcomes, such avoidance will be maintained.; typically through negative reinforcement One behavioural technique for breaking such associations is exposure and response prevention, where an individual experiences a feared situation without attempting their usual avoidance techniques. Often such techniques are conducted in vivo, however it has been suggested that use of imagery may serve as a method of distal exposure and response prevention (Vaughan & Tarrier, 1992).
Another explanation for the processes involved in imagery techniques come from the realm of memory and the dual representation model (Brewin, 2001). This model suggests that verbally accessible memory (VAM) is the type of memory that was consciously encoded at the time of trauma and that is subsequently used to describe it. It is claimed that VAM is restricted by reduction of the ability to attend to events due to stress elicited by trauma. VAM may also be cognitively reconstructed after the trauma. The model also suggests that there is another type of memory that operates in parallel to VAM, called situationally accessible memory (SAM). SAM is proposed to contain information that is not available within verbally accessible memory. Such memories may be the result of lower level perceptual processes, perhaps outside the realm of conscious awareness, such as sights or sounds, peri-traumatic emotions or bodily sensations. As such memories are not within the conscious verbal realm, they are difficult to communicate or understand. Within this model, it is suggested that use of imagery may allow access to SAM which can then be transferred to VAM, allowing cognitive restructuring (Brewin, 2001; Brewin, McNally & Taylor, 2004, as cited in Taylor, 2006). In this sense the model suggests that imagery is effective as it bypasses many verbal and cognitive processes (or psychological defences) to access the exact event which resulted in the original trauma.

Gestalt Therapy also holds that imagery is a vital component of the therapeutic process. Edwards (1989) states that “words are powerful tools of thought and communication, but visual imagery has a similar role that is more archaic, powerful, and encompassing” (p.283). He suggests that humans represent the world to themselves in pictures before they have access to verbal communication. He further proposes that as a result imagery has a holistic characteristic that allows it to capture relationships between facts, beliefs and assumptions that are not verbally available. Within the Gestalt approach imagery is believed to be able to show cognitive distortions more clearly than would be able if someone accessed these through conscious cognitive processes.
A further explanation of the processes involved in therapeutic use of imagery can be found within the concept of emotional processing (Meadows & Foa, 1992 as cited in Folette, Ruzek and Abueg, 1998). This suggests that fear is a cognitive structure which aids in the escape of danger. Within emotional processing imagery may be used to evoke the emotion of fear directly by imagined confrontation of the feared event. Following this, cognitive techniques such as challenging and restructuring of thoughts and beliefs around the event can be implemented. Within this model, imagery allows the individual to remember the event without physically re-experiencing it.

The latter position is further supported by the literature surrounding the processes involved in imagery, which explores the belief that there is a specific link between imagery and both the expression and the subjective experience of emotions (Holmes and Mathews, 2005). Within this study participants were assigned to conditions where they either listened to descriptions of unpleasant events and thought about their verbal meaning or imagined those events. It also incorporated a condition where benign and unpleasant images were either described and thought about or imagined. Reports of anxiety were higher in the imagery conditions. Also when participants were asked to rate ambiguous emotional paragraphs (which were conducted pre and post test) these were rated as more emotional (post test) in the imagery conditions than in the verbal description conditions. The unpleasant imagery condition also provoked higher ratings of anxiety than the benign imagery condition. The study is however limited in the conclusions it can draw. It only relates to the emotion of anxiety and does not produce any evidence that this might generalise to other emotions. It also is the first study of its kind and therefore would need to be replicated before its findings could be considered reliable. It is also possible that the emotion rating of ambiguous paragraphs may reflect the mood state of the participant at the time rather than tap into processes involved in imagery.

The findings of Holmes and Mathews (2005) were supported by a later study by Holmes, Mathews, Mackintosh and Dalgleish (2008). In this study participants were shown a series of pictures accompanied by words, each set was designed to have either a negative or benign meaning. Three conditions were applied as
participants were either 1) free to combine the picture and the word in any way they wanted, 2) instructed to combine them using a mental image or 3) instructed to combine them using a descriptive sentence. This study demonstrated that ratings of emotional responses were more intense following the condition where participants were instructed to use images to combine the pairs. Participants in the imagery condition also reported their task as being more similar to memories and as having more sensory associations than those in the description condition. It demonstrated that imagery has a more powerful impact on emotion in both positive and negative directions than verbal reasoning does. As the first section of the study allowed participants to choose how to combine the pictures and words, it is possible that more than one strategy (relating to either imagery or verbal descriptions) were used and therefore the results may have been confounded. Also, as a correlational methodology was used it was not possible to suggest causal links between use of imagery and emotion. It is also of note that the descriptions of imagery used and the ratings of emotions were based on self report and therefore may have been subjective and idiosyncratic. It was also unclear whether the results generated beyond general positive emotion and anxiety, or indeed whether they represented a general emotional state of arousal. Finally, the study also found that there was a correlation between the use of personal memories and intensity of rated emotions where imagery was used (but not where verbal description was used). Although the authors considered this to be a limitation of the study as it represented a confounding variable, it is relevant to the current study, as it suggests intensity of emotion may be higher where imagery for personal memories is used (as within Schema Therapy), however the evidence for this is minimal.

2: Extended Methodology
2.1.1: Aims and research focus of the study.
The aim of this study was to explore experiences of the imagery component of Schema Therapy (Young, 1990, 1999) in people diagnosed with personality disorders, who had offended. This was undertaken by conducting semi-structured interviews which were facilitated by an interview schedule informed by theories underpinning Schema Therapy (Young, 1990, 1999) and the
method of analysis; Interpretative Phenomenological Analysis (IPA; Smith, Jarman & Osborn, 1999) with people who had used imagery techniques as part of Schema Therapy.

As the study employed the methodology of IPA (and the epistemological position of this claims that an objective truth cannot be discovered, therefore understanding of experiences should be derived from collected data) there were no explicit hypotheses prior to analysis. Instead, the study was an exploration of what the experience of using imagery techniques in Schema Therapy was like for participants, how each individual made sense of their experience, and how the researcher made sense of participants’ accounts of their experience.

2.1.2: Participants

All potential participants had received Schema Therapy from one of seven therapists trained by Dr. Jeffrey Young and/or Dr. Kerry Beckley. It was felt that the consistency of training should ensure equivalence in the delivery of Schema Therapy, although this would not mean that all participants’ experiences would be the same. Regarding sample size for IPA, Smith and Osborn (2003) have stated “In the recent past, five or six has sometimes been recommended as a reasonable sample size for a student project using IPA” (p.56).

Participants were excluded from the study if they were unable to speak fluently in English. This was done because IPA involves analysis of spoken English to access participants’ experiences (requiring a relatively high level of fluency) and use of interpreters would not be feasible within the restraints of the study’s timeframe and funding. Lack of fluency in English is also an exclusion criterion for Personality Disorder services at Rampton.

2.1.3: Materials

Demographic information relating to the participants was not collected as this was not required for the research.

The semi-structured interview was developed by focusing on the methodological concepts of sense-making, temporality, perception, intentionality
(i.e. the relationship between consciousness and the thing consciousness is directed toward), and reflection. These were combined with the researcher’s understandings of anecdotally reported effects of imagery work, from the clinical research supervisor (who has worked using this technique), to generate the discussion points. These were designed to generate a combination of descriptive and analytical responses, as recommended by Smith, Flowers and Larkin (2009). The first and last points (an open-ended invitation to talk and an open-ended closure respectively) were the only ones that were systematically asked. The clinical research supervisor for the study, a clinician who was qualified and experienced in working using Schema Therapy was consulted during the development of the interview schedule to ensure discussion points were consistent with the therapy’s theoretical underpinnings and therefore would tap into participants’ experiences.

The interview schedule was made up of 16 points. This was a relatively large number for an IPA study, but was generated based on fore-conceptions that this population may experience difficulties in engaging due to their schemas. The other points were used as prompts when required by participants. This was in order to attempt to facilitate a comfortable interaction during the interview. The discussion points explored participants’ understanding of the term ‘imagery work’ and their experiences of using this. They asked about changes in thoughts, feelings, bodily sensations and memories during imagery, how they made sense of this and whether this had changed over time. The interview points also invited comparisons between imagery and other techniques used in Schema Therapy and between the usefulness of imagery within and outside of therapy sessions. They further asked participants to explore their perceptions of the ‘best’ and ‘hardest’ parts of using imagery as well as considering the impact of the therapeutic relationship on imagery work. Finally the discussion points encouraged reflection of self awareness as a result of imagery work and of any impact that using imagery had, holistically on their lives.

The interview schedule was not piloted for two main reasons. Firstly, the epistemological underpinnings of IPA suggest that the interview is a narrative construction where the researcher is making sense of the participant making
sense of their experience (the double hermeneutic) and therefore piloting could not inform future interviews as each will be a unique interaction. Secondly, IPA has an ideographic focus which proposes that although people may share common experiences, their perceptions and understandings of these will be different (as each person creates their own reality), and that each construction is equally valid, so once again piloting the interview schedule would not add to the methodology as this should only be informed by the individual interview as it is occurring. These key emphases within IPA suggest that the concept of reliability (as it is applied to quantitative research methodologies) cannot be appropriately applied to a qualitative IPA methodology. Instead, the concept of validity (specifically applied to qualitative methodology) may be a more useful way to ascertain the quality of the research. Such ideas (particularly for a critical realist epistemological position) are supported by an article examining objectivity and reliability in qualitative analysis (Madill, Jordan & Shirley, 2000).

2.1.4: Apparatus and Transcription

2.1.4.1: Apparatus

Interviews were recorded on Olympus DS-30 digital stereo voice recorders, which allow 67 hours of recording. This was used in conjunction with Olympus AS-2300 PC transcription kit, which included footswitch (RS27), stereo headset (E102), DSS player and transcription software.

2.1.4.1: Transcription

Within IPA, the analysis begins at the stage of interview (for introduction to the methodology see extended methodology), however becomes more formalized during transcription. Interviews were transcribed (and line numbered) verbatim from the audio recordings by the researcher and also by a member of the administrative staff where interviews were conducted. An informal coding scheme was employed. This involved non-verbal utterances and behaviour (e.g. pauses, laughter etc.) being included in the transcript as bracketed notes. During transcription pseudonyms were assigned to participants, which were matched to numerical codes corresponding to consent forms. Identifiable material was removed at this point so transcripts were anonymised.
2.1.5: Reliability in the methodology: Audit

A virtual audit trail was used (i.e. all data was stored in such a way that the path from initiation of the study to final report could be followed). Audit was also used to check notes and emergent themes in terms of their relationship to the data. This was done by passing the anonymised, annotated transcripts and theme lists to the clinical and academic research supervisors (who have knowledge of IPA and therefore understand the process and their role within it). Differences relating to interpretation were discussed, however as the double hermeneutic process is central to the methodology, the researcher's interpretation was prioritised. The role of such discussions was to ensure the interpretation was tied to the data rather than to influence the researcher's interpretation. It is important to note that this type of audit did not confer inter-rater reliability, as IPA does not aim to uncover a universally true account, but rather to provide one of many credible accounts.

2.1.6: Validity in the Analysis

The criterion of 'sensitivity to context' was met in several ways. The researcher ensured they were immersed in the data and that analyses had a strong grounding in the transcripts demonstrated by support for the proposed themes from a large number of quotes. The latter allowed the reader to check the interpretations that were made and understand how the researcher made these interpretations. A thorough, in-depth IPA analysis of all the recommended levels (especially ideographic engagement and interpretation) added to the demonstrated rigor and coherence of the study. Another measure of validity can be said to be demonstrated by the interest and usefulness of the results of the analysis.

2.1.7: Procedure

The information sheet and consent form both stated that participants were free to withdraw from the study at any time and that this would not in any way affect their treatment. The forms also stated that all information gathered would be treated anonymously. These points were verbally reiterated by the researcher prior to the start of the interviews. It was also explained that the researcher was independent to the clinical team within the directorate and that although the
interviews were being recorded these would be kept confidential and no-one outside the research team would have access to them. It was further explained that the research was being conducted to inform future use of Schema Therapy and therefore expressions of satisfaction and dissatisfaction with the technique in question would be equally informative. The latter was expressed to attempt to minimise the possibility of participants avoiding expressing dissatisfaction due to the location of the interviews.

2.1.8: Ethical Approval

To conduct the research an honorary contract with the High Secure Hospital was issued (following completion of all appropriate security checks) from their Human Resources department.

The main ethical considerations within this study involved capacity to consent and assessment of this, and potential burdens to clients around discussing sensitive issues and confidentiality. The first of these issues was addressed via use of exclusion criteria, so only people deemed (by their Responsible Clinicians) to have capacity to consent to participate in the study were invited to participate. This was felt to be appropriate as the research does not offer new therapeutic results, but instead explores therapy that has already been undertaken.

Regarding the second ethical issue, it was possible that discussing sensitive material (e.g. previous experiences of therapy) could prove distressing for participants. This was addressed by informing participants (prior to interviews) of the topic of the study, allowing them to choose how much they disclosed during the interview, and providing the right to withdraw from the study at any time without their treatment being affected. Also the researcher had received training as part of her doctoral course of study into the containment and management of distress and could therefore immediately help to manage any displayed distress. Further support was available from the participants’ clinical teams following the interview.

The final ethical consideration was that of confidentiality. Management of this involved ensuring that only the researcher and participant were present in the
room during the interviews, and that following transcription recordings were erased. Additionally raw data (i.e. verbatim transcripts and demographic information) were stored in a secure location within the Personality Disorder Directorate of Rampton High Secure Hospital (with personally identifiable data kept separately from research data). Numerical codes were assigned to link the consent forms to the anonymised data. Within the transcripts, pseudonyms were used for participants and identifiable information (e.g. other names, addresses, dates etc) was either excluded or disguised to preserve anonymity. The research findings were discussed with participants prior to dissemination of the findings, which provided an additional opportunity to ensure that confidentiality was preserved.

2.2: Analysis
2.2.1: Introduction to the Methodology
IPA employs a double hermeneutic, that is, “the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world” (Smith & Osborn, 2003, p.53). Smith and Osborn (2003) also claim that IPA has links with symbolic interactionism, as it refers to meanings ascribed to events. Smith and Osborn (2003) state “it attempts to explore personal experience and is concerned with an individual’s personal perception or account of an object or event, as opposed to an attempt to produce an objective statement of the object or event itself” (p.53). The process is dynamic as the researcher has an active role in creating the narrative. It is also felt to be allied to a cognitive paradigm as it assumes links between people’s narratives, thoughts and feelings. This was felt to be especially applicable to the study of an experience within Schema Therapy, as this also makes use of cognitive concepts. IPA identifies super-ordinate and subordinate themes in a data-driven, hypothesis free approach, and has an analytic, reflexive focus. The procedure of analysis involves moving from single interviews to shared constructs and from descriptive accounts to interpretations using an iterative, inductive approach. The conclusions of the analysis are “an account of how the analyst thinks the participant is thinking” (Smith et al., 2009, p.80).
2.2.2: Validity

Within the analysis, validity was assessed using the criteria mentioned above (Yardley, 2000). Grounding the analysis in transcript data and supporting themes with quotes, conducting a thorough analysis and the final usefulness of the study allowed a platform to assess sensitivity to context, rigor, coherence and impact and importance (respectively). Use of a virtual audit trail and internal audit were also undertaken to add to the reliability and validity of the study. It is of note however that IPA does not claim to uncover an objective truth but rather one of many possible credible accounts.

2.3: Epistemological Position

2.3.1: Phenomenology

Edmund Husserl developed the concept of Phenomenology and was initially interested in how people came to make sense of their own experiences (Zahavi, 2003). Husserl conceptualised knowledge as having two distinct parts, the material of knowledge and the concept of knowing, the latter of which he considered to be the real world, subjective experience. He also used the term ‘intentionality’ to explain that recall of all experiences were directed towards an event, and were therefore relational in nature. His interest was in the meaning that people gave to events and the abstract experience of this. He proposed that the most important factor in experience was the meaning ascribed to it (as opposed to the actual events or the internal mental constructs attributed to it), and that our interpretation of events causes them to become part of our experience. Within this stance, Husserl (1927) proposed that phenomenology is descriptive and cannot uncover universal truth, yet despite this, he believed it could be scientifically studied through a process of disclosure, identifying themes and clarification of ideas relating to philosophical questions around being and reality. He added a caveat to this however. He suggested that although some experiences are ‘public’ (i.e. that they exist for others as well as for the individual) the meaning of these is subjectively created, but understanding the key elements of these, could allow the experiences to ‘transcend’ the events so others could identify with them. Despite this, he asserted we cannot truly understand even a shared public experience in exactly the same way as another, therefore, he proposed an interpretative, reflective
component was necessary to understand the meaning attributed to lived experiences of others (Husserl, 1927). Thus (according to phenomenology) meaning is constructed by exploring the individual’s relationships with and reactions to events.

Following on from Husserl’s ideas, Martin Heidegger agreed with Husserl’s assertion that experience was relational, however he attempted to expand this point by considering what it is to be human. In this exploration he included thoughts about perspective, time and language (Mulhall, 1996). Keller (1999) compared the works of Husserl and Heidegger and claimed that Heidegger attempted to break down the philosophical divide between the internal and external worlds. He claimed Heidegger thought Husserl’s view of phenomenology was too abstract, and an exact understanding of another’s experience was not possible. Heidegger’s stance appeared to focus on the way that people made sense of their experiences (the significance they attribute to it). Keller (1999) also claimed Heidegger differed from Husserl in that he was less interested in the individual processes of experience and more in the nature of existence as an embodied and relational state between people and therefore the context people exist in. Heidegger emphasised the importance of the interaction between the individual and their immersion in existence of relationships, language and their perspective on these experiences which linked to emotional states, how social they are and the ability to self-reflect (Keller, 1999). Heidegger’s ideas also lead to the notion that it is not the experience itself but the interpretation of it that is available to others.

Heidegger’s ideas of experiences as being lived in relation to others and understood through our own individual points of view were taken forward by other philosophers such as Merleau-Ponty and Satre (Smith et al., 2009). Merleau-Ponty’s ideas focused on the idea that we experience things through our bodies and therefore cannot be objective about the experience. This view expands to the idea that no two people will experience the same event in the same way as all experience is filtered through the human body and the subjective understandings and interpretations of these (Marshall, 2008). Satre also took these ideas forward, however his emphasis was on consciousness of
the self and our ability to intentionally act to understand our experiences. He proposed that we actively attempted to make sense of our experiences and that these are shaped by other things (or people) that are either present or notably absent from the experience (Smith et al., 2009). Sartre’s idea may link into the notion that also, when we describe our experiences it is not only how we described this to others that is important but also what we leave out.

2.3.2: Hermeneutics

As mentioned earlier Heidegger stressed the importance of the individual’s interpretation of their experiences and the study of interpretation is the underpinning of hermeneutics. Indeed, he originally called his early work on phenomenology the ‘hermeneutics of facticity’ (Sembera, 2007) to emphasise his focus on providing an interpretative description of lived experiences. Sembera (2007) claims Heidegger took the term ‘hermeneutic’ from the work of Schleiermacher and applied it to phenomenology as originally proposed by Husserl. For Heidegger, this meant people’s experiences could be studied at a more practical, less abstract level. His work emphasised the importance of hermeneutics as he proposed that we may unconsciously make sense of our relational interactions with things or events, but as this act is not one we are aware of, that these meanings may not be immediately accessible to us without our conscious reflection upon them (Sembera, 2007). He also argued that we ‘understand’ in terms of the referents we use from knowledge in a wider context (i.e. that we use “systems of reference” Sembera, 2007, p.37). Heidegger suggested that this wider context (that we may not be aware of) always shapes our understandings and therefore our previous experiences may lead to assumptions or biases that could influence our understanding of the experience in question. He hypothesised that in the act of understanding we need to attempt to make ourselves aware of these assumptions or biases to be able to scientifically study the experience in terms of the actual event. He did acknowledge however that sometimes we may not be aware of our assumptions before the event, so it may be helpful to use the event to reflect on previous experiences and consider how these may have shaped our preconceived ideas. From this it is possible to conclude that Heidegger
considered the study of lived experiences to be fundamentally an interpretative approach.

Ideas around hermeneutics were also considered by Gadamer, who agreed with Heidegger’s proposal that there was a complex interpretative dynamic involved in assigning meaning to events (Dostal, 2002). He philosophised that an event may influence the interpretation of it, however the interpretation could influence (and be influenced by) preconceived assumptions. Gadamer conceptualised understanding as a combination of three things, cognitive processes, the practical act and also as an agreement between two people. The latter implied that to understand another’s account we do not just disinterestedly construct their words, but rather we share an understanding of the topic (in that we know what is being discussed) based on our previous knowledge and experiences. He went on to suggest that initially we only understand what is being said, but following this we can come to understand the meaning that the speaker has placed upon their experience (Dostal, 2002).

These ideas support the idea of the existence of a hermeneutic circle. This construct has been proposed by many hermeneutic philosophers (Smith et al., 2009). It suggests that to understand the whole, we must look to the parts; however the parts cannot be understood without the context of the whole. Although circular in its argument, this idea suggests repeated analysis of text from different perspectives without allowing the reader’s preconceived assumptions to bias the interpretation.

2.3.4: Critical Realism

It is my belief that critical realism accepts that the reality of experiences of imagery will be different for each individual and these experiences have been mitigated and constructed via cognitive processes in an attempt to create their meaning. Therefore in this study themes inherent within the individuals’ meaning making were explored from a critical realist perspective.

It was also the aim of this study to examine the interaction that occurs between the interviewer and the participant in the context of each interview and how the
The responses of participants were examined within the context of their experiences from an individual (ideographic) focus, treating each person’s responses as equally valid information. This was an exploration of a seemingly common experience of individuals; however within this the concept of true homogeneity was rejected. This concept was rejected because it was my belief that experiences would be different for each participant, as each person creates their own reality and each is equally valid. Therefore this study was not an attempt to find commonality, but rather to explore the richness of lived experiences related to using imagery. It also attempted to analyse the language that participants used to explain their experiences, within the context of language being used to construct the individual’s perception of their reality.

The epistemological and methodological framework employed by this study may be criticised in different ways. A critique of the methodology might suggest that whilst IPA allows an in-depth, thematic exploration of subjective, lived experiences from the expert perspective of individuals who have had them, it has many limitations. These may include a focus on the individual’s perceptions of their experiences without analytic follow-up questioning why their perceptions were made, a subjective bias in the data, and a lack of generalisability of the findings to a wider population. These criticisms could be addressed by applying another qualitative methodology to the study (i.e. discourse analysis, grounded theory or thematic analysis). Use of these however would come with different
criticisms. Using discourse analysis would place more emphasis on the language used to describe and construct the event and would interpret the meaning attributed to the lived experience itself through this, whereas IPA focuses on the analyst’s interpretation of the participants’ accounts of lived experience with language use as a less predominant focus. Discourse analysis may also fit better with a social constructionist epistemological position. Use of grounded theory would allow for an analysis of the event (from a similar epistemological position), and recently has altered to explicitly acknowledge the interpretative element of the researcher’s contribution. Grounded theory holds that findings are generalisable via the emergent theory; however this is from a small sample size and therefore comes with its own limitations. Similarly thematic analysis would allow a detailed, thematic analysis of the event, and could even allow interpretation from the researcher’s perspective to be included, however it does not have an explicit focus on phenomenology and therefore the analysis could be drawn away from the participant’s experience. It was felt that in order to fully answer the question of interest in this study (what are forensic service user’s experiences of the imagery technique within Schema Therapy?) use of IPA was most appropriate as it encompassed ideography, phenomenology and hermeneutics and actively acknowledged the researcher’s role in constructing the understanding of the experience.

3: Extended Results

3.1: Early Emergent Themes

At the first stage of analysis, multiple emergent themes were identified from the data. When numerated and contextualized this yielded the list below (NB: each theme was comprised of several smaller themes referenced within the text):

- Temporality
- Relationships
- Emotions
- Sense of Self
- Morality
- Process of Therapy
- Cognitions
When the function of language, narrative and response was considered these themes changed. Some of the smaller themes within then gained relative importance via subsumption and six super-ordinate themes were identified. When the concept of polarization was included into the analysis the themes changed again to the ones reported in the article. The initial themes however were:

- The Image Itself
- Therapeutic Processes
- Reintegration of Multiple Selves
- Equality with Others
- Imagery as a Catalyst for Growth
- Emotional Pain

The first of these themes reflected description of revisiting the trauma as somehow special. The quote below from Eoghan\(^\text{18}\) highlights this:

> You’re actually feeling like the real emotion of it and the real depth of the pain or hurt or sadness and, and it’s dealing with that, that’s what makes you want to carry on with it, it makes you quite strong actually, you know like, it gives you a bit of strength about things that have happened in the past. But it, it can be a little bit frightening at first, you know it can be a little bit frightening and daunting because you’re, you’re looking at things and dealing with things that you’ve suppressed for so long.

Eoghan’s use of language in this passage was interpreted to demonstrate his attempts to convey the importance and unusual nature of this experience. He uses terms like “you’re actually feeling like the emotion of it”, “the real depth of the pain”, “makes you quite strong actually”. Also Eoghan goes from talking about emotional pain to relating how addressing this strengthens him and then returns to talking about emotions. This was interpreted as an attempt to relay how important the act of engaging with the image is, how revisiting this causes

\(^{18}\) Pseudonyms have been assigned to participants to preserve their confidentiality and anonymity.
extreme emotional pain because it involves returning to a fundamental moment in time and therefore becomes an elemental experience.

Aadil also highlights the fundamental nature of this experience in the following quote:

You’ve got to close your eyes and you’ve got to concentrate on what you’re thinking about and then you just. You don’t have to think, you know what I mean, you’re just there. Er, you it’s just weird you know, you can smell stuff, you know what I mean, you can taste stuff, er, it’s, er it’s, it’s weird, it’s like, it’s horrible, like you’ve had some kind of drug, designed to take you back there, it’s weird. Er, like being in total recall.

Aadil was also interpreted to use language to strengthen his account of experiencing the image. He used terms like “like you’ve had some kind of drug, designed to take you back there”, “it’s weird” and “like being in total recall”. Aadil’s account seems to speak of an altered sense of reality, as captured by his analogy to taking a drug, which implies altered perceptions, a sense of unreality and a loss of control. This seems to be in line with Aadil’s use of the word ‘weird’, as this word has synonyms such as bizarre, odd, peculiar, uncanny, eerie and creepy. Through use of this word Aadil manages to convey a sense of horror and strangeness as being associated with the experience. This connects to Eoghan’s account above as it also marks out the experience as special. This appears to be conveyed again in the use of the term ‘total recall’, as this suggests a complete and encompassing memory, again highlighting the special nature of the experience, although in Aadil’s case this is not in such a positive way as Eoghan recounts it.

The theme of therapeutic processes was represented in references to understanding of the self growing over time, connection with the emotional pain, the therapist as providing what was needed and putting learning into practice. After consideration however, these were felt to represent different things and not form one over-arching theme. Three of these formed parts of three later themes. Connection with the emotional pain was found to have two parts. One was felt to relate to connection, and this was later abstracted to form part of the
subtheme of reconnecting with the childhood self in opening the suitcase or revisiting the trauma. The second part was felt to relate to emotional pain, which was later believed to penetrate all other themes and therefore was subsumed to become a major penetrating theme. The idea of the therapist providing what is needed was abstracted into a subordinate theme of unpacking and ordering the contents of the suitcase or the therapeutic process. This was believed to fit better with the importance of developing trust, and losing control as facilitating interpersonal connectedness. Similarly the theme of putting learning into practice was abstracted to become a subordinate theme of repacking and closing the suitcase or therapeutic outcomes, as this was interpreted to reflect a sense of accomplishment and to describe beneficial results of undertaking imagery.

Reintegration of multiple selves was originally felt to encompass ideas of fractured personality, moving on versus stagnating, emotional distance and coping. After reflection this theme was abandoned as it was not interpreted to form a coherent holistic concept. The ideas of fractured personality, moving on versus stagnating and emotional distancing were abstracted into different super-ordinate themes. As mentioned earlier, emotional pain had been incorporated into a penetrating theme. Adding to this, the notion of distancing was also moved into that penetrating theme, as it was interpreted to add a depth to the theme relating to the ability to vacillate between closeness and detachment. The idea of reintegrating the fractured self was adapted into the subordinate theme of healing the fractured self which was incorporated into the super-ordinate theme of repacking and closing the case or therapeutic outcomes. This was done as it was interpreted that healing the fractured self reflected a positive outcome of undertaking imagery work. The idea of moving on versus stagnating was also kept under the subordinate theme of moving on versus being stuck in the past. It was interpreted that this theme had the function of conveying part of the process of therapy and as such it was incorporated into the super-ordinate theme of unpacking and ordering the contents of the suitcase.

The idea of equality evolved from quotes such as the one by Daniel\textsuperscript{1} below:
I’ve had the help and the support from the people that matter and got me to where I am now (pause). And that’s it for me. I don’t wanna look back. I want to take things on head on. I will move on from my mum and I will move on from my dad, and the experiences I had with them. And I can live the rest of my life thinking yeah, I aren’t doing that. Certain somebody [my therapist] that was there for me and got me through all my whatever and I hope good things happen to them and I hope they get what they want in their life, same as they want me to get the things that I want in my life.

This quote was initially interpreted to reflect a development of an equal relationship between client and therapist as Daniel spoke about progress in his life as a result of therapy and linked this to moving on from childhood experiences. After this statement he began talking about his therapist and how they had been there for him and seemed to be conveying a need to repay this nurturance. This was interpreted as representing a shift in his interpersonal behaviour from being a passive recipient of care to providing care to others. It was further interpreted that this reflected a sense of equality with others. Eventually however equality as a theme was rejected as it did not seem to holistically represent a super-ordinate concept within the interviews.

The theme of imagery as a catalyst for growth originally developed around ideas linked to therapeutic processes as these were described throughout the interviews. This theme encapsulated ideas of reliving events, emotional responses, moving from isolation to connectedness in interpersonal relationships and a need to repay nurturance. This theme was eventually abandoned as the concepts within it were believed to fit better into other themes. Reliving was discarded in favour of the term revisiting, and emotional responses were interpreted to represent pain and so was abstracted into that theme. Moving from isolation to connectedness was kept as a subordinate theme and was contextualised as being part of unpacking and ordering the contents of the suitcase or the process of therapy, and the need to repay nurturance was not considered to be prominent enough to remain in the analysis.
The final theme of emotional pain was kept. As has been discussed earlier this theme was changed to include ideas of distancing as protection. This was believed to be a penetrating theme within the data, as it was found in all themes. This theme remained in the analysis, and although the name changed, can be found in the article.

After consideration, the concept of temporality was found to saturate every other theme as reference to a life journey. In conjunction with reflection on fore-conceptions regarding patients in secure forensic settings and re-reading of the reflective journal the temporal life journey was believed to be an overarching theme of all the other themes. This was interpreted to be a reflection of the way the passage of time differs when people are detained for treatment without specification of time. It was believed to represent the temporal course relating to the development of personality disorders, as these are triggered in childhood but develop and evolve over the life course of the individual. This theme was included in the final article.

3.2: Additional Emergent Themes

3.2.1: Professional language

Conner’s use of professional language in relaying the schema therapy terms ‘angry child’, ‘vulnerable adult’ and ‘angry adult’ was interpreted as an attempt to place himself on an equal footing with the first author. This in part incorporates a fore-conception that participant’s own schemas might influence their interviews. For example Conner’s apparent attempt to speak to the first author in psychological language (what he might understand as her language) could reflect a defectiveness schema. The use of professional language might also highlight a potential bias within the interview procedure. It is possible that as a result of the first author being a trainee clinical psychologist asking questions about a psychological therapy Conner might have felt the need to respond positively about this. Also as interviews were conducted in a high secure hospital where this therapy was used Conner may also have wanted to present the therapy as positive as this reflected back on him in a positive light. This interpretation however may just reflect the first author’s fore-conceptions,
as participant’s desire to present themselves in a positive light was identified as one of these.

Despite this possibility use of professional language was found to pervade transcripts. The quote below from Brynn\(^1\) demonstrates this:

> And schema’s not difficult you know, once, once you break it down it’s a doddle, it’s almost like common sense, you know, but you never thought about it before and like, like it gives it name, it gives it a label, it explains what it is and what it’s function is, so then you understand, it’s like well ok fair enough, I understand that bit and that’s mistrust/abuse, yeah, punitive, defectiveness, shame, vulnerable child whatever, and it makes, makes, makes it all, and making sense of it all so much easier.

This passage is littered with terms from schema therapy. Brynn uses the words ‘mistrust/abuse’, ‘punitive’, ‘defectiveness’, ‘vulnerable child’. This was interpreted to reflect a desire on his part to demonstrate his knowledge and to place himself on an equal footing with the interviewer, and therefore in the same way as Conner’s account was above. The above interpretation was made by the first author as a result of the use of language combined with the postures, gestures and body language of the participants during these passages. Both Conner and Brynn appeared more animated and gesticulated more during times when they used this language and seemed to the first author to be more confident in speaking. This was combined with multiple uses of the phrase “do you know what I mean?” which the first author interpreted as a search for understanding on the part of Conner and Brynn. In conjunction these things led the first author to interpret the use of professional language as an attempt to convey equality rather than purely assuming that Conner and Brynn were using the language that they had learnt as a way of communicating their difficulties in terms of schema modes.

### 3.2.2 Avoidance

This seemed to be evident throughout the interviews. Finn\(^1\)’s quote shows this:

> But, when you’re doing it one to one it’s, they’ll put, psychologists and that, they’ll put you in that, in wherever it is and they might ask you a question and I don’t know what questions are coming or, or a question I
might ask or come what the answer going to be, it’s, (long pause). I’m trying not to keep on going back there.

It was interpreted that Finn final sentence ‘I’m trying not to keep on going back there’ had two meanings. First he might have been attempting to convey that a process of revisiting was occurring because he was discussing his experience of imagery. Assuming that this interpretation is accurate then Finn’s motivations for explaining this might also have been twofold. He might have been attempting to convey that he did not want to re-experience his earlier imagery experience as he wanted to focus on the interview. Alternatively, Finn may have been explaining that he was re-experiencing his imagery in an attempt to avoid conducting the interview. This might have been the case if he felt uncomfortable talking about the subject, or speaking with someone he didn’t know. The second interpretation of Finn’s words could be around conveying a desire to cease the imagery work as a result of the painful emotional consequences that he felt as a result of undertaking the imagery work.

Avoidance can also be noticed in the following quotes from Aadil:

I know psychologists have tried to get onto it [imagery] and I change the subject onto something else you know what I mean? I just don’t like it. I don’t like it.

I don’t know that much about it [imagery]. I really don’t. I do a little bit with [therapist 1] and I’ve done a little bit with [therapist 2] and like I said, I, I’ll do anything to get out of doing it, I don’t like it. It’s just spoils your day it just sends you on a downer and makes you depressed. Err, you feel ill and not something I like to bear.

It was interpreted that Aadil was trying to convey the difficulty that he found in engaging with traumatic events from his past. Initially Aadil states that he doesn’t like imagery, however he avoids specifying what he dislikes about it. In his second paragraph he explains the consequences that he experiences when he engages in imagery. He describes physical and mood related consequences of feeling depressed and ill. This may be interpreted as somatising his
emotional pain from his past into the present. It appears that Aadil’s avoidance of imagery work is actually a form of self protection. By avoiding engaging in the work, he is in fact protecting himself from and avoiding his emotional pain.

It was also interpreted that avoidance was present in the transcripts in another form, which cannot be demonstrated by quotes. Interviews were conducted in a High Secure Hospital setting however there were surprisingly few references to either the setting or the offences that were linked to the schemas people held. Avoidance appeared to be present in what people did not say. An example of this was found in interviews where participants initially seemed resisted to discussing the therapeutic relationship and instead appeared to over-emphasise their own self-reliance. This may have been a protective strategy, as many participants reported finding it difficult to trust others and initially believed that the only person they could rely on in life was themselves. This is exemplified in the following quote from Daniel:

Oh but they [my parents] left me, so why won’t you? These were the two people who brought you into the world; they’re supposed to look after you. So if they can do it, ain’t nothing to stop any other person from coming along and doing whatever is there?

4: Extended discussion
4.1: Critique and Limitations
This study was potentially limited by lack of piloting the interview schedule. The decision not to undertake this, however, was made in order to complement the epistemological underpinnings of IPA and respect the ideographic and hermeneutic nature of interviews. Despite this point however, piloting the interview schedule however would have ensured the questions made sense to someone who had experienced imagery and might have helped identify points at which use of specific prompts would have been beneficial. This could have allowed for a more structured and equitable experience across interviews.

Although issues of reliability within the study were addressed through the use of audit, it is of note that analysis was largely interpretative and therefore if analysis of the data had been conducted by another person, there is a likelihood
that different emergent themes may have been identified, and different interpretations drawn. This is not necessarily a limitation of the study as the epistemological position that the study is based on does not accept the concept of a single quantifiable truth, but rather emphasis the existence of multiple, equally valid truths. The element of limitation occurs in the extent that the results, as they reflect one of a potentially infinite number of truths, are applicable to a wider population. The choice of a qualitative, interpretative methodology allows for a rich analysis of the lived experience of a small number of people who share a specific culture and/or experience. Although this information is valuable as a first step in generating a body of knowledge pertaining to the lived experience of interest, it must be remembered that the findings of this study represent only the starting point of knowledge. Future research might build upon this and test the findings but until this is completed, the results represent only suggestions for experiences that people in a similar position to those in the study might have when they experience the technique of imagery in schema therapy.

The emphasis in the study on interpretation and the double hermeneutic might also impact on issues of validity as in qualitative studies this is related to emersion in the data and although closely tied to the data, the hermeneutic, interpretative element of the study takes analysis one step removed from the original account. In terms of Yardley’s (2000) criteria for validity in qualitative studies, this study was sensitive to context and rigorous. Context was an underpinning value throughout the study. This was demonstrated by the understanding of the setting from which participants would be drawn and the technique which participants had engaged in. It was also attempted to ensure sensitivity to context through a strong grounding in the data, which has been exemplified in this study by the use of quotes, which allow the reader to follow the interpretations of the data and draw their own conclusions. Rigor was attempted by selecting a group of people who had had equivalent experiences in that they had all undertaken the same psychotherapeutic technique within the same setting, however this did not convey homogeneity as no two people will experience the same thing in the same way. Rigor was further attempted by conducting an in-depth IPA according to the suggested guidelines for
completing this type of analysis. This helped to demonstrate the consistency within the study. Other criteria were harder to demonstrate however. Commitment is generally demonstrated by adherence to the methodology and loyalty to the interview data. It could be argued that the points raised regarding sensitivity to context also provide evidence for commitment, however I feel that this concept is a more difficult one to demonstrate within a study, and therefore this may limit the degree to which validity can be claimed. Transparency is another difficult concept to show. It has been suggested that use of audit trail and a reflective diary lend strength to this concept; however these can only be explicitly demonstrated to a certain extent due to the confidential nature of the study data. Whilst some evidence may be given, and indeed has been within this study, to demonstrate the existence of these, the whole process cannot be conveyed. Therefore, with special reference to the criteria of commitment and transparency as difficult to communicate, I feel it is reasonable to state that validity is a complicated notion to express in an IPA study and this might potentially limit the applicability of the findings to a wider audience.

4.2: Critical Reflection
As has been discussed earlier the epistemological underpinnings of this study relate closely to the method of analysis, IPA. These include phenomenology, hermeneutics, and ideography. The philosophy of science applied to the research was critical realism. The key idea taken from this was that although some external objects might communicate a shared understanding in people, that experiences by their nature create feelings and ambiance that will be different for different people. In this study this philosophy was applied to incorporate not only the phenomenological element applied to participants’ accounts but also the hermeneutic stance around interpretation. This meant that there was an explicit acknowledgement that around any experience there would be multiple versions of the truth of that experience that have been mitigated and constructed in accordance with the individual’s prior experiences and beliefs. This philosophical position also allows an acceptance that all versions of the truth are equally applicable. In reference to the hermeneutic element, critical realism allows for the explicit acknowledgement that in the process of attempting to understand the account of another person, the researcher will
interpret the meaning that they convey through their own phenomenological lens. That is, the researcher’s understanding of the way the individual makes sense of their experience will also be cognitively mitigated and constructed. In the researcher’s case, this might also be on the basis of personal experiences; however it may also incorporate prior knowledge of the experience in terms of theoretical understanding. This has implications regarding Yardley’s (2000) criteria for assessing validity in qualitative studies as one criterion is sensitivity to context. To demonstrate this, a thorough understanding of the setting that people had their experience in (high secure hospital), as well as a theoretical understanding of the basis of the experience (the technique of imagery) was necessary, however this ensured that the researcher had more foreconceptions (beliefs based on previous life experience and knowledge) related to the study. Although these could be acknowledged and bracketed out, total objectivity is not possible. Therefore, the end result of analysis was a co-constructed creation between the participant and the researcher. In order to appropriately convey the influence of the researcher’s fore-conceptions on the analysis, these will now be discussed with reference made to excerpts from the researcher’s reflective diary.

At the project design stage I attempted to note down the assumptions that I had about asking people in a forensic setting about their experiences of imagery. I questioned my beliefs about the responses that I might get and the possible motivations behind these. In doing this I tried to consider the impact that being in a high secure setting could have on the way people spoke about their experiences. The selection from the reflective diary below reflects my thoughts about these issues:

Having worked in forensic mental health services before training, I find myself wondering whether my experiences there have shaped my views about people in these settings. I remember that in forensic services people’s main motivation was to get out of hospital. People often told staff what they thought they wanted to hear. They seemed to be trying to present themselves in the most positive light possible. This didn’t mean that they only said good things about themselves, but rather that they often seemed to overstate the progress they had made. This seemed
understandable to me. Hospitals are not places that most people want to be, and being detained on a treatment order, especially when your ability to rejoin the community is decided by professionals based on their opinions of your levels of risk and mental health, must feel restrictive and controlling. It seems plausible to me that this loss of freedom could become an obsessional factor in people’s lives and therefore could lead them to attempt anything in order to escape from it. I imagine that in high secure settings this would be felt even more, as people there will already have lost so much and their freedom is likely to seem even harder to win back. This leaves me feeling concerned that in a methodology based on semi-structured interviews people might try to inflate their progress and present themselves in a positive light. My concern about this is that using a qualitative methodology based on critical realism I have to take all accounts as different but equally valid versions of truth, when it is possible that at least some of what I might be told in interviews may not be the truth but rather a representation of what the participants want me to see. However, the analysis of this using IPA could lead to some interesting results.

I also thought about the way that my role as a trainee clinical psychologist conducting research into schema therapy might affect the collection of data. The following excerpt was concerned with this:

I have been thinking about my interview questions a lot. I’ve generated 16 questions, which is a lot for an IPA study but I don’t have to ask them all systematically. I think the reason I have so many questions is that I am worried that people may agree to meet with me but not say very much, or talk about things that are not related to my research question. By having a list of prompts or pointers back to the subject I feel more confident that I may be able to get good data from the interviews. My anxiety about that however is that if I stick rigidly to an agenda I could lose a lot of important information about people’s experiences as my interview could become more focused on me and my needs for research project than about finding out about people’s experiences. If I focus too much on the questions I have, then I could bias the content of the
interviews. Of course, bias is something that I need to think more about reducing in the study, but the more I think about it the more dubious I am that I can truly be an objective researcher. Although IPA seems like a good approach for this because it acknowledges that the researcher has an active role in creating the account, I’m not sure that that is enough. I plan to go into a high secure hospital, which in itself has implications as the people I am going to recruit may not have many visitors and that could bias their choice to be involved. Also I am going to be going in and introducing myself as a trainee clinical psychologist asking about a psychological technique. Whilst I’m not scared about interviewing the participants I am scared that being identified as a psychologist in a service where psychology is respected and valued could lead to a massive positive bias in the responses. Even if they hated it or thought it hadn’t helped, would they be able to tell me this? Would they want to? How can I be sure that I am getting a true representation of their experiences and not just a sanitised version? Is there really any way to avoid this? If I say that hearing stories about things that didn’t go well or things they didn’t like is just as helpful to me as hearing good things, will that help or will it bias them to tell me negative accounts if that’s what they think want to hear? Perhaps I just need to accept that bias may be present and think about this more during analysis.

My role was of further concern to me throughout the study. This was twofold. I was apprehensive about being a trainee and how this would be received and also uneasy about my ability to change my perspective while conducting interviews from that of a clinician to that of a researcher. The passages below highlight these dilemmas:

I’m wondering whether being a trainee clinical psychologist will mean the participants see me in a certain way. Will they think of me more as someone who is doing research, a psychologist or a trainee? If it’s the latter will there be more role challenges in this environment. The literature seems to suggest that people with personality disorders (especially anti-social and borderline personality disorders) use aggression and role manipulation as avoidance strategies. The people I’ll
be interviewing won’t know me, and so there will not have been a chance to develop a rapport. Why should they trust me to talk about a subject that could be emotionally painful? Even if the topic of imagery is relatively safe, it will have been used to address abuse issues in their childhoods and so there might be an association there for them. If this is the case, then talking about it could be raw and they may want to avoid that.

Today I’m thinking about conducting the interviews. I’ve been concentrating so hard on developing the schedule and planning the study that I haven’t really thought about the applied aspects of it. My background is as a clinician not a researcher, and therefore I wonder if when I’m in the room I will be able to keep to the role of a researcher or if I will fall back into a default position of therapist. I think it will be difficult not to follow up on points they make and to interpret in the interviews. Adopting an IPA methodology also complicates this for me as it acknowledges that the final account will be co-constructed, but I’m not sure how far this can be taken. I think I have to try to stick to the point of the interviews, i.e. to find out about their experiences of imagery without adhering rigidly to the schedule or going off topic by following up on things that are clinically interesting to me. Checking interpretations may be ok within IPA, but it would probably be better to try to avoid doing this.

Another area for reflection was the possible impact of people’s schemas on the interviews. This again related to the content of the interviews for me. Similarly to the concerns I mentioned earlier about people presenting themselves in a positive light affecting the results, I wondered whether people’s schemas might be triggered by the discussion of imagery work, and if this did happen, what the consequences of that would be for the data. The extract below highlights my consideration of this:

Having started thinking about conducting the interviews I find myself wondering about the schemas that people might have. I’m deliberately not asking about these before the interviews because they’re not relevant to the research, but they might be relevant to the way interviews go. I’m going to be asking about a technique used in schema therapy and so I
have to think about the possible impact of schemas of the interviews. It is possible, that as I don’t know the participants, I could say something that might trigger their schemas. I don’t think there’s any way to know how to cope with this if it occurs as there are so many different schemas that may interact with each other, and multiple modes of responding to these, which means that presentations could be very different for different people. I think that the worst schemas that could be triggered in terms of data collection would be mistrust/abuse and defectiveness as either of these could lead to people not responding at all. If they don’t trust me or think they’re not worth talking to then I’m less likely to obtain usable data in the interviews.

After collection of the data my feelings about the interviews changed dramatically. The following quote from my reflective diary was written after I had completed the first interview and demonstrates the change in my feelings about conducting and IPA study:

I find myself completely amazed by the experience today. It was so much easier to generate a conversation than I thought it would be and the atmosphere of it was so much more relaxed than I expected. I feel much more comfortable about conducting the interviews and more confident that the data I’m collecting will be useful and interesting to analyse. My earlier concerns about interpreting in interviews or sticking too rigidly to the schedule seem to have been overblown. The interview flowed well and the questions weren’t really needed, which meant it didn’t feel too constrained. Also I feel like I did interpret during the interview through checking out my understanding of what [he] was saying and although at the time I felt really nervous about this because it felt more like a clinical skill than a research one, now, after some time has passed I feel like it helped the interviews to seem natural and aided the flow of the conversation.

Regarding interpretation, I felt that as well as being present in the interviews I began to make interpretations immediately following them. One of these related to my earlier concerns about schemas interfering with the interview and
potential avoidance of difficult issues. My experience of conducting the
interviews altered my perceptions about the impact of these things and
alleviated my concerns. The section below (written after the third interview had
taken place) makes reference to the feeling that I had about the way my
reactions to the interviews had influenced my interpretations:

I am struck by the power that emotions had during the interviews.
[Participant three] was so articulate about his experiences that I found
myself engrossed in his story and genuinely surprised by the way he was
able to convey the depth of the emotions he felt and how palpable they
felt in the room. This is even more surprising as it is reminiscent of the
other two interviews. My expectations before I started were that people
might be guarded about their experiences and could find it difficult to
trust me enough to talk about imagery. This could not be further from the
reality of the interviews. I have been moved and feel quite honoured that
participants have been so open and earnest with me. I haven’t asked
about index offences but all participants have told me why they are in
[high secure hospital] and how they think their schemas contributed to
their offences. I had expected that they might try to shift the responsibility
of their actions on to others through the schemas but none of them have.
They have all explained that they feel their schemas came from their
childhood experiences and that they were ultimately unhelpful, leading
them to do things that hurt others, but they accepted their responsibility
for what they did. They all expressed a deep need to change and even
talked about what they had done as ‘wrong’ which on language alone
struck me as strange because it seems judgemental, but in the room,
they spoke with compassion directed towards themselves. This didn’t
feel like they were trying to justify their actions but rather that they were
trying to move past it.

As much of a surprise as this was, the way they talked about
reconnecting with their childhood experiences was even more so. Not
only did they speak about feeling vulnerable but they showed me this.
There have been elements in all three interviews when they spoke about
relating as the vulnerable child that reminded me of dissociation, but
without the emotional distancing. Even though I have seen this three times now it still strikes me as bizarre. Their body language has changed, they seem smaller, more exposed and helpless, without any defences, their speech patterns change and they seem to me like children. It has been a truly surreal experience to see grown men in this light and to almost observe the children that they were when their schemas originated. Although it not something that I expected to encounter at all, I feel humbled and privileged that they could trust someone they hardly know enough to share that with me. In contrast to my earlier concerns about deception, I now feel that although I will still need to consider the possible impact of participants attempting to present themselves in a positive light, that this will not be an overwhelming element of my interpretation. To me it felt as though they have genuinely tried to tell me about their experiences because they believe that psychology has been helpful to them and they want to be a part of helping to further knowledge about that. I was struck by how sincere and likeable they seemed and the apparent very real desire to help me understand that they had. This desire to convey knowledge has come to be the main interpretative theme that I am using to understand their experiences.

The thoughts above remained with me throughout the interviews and rather than discarding my previous thoughts and reflections in light of the newer ones, I incorporated both sets into my thinking about interpretation and analysis. Although this felt difficult initially I have come to believe that this is in keeping with my epistemological position of critical realism. The following excerpt from my reflective diary after all interviews had been completed and analysis had formally begun, demonstrates this:

If I believe in multiple versions of truth, and that these are all equally valid then it seems logical to extend this to say that different versions of truth do not have to be or even cannot be mutually exclusive. Therefore is it possible that I can hold more than one version of truth in relation to my beliefs about this study? Can I believe that sometimes people might try to present themselves positively, and at other times they might show me
the uncensored truth of their reality? Can I believe that schemas can hinder the interpretation of events at some points but elucidate them at others? Can I accept that introducing myself as a trainee clinical psychologist might result in a bias towards positive responses but might also lead to imparting a sense of trust that has been built up by other psychologists to me? I think that if I believe that such things are transitory states rather than fixed traits, then I can hold all of these truths at the same time without them contradicting each other. I also believe that this could lead to a richer, more balanced interpretative analysis.

It may also be of note that different ethical concerns were raised for me during the analysis and write-up of the data. Although these were linked to my initial thoughts about confidentiality, these had evolved into something quite different from the way that I originally thought about it. To begin with, my major concern was protecting participants’ identity, however over time my feelings about this have changed. Although preserving anonymity has always remained a central concern for me, I have increasingly considered the impact of using quotes to support my interpretations of people’s accounts. The passage from my reflective diary below, written during the writing up of the first draft of results highlights this:

I find it strange that suddenly I have begun to feel uncomfortable about choosing quotes to support my analysis. This feels very personal somehow. Although I gained informed consent before the interviews, and discussed the recording of them a length, I have begun to wonder if this truly is sufficient. In unguarded moments people may say more than they meant to, or they might not say things quite as they intended, and it is possible that I will chose those quotes to illuminate my interpretations. Did my participants really grasp the power that their words could have; did they fully understand that I would be using them to support my interpretations of the account? I cannot say for sure. I was worried that they might forget the tape was running if they became too comfortable talking, but did this really happen? Although I cannot be completely sure of this, my fears were allayed somewhat by a comment made by [Daniel], about half way through the interview he was talking about the therapeutic
relationship and the beginning of his sentence made it sound like he was imparting a confidence, but he said ‘And er, between you and I, and the tape’. His addition of and the tape at the end of that sentence made me realise that although I had assumed he had forgotten he was being recorded, that this in fact was not the case. Although this alleviated my concerns as it led me to believe that perhaps I underestimated the levels of attention and awareness in participants from a high secure setting regarding the interviews, I have become increasingly aware that I feel a sense of loyalty to them, and to their words. This feels uncomfortable to me as I undertook this study to understand more about their experiences of imagery and I need to use their words in order to communicate this properly. Despite knowing this though, participants spoke about traumas they had suffered in childhood, people who were important to them, and offences they had committed. This disclosure had a quality of clinical sessions to it and describing the minutiae of the private experiences feels like betraying a confidence. I am surprised to feel this way and wonder whether this is the difference between a clinical and research role, or my naivety in conducting qualitative research. Either way, I feel I need to respect people’s anonymity and to a certain degree privacy, but not to the detriment of the study. I will have to try to keep a balance in choosing quotes between showing what I think is important and supporting this with verbatim quotes, and not using material that could potentially cause distress to participants if they saw it out of context to the interviews. I suppose in the end, this ties in with issues of validity in qualitative research as for me it makes sense of why sensitivity to context is highlighted as important. As long as I handle the write up with compassion from the point of demonstrating an understanding and with sensitivity to context, then I should be able to meet my own objectives, whilst respecting their right to privacy.

Also during analysis and write-up, it is of note that I questioned the philosophy of science that the study was based on. Although critical realism was chosen, I came to realise that a social constructionist position could be equally compelling. This was based on the acknowledgement that results are influenced
by the researcher’s fore-structure and interpretations will be different for different researchers based on these fore-structures. It could be the case that such fore-structures were socially constructed. However, critical realism was chosen because I believe that participants’ perceptions of experiences are cognitively mitigated and the researcher’s fore-structure informs fore-conceptions (e.g. cognitions) and therefore both were thought to be intra-psychic and ideographic rather than inter-personal or social. Consequently, although social constructionism would also be an appropriate epistemological position, the focus of interpretation in this study has been the ideographic rather than the social and therefore critical realism seems most applicable.

The final reflection that I will make relates to my feelings about the process of writing up the results. I feel that I planned a study grounded in IPA, and conducted interviews that yielded good data. I also believe that analysis uncovered interesting findings that described positive results for participants, and highlighted possible processes involved in imagery. Despite this, what I found difficult about the process of writing was completing the discussion, as I found myself limited by the methodology. After reviewing the results, I wondered how these were relevant to the wider scientific community and literature and how these findings could expand the knowledge base or relate to clinical practice. The limitations regarding generalisability within IPA and its approach as looking at the experiences of specific people, at one specific point in time, related to one specific experience constituted part of the difficulty. In conjunction with this, the acknowledgement that results are interpreted and therefore someone else could look at the same data and reach an altogether different conclusion led me to the question ‘now what’? This uncertainty relating to how much the results can be applied and how useful they ultimately are contributed to my difficulties in writing the discussion.

In summary then, the excerpts (above) from the reflective journal were chosen to demonstrate (at least in part) the complexity that I felt was involved in conducting an IPA study. For someone new to this method of research, there seemed to be an almost overwhelming amount of issues to consider. This included theoretical issues related to the technique being explored,
epistemological frameworks and how they applied to the study in broader terms, the impact of co-constructing accounts in IPA and the understanding of the role of interpretation in this method. In summing up my feelings about how well I may have handled these issues, I believe that my overriding concern throughout was to conduct a study that was ‘right’. As I have progressed through the process however, I have come to believe that in accordance with my epistemological position there is no ‘right’ way to do it. Instead I have to consider whether I have done a good enough job of considering the relevant factors and remaining true to the methodology and epistemological position. I believe that I have done this to the best of my ability and have presented a co-constructed account of people’s experiences of imagery in schema therapy, which offers insights into things that sometimes happen during this technique to clinicians who use it. Despite this however, as results are not generalisable, the applicability of the findings is questionable.

Total Thesis Word Count (minus references, appendices, figures and references to extended paper) = 27051.
References


26 January 2010

Miss Samantha Durrence

University of Lincoln
Court 11, Satellite Building 8
Brayford Pool
Lincoln
LN6 7TS

Dear Miss Durrence

Study Title: Forensic Service Users' Experiences of Imagery in Schema Therapy
REC reference number: 10/H04/03/4
Protocol number: 1

The Research Ethics Committee reviewed the above application at the meeting held on 12 January 2010. Thank you for attending to discuss the study.

Documents reviewed

The documents reviewed at the meeting were:

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Provisional opinion

In discussion, the Committee queried the following issues:

1. For the benefit of the Committee, you gave an overview of what Schema Therapy is. You clarified that it is a third wave therapy from CBT, and adds to CBT, tapping into

This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority.
The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.
emotional difficulties.

2. The Committee asked what would happen should less than 5 people wish to take part. You confirmed that the research could be undertaken only using 1 (one) participant.

3. You were asked how your safety would be ensured whilst undertaking the interviews and if the interviews will be on a 1:1 basis. You confirmed that you will be interviewing participants on a 1:1 basis, and you are undergoing safety training e.g. 'break-away' and 'restraint' etc. which is mandatory practice/training for staff within the Trust. Also, regarding safety, the Committee asked if any debriefing and emotional support is available should you become distressed whilst undertaking the research. You confirmed that you will undergo debriefing with your Supervisor, whose expertise is in this field of work. The Committee asked if your Supervisor would have an invested outcome in the study and would be able to identify those participating i.e. would there be any clinical disclosure in the tapes if the Supervisor has access to them? You stated that they may be identifiable given the client group you are researching.

4. The Committee asked who would be transcribing the interview data. You confirmed that you will be and that you will be discussing themes with other students.

The Committee is unable to give an ethical opinion on the basis of the information and documentation received so far. Before confirming its opinion, the Committee requests that you provide the further information set out below.

The Committee delegated authority to confirm its final opinion on the application to the Chair.

Further information or clarification required

1. The Committee request changes to the Participant Information Sheet (PIS)-

   - The PIS should be expanded to include heading and paragraphs as required using the NRES template e.g. advantages and risks should be considered etc.

   - The closing sentence should also be removed i.e. 'I hope to meet with you soon'.

2. Although it was not discussed at the meeting the Committee would find it helpful to have further clarification as to why the responsible clinicians are being asked to confirm, by an entry on the RIO system, that they feel it is appropriate that the researcher approached particular patients. The clarification should elaborate on how this will be managed, in particular whether you can be confident that the responsible clinicians will action this request.

If you have any queries about the content of this letter, please contact the Co-ordinator.

When submitting your response to the Committee, please send revised documentation where appropriate underlining or otherwise highlighting the changes you have made and giving revised version numbers and dates.

If the committee has asked for clarification or changes to any answers given in the application form, please do not submit a revised copy of the application form; these can be addressed in a covering letter to the REC.
The Committee will confirm the final ethical opinion within a maximum of 60 days from the date of initial receipt of the application, excluding the time taken by you to respond fully to the above points. A response should be submitted by no later than 25 May 2010.

**Membership of the Committee**

The members of the Committee who were present at the meeting are listed on the attached sheet.

**Statement of compliance**

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H0403/4  Please quote this number on all correspondence

Yours sincerely

[Signature]

Dr K Pointon
Chair

Email: trish.wheat@nottsptc.nhs.uk

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments.

Copy to: Dr Mark Gresswell
R&D Department for NHS care organisation at lead site –

Dr David Dawson
16 March 2010

Miss Samantha Durrance
University of Lincoln
Court 11,
Satellite Building B
Brayford Pool
Lincoln LN6 7TS

Dear Miss Durrance

Study Title: Forensic Service Users' Experiences of Imagery in Schema Therapy
REC reference number: 10/H0403/4
Protocol number: 1

Thank you for your letter of 08 March 2010, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study:

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements. Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rftforum.nhs.uk
Where the only involvement of the NHS organisation is as a Participant Identification

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Centre, management permission for research is not required but the R&D office should be notified of the study. Guidance should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

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Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document "After ethical review – guidance for researchers" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our
service. If you would like to join our Reference Group please email
referencesgroup@hrsa.npea.nhs.uk.

Please quote this number on all correspondence

Yours sincerely

Dr Kate Pointon
Chair

Email: trish.wheat@notispct.nhs.uk

Enclosures: "After ethical review – guidance for researchers"

Copy to: Sarah Owen – University

R&D office for NHS care organisation at lead site

Dr Deivid Dawson – Academic Supervisor
10 June 2010

Miss Samantha Durrance
University of Lincoln
Court 11, Satellite Building 8
Brayford Pool, Lincoln
LN5 7TS

Dear Miss Durrance

Study title: Forensic Service Users’ Experiences of Imagery in
Schema Therapy
REC reference: 10/H0403/4
Amendment number: 1
Amendment date: 03 June 2010

Thank you for submitting the above amendment, which was received on 08 June 2010. I
can confirm that this is a valid notice of a substantial amendment and will be reviewed by
the Sub-Committee of the REC at its next meeting.

Documents received

The documents to be reviewed are as follows:

<table>
<thead>
<tr>
<th>Document Description</th>
<th>Version</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Protocol</td>
<td>2</td>
<td>01 June 2010</td>
</tr>
<tr>
<td>Notice of Substantial Amendment (non-CTIMPs)</td>
<td>1</td>
<td>03 June 2010</td>
</tr>
</tbody>
</table>

Notification of the Committee’s decision

The Committee will issue an ethical opinion on the amendment within a maximum of 35
days from the date of receipt.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the
relevant NHS care organisation of this amendment and check whether it affects R&D
approval for the research.

This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority
The National Research Ethics Service (NRES) represents the NRES Directorate within the
Yours sincerely

Miss Heather Harrison
Administrative officer

E-mail: heather.harrison@nottspct.nhs.uk

Copy to: Sponsor - Dr Mark Gresswell
R&D office for NHS care organisation at lead site – Jayne Simpson
13 July 2010

Miss Samantha Durance
Trainee Clinical Psychologist
University of Lincoln
Court 11, Satellite Building 6
Brayford Pool
Lincoln
LN6 7TS

Dear Miss Durance

Study title: Forensic Service Users' Experiences of Imagery in Schema Therapy
REC reference: 10/H3403/4
Amendment number: 1
Amendment date: 03 June 2010

The above amendment was reviewed at the meeting of the Sub-Committee held on 13 July 2010.

Ethical opinion

Favourable Opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

The Committee note however, that the approved Participant Information Sheet (PIS) version 2 dated 08 March 2010, states that only yourself and Kerry Beckley will have access to the recordings. The Committee suggest you revise the details in the PIS accordingly to include a transcriber, and forward a copy to the Committee for review as a minor amendment. This can be emailed to and signed off by the Coordinator. It does not require review by the Committee.

Approved documents

The documents reviewed and approved at the meeting were:

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<thead>
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<th>Document</th>
<th>Version</th>
<th>Date</th>
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<tr>
<td>Notice of Substantial Amendment (non-CTIMPs) – To use a transcriber</td>
<td>1</td>
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This Research Ethics Committee is an advisory committee to East Midlands Strategic Health Authority. The National Research Ethics Service (NRES) represents the NRES Directorate within the National Patient Safety Agency and Research Ethics Committees in England.
Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

R&D approval

All investigators and research collaborators in the NHS should notify the R&D office for the relevant NHS care organisation of this amendment and check whether it affects R&D approval of the research.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

10/H0403/4: Please quote this number on all correspondence

Yours sincerely

Ms Trish Wheat
Committee Co-ordinator

E-mail: trish.wheat@nottspct.nhs.uk

Enclosures: List of names and professions of members who took part in the review

Copy to: Dr Mark Gresswell – University of Lincoln

R&D office for NHS care organisation at lead site
Appendix II: Letter to Responsible Clinicians version 1: 16/04/09.

I am a first year Trainee Clinical Psychologist studying for the Trent Doctorate in Clinical Psychology. For my dissertation thesis I am hoping to use qualitative methods to explore forensic service users’ experiences of imagery within Schema Therapy. Although there has been some research into imagery within other therapies this has not previously been investigated within Schema Therapy. Because this is a new area, I hope to interview people who have used these techniques as part of their treatment within the Personality Disorder Directorate of Rampton Hospital to find out more about their experiences and views of its utility as a therapeutic technique.

I am writing to you as the responsible clinician for someone who has been identified as a potential participant. I would be grateful if you would allow me to approach [INSERT PARTICIPANT NAME HERE] as they have been identified by Dr Kerry Beckley as someone who has engaged in imagery work as part of their schema therapy in the last two years. For the purposes of this study, participants need to have capacity to consent to the research, and have fluent levels of spoken English. If you do consider it appropriate for me to approach [INSERT PARTICIPANT NAME HERE], could I ask that you make a RiO entry to confirm this?

The study is entirely voluntary, and I would ask you to initially pass the study information sheet to potential participants for them to consider. I have asked them to respond to you within one week, so that initial consent can be passed back to me. For those who consent to participate, I will arrange to visit Rampton, to take written informed consent and to arrange for audio recorded interviews lasting between an hour to an hour and a half, regarding their experiences. I plan to transcribe and anonymise the interviews and then code them for themes using Interpretative Phenomenological Analysis. I also plan to visit Rampton Hospital once the research has been completed to feed back the results of the study to participants.

My Clinical Research Supervisor for this project is Dr. Kerry Beckley. Further information regarding this project can be obtained from Dr. Beckley, or from myself:

Samantha Durrance
University of Lincoln, Faculty of Health Life and Social Sciences,
Court 11, Satellite Building 8,
Brayford Pool, Lincoln.
LN6 7TS

Thank you for your time and cooperation.

Samantha Durrance, Lead Investigator
Appendix III: Participant Information Sheet version 3: 19/07/10

Information about the Research:
Forensic Service Users’ Experiences of Imagery in Schema Therapy.

I would like to invite you to take part in a research study. Before you decide, you will need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. You may find it useful to talk to other people about the study, and whether or not you would like to take part.

**Purpose of the study and who is doing it.**
I am a first year Trainee Clinical Psychologist at Lincoln University and am completing this research as part of my studies. The University of Lincoln are funding this study. I am very interested in the experiences of people who have had Schema Therapy and am particularly interested in what it was like to use the imagery techniques. There has been some research done into imagery in other therapies but not specifically Schema Therapy, so I would like to interview people who have used these techniques to find out what it was like for them.

**Why have I been invited?**
You are being invited to take part as you are somebody who has worked using imagery within Schema Therapy. I am hoping to interview eight people in total about their experiences.

**Do I have to take part?**
It is up to you to decide whether or not to take part in the study. You will have a week to look through this information and to ask any questions that you might have about the research. You can ask the person who gave you this form and they will pass any questions on to me. If you decide to take part, we will go through the information in this letter again and you will be asked to sign a consent form to show that you have agreed to take part. You will be free to withdraw from the study at any time and you do not have to explain why. If you decide not to take part or to withdraw from the study, your rights and treatment will not be affected in any way.

**What will I have to do?**
If you decide to take part, I will arrange to meet you at a convenient time. I will ask you some questions about your experience of Schema Therapy and the imagery technique. You will be able to choose how you answer the questions and how much you say. The interview will not ask about any other parts of your therapy or any personal details. The interview is expected to last for between an hour to an hour and a half. The interviews will be audio recorded, but no-one outside the research team will have access to them. The recording will be kept in a secure, locked area and will be destroyed after the research is completed. All information about you will be handled in confidence.

**What are the possible benefits from taking part?**
It is not expected that the study itself or the results of the study will benefit you personally. It is hoped that the study will help us to know more about what it is like to use imagery. I hope this will benefit both therapists and people who receive Schema Therapy in the future.
What are the possible risks/disadvantages from taking part?
It is expected that potential disadvantages will be minimal. Arranging the times for interviews may be inconvenient, although I will try to make them at a time that suits you. It is also possible that taking about a technique you used in therapy may be emotional for you. If this is the case, support will be offered to you by the interviewer and by members of you care team at the hospital.

What if I don’t want to carry on with the study?
You can change your mind about being in the study at any time and if you choose to leave the study this will not affect your treatment in any way. If you chose to leave before the interviews were analyzed, your information would not be used in the study, but if the data had been analyzed your information would still be included. No extra information would be collected about you.

Will my participation be kept confidential?
Yes. I will record the interviews and they will be written out word for word by either myself or a member of the admin staff from the psychology department. During the writing out I will give you a new name and change or take out any personal details that you have used, so that it will not be possible to identify you. The recordings will be kept in a secure locked area in the Psychology Department and will not leave the hospital. Only people from the research team (the administrator and myself) will have access to them. The recordings will be destroyed after the research is completed.

Results of the study and confidentiality.
I hope to publish the results of the study when it is finished and this will involve using direct quotes of what people have said in interviews. I will change the names and identifiable or personal information of everyone who has taken part and will make sure that all quotes are kept anonymous. Any information which is collected about you and which leaves the Hospital will have these changes made so that you cannot be recognized. Before the results are submitted I will come back to the Hospital and arrange for a meeting for everyone who took part, to discuss the findings of the study and to make sure that you are happy for this information to be published. You will not be identified personally within the published results. I am hoping to publish the results so that people who use Schema Therapy will know more about what it is like to use imagery. I hope this will benefit both therapists and people who receive Schema Therapy in the future.

Who has reviewed the study?
All research in the NHS is looked at by an independent group of people called a Research Ethics Committee to protect your safety, rights wellbeing and dignity. This study has been reviewed and given a favorable opinion by the Nottingham Research Ethics Committee.

What should I do if there is a problem?
If you have any concerns about any aspect of this study, you should ask to speak to myself or Kerry Beckley, and I will do my best to answer any questions that you have. You can contact me by asking the person who gave you this letter. If you are still unhappy about the research and wish to complain formally, you can do this through the NHS Complaints Procedure. Details of how to do this are available from the Hospital.

If you choose to take part in the study, you will be given a copy of this letter and a copy of the consent form that you will have signed.

Thank you very much for your time.

Samantha Durrance, Lead Investigator
Appendix IV: Consent Form version 1: 16/04/09

Consent Form

Patient Identification number:……………
Title of Project: Forensic Service Users’ Experiences of Imagery in Schema Therapy
Name of researcher: Samantha Durrance

1. I confirm that I have read and understood the information sheet dated 16/04/09 (version 1) for the above study. I have had the opportunity to think about the information and ask questions, and have had these answered to my satisfaction.

2. I understand that I do not have to participate in this study, and that I can withdraw at any time without giving a reason, and that this will not affect my rights or treatment in any way.

3. I agree to have my interview audio recorded. I understand that may include recording personal details, but that this will only be accessed by members of the research team. I also understand that the recording will be securely stored in a locked area and that it will be destroyed after the study is completed.

4. I agree that direct quotes that I have said may be used in the publication of the study results, but that these will have any identifiable information changed to protect my identity and to preserve confidentiality.

5. I agree to take part in the above study.

………………………
Name of participant
Date
Signature

………………………
Name of Person taking consent
Date
Signature

When completed: 1 copy for participant, 1 copy for research files, 1 copy for medical notes
Appendix V: Interview Schedule

Interview Schedule

Primary research question: Forensic Service Users’ Experiences of Imagery in Schema Therapy.

Questions: (NB: The first question is an open-ended invitation to talk and the final question is an open-ended closure which are therefore the only questions guaranteed to be systematically asked, other questions will be used as prompts or guides if participants require them).

1. Have you had any thoughts about what was in the information letter for this study?
2. Can you tell me what you understand by the term ‘imagery work’?
3. Tell me about your experiences of using imagery.
4. What was it like for you when you used the imagery techniques, what happened to your thoughts, feelings, body, memories?
5. What do you think was happening?
6. How did you come to understand it that way?
7. Has the way you have thought about this changed over time?
8. Did you find the imagery techniques more or less helpful than other techniques that you used in therapy?
9. How do you think using imagery techniques helped in the therapy sessions?
10. How do you think using imagery has helped you outside of therapy?
11. What was the best part of using imagery for you?
12. What was the hardest thing about using imagery for you?
13. Did it matter who the therapist was who was using imagery with you?
14. What have you learned about yourself from using imagery that you wouldn’t have known otherwise?
15. How do you think your life would be different if you hadn’t used the imagery techniques?
16. Is there anything else that you think is important for me to know about, so I can understand your experience?
Appendix VI: Transcript Excerpts Demonstrating Analytic Process

Interview 1

1. I: Okay, so have you had any thoughts about what was in the information sheet about the study?
2. P: I haven’t actually.
3. I: Fair enough. So can you tell me what you understand by the term imagery work?
4. P: umm well I’ve only just started recently doing a bit myself. We talked about it, I talked about it with my psychologist in the past and we have done like little bits in the past but umm it’s got really intense now and err what’s, I like to do it in a relaxation state.
5. I: mmm
6. P: Where I lie down on the floor and she takes me to my little place where I used to go when I was a little boy.
7. I: Mmm
8. P: And then she err err makes me visualise in my little place my relationship with my mum and my dad. And err we go from there. I found it quite helpful.
9. I: Mmm
10. P: Cos it helps to get rid of the baggage that I’ve been carrying for all these years.
11. I: Right
12. P: Sometimes it becomes, it can be quite scary (pause) sometimes it can be quite upsetting which is what happened on Monday (pause) and erm, I believe that (pause) all that pain that I carried all those years comes out through doing this imagery work cos it’s, it’s what’s kept me in a, in a stationary position. I can’t move backwards and I can’t move forwards, so (pause) yeah I think it’s a, it’s a great help and err (pause) my psychologist err (pause) knows what she’s doing and she keeps me if I get upset and she knows how to look after me. I know she looks after me anyway but she looks after me that little bit more to (pause) umm talk me through what’s upsetting about what we’ve just done. And err (long pause) she, I agree with her that it gets rid of (pause) the stuff that you’ve been carrying (pause) really (pause) so (pause) I think it’s good. It’s a good piece of work to do, it’s good.
13. P: (pause) You’ve got to make your mind up in your head about thinking steps to do to.
14. I: In the past, I’ve not really been forward in coming forward (pause) and erm (long pause) but this, for me this is my last chance to get things into perspective and to move on (long pause) from living under the thumb of parents (long pause) and err yeah it’s painful but we’re getting there.
15. I: So something about changing this I guess – you sort of said moving on?

---

- i) Sharing emotional pain
- ii) Seeking confirmation of understanding
- iii) Struggling to articulate
- iv) Showing something is important or difficult to say
Interview 2

1. Okay, so have you had any thoughts about what was in the information sheet about the study?
2. P: Erm, basically that you want to find out what happens when you do imagery, what it feels like.
3. I: Hmm
4. P: And talk about that. But erm, I don't know, I uh, I'm pretty negative about imagery, I don't like it. Erm, I don't know. I just, I don't know if it's because one of my Schemas is avoidance and imagery is a difficult subject. And err, and what I avoid. I know psychologists have tried to get onto it and change the subject onto something else you know what I mean? I just don't like it. I don't like it.
5. I: Right, so what do you understand that imagery is then?
6. P: Erm, it's, it's taking you back to difficult places and situations. Erm [indicating] I don't like being there. Well, I haven't seen anything good about imagery. You know what I mean? I don't know what I mean. I don't know that much about it. I really don't. I do a little bit with K and I've done a little bit with L and like I said, I, I do anything to get out of doing it. I don't like it. It just spoils your day. It just sends you on a downer and makes you depressed. Erm, you feel ill and not something I like to bear.
7. I: Like physically ill?
8. P: Yeah, I feel sick and get a headache because it or you. It sets you on a train of thought about all the bad things and you know what I mean. And then suddenly, everything is just spinning in your head and all the bad stuff that went on and err, I don't know it just takes you places I'd rather not be.
9. I: What is that like?
10. P: It's like being back where you were. Erm, you can smell things, you can taste things, or it's just horrible. It's horrible. Just, it takes you to places that you don't want to be. You, you just don't want to think about them. Well I don't anyway.
11. I: Personally, I can't see the benefit of taking you out to places. You know what I mean? I don't know. Like I said before, I, it's maybe because I'm avoidant. I don't know. I don't know.
12. I: The way you describe it, it sounds really unpleasant.
13. P: Well, I don't like it. I, er, [nudging] I know a lot of people who have done quite a bit of it and err, I don't know. I can't see what I could get out of doing anymore of that, like I said, it's, it just doesn't want to be there. You know what I mean? I just, er, takes you back to being that vulnerable child. And err, no, I've only lived through that stuff once. I don't want to do it again. And er, er,
14. I: And yet you have done that with people.
Interview 3

Have you had any thoughts about what was in the information letter for the study?

Yeah, erm, as I say I think that the schema terminology I worked better with the imagery work and going back to the safe place and then dealing with your problems as an adult, what happened in your childhood and erm, in a safe way. Even though the feelings and emotions are still there, it’s quite good to do it in a safe environment, you get a better understanding of it. So that did help, help me personally to try to deal with certain problems that I have and things that I have struggled with and still do at times. You know what I mean, but you, you know, and it’s funny you, you can self-teach yourself not to go back there a bit, you know and do it yourself basically. You know, when when you know you worry about something or you’re conscious about it, you can go back and I can look at it in a healthy way and I quite like that, I like that and it’s safe, you know what I mean, it’s no problem, I can do just deal with it, it’s good.

I: Right.

P: Mm.

I: So, what’s it like when you’re doing imagery work?

P: It can be very, I mean at first, it can be very, because I mean obviously I tend to block out feelings and, and, and emotions, what happened in the past and you try not to visit them if you like in a way and I think when you, you know when you talk about it and then you start to use your work and you go back, it can feel as real as it was then in a sense. Erm, and emotions and feelings come back to you, you know like you, you’re relaxed, but you’re aware of all these feelings that maybe you, that aren’t as powerful as they were when you’re just in everyday life and it, and you actually feel like the real emotion of it and the real depth of the pain or hurt of sadness and, and its dealing with that, that’s what makes you want to carry on with it. It makes you quite strong actually, you know like, it gives you a bit of strength about things that have happened in the past. But it, it can be a little bit frightening at first, you know it can be a little bit frightening and daunting because you’re looking at things and dealing with things that you’ve suppressed for so long. So if it can become quite frightening at times, but I think there’s a safe place that you can always go to.

I: Mm.

P: You know, in the imagery work where, you know you can feel like you can just breathe and start again if you need to. Erm, so it is quite good work.

I: Mm.

P: It’s a safe way to deal with things in the past and, and, I mean I, I’ve got, I enjoyed it, after this, I mean I wouldn’t say, maybe enjoying is not the word, right word to use, I’ve got benefit from it.

I: Mm.

P: If that’s if that’s the right word, err, rather than looking at like schema terms, even though I’m aware more of schema terms now and I look at schema schemas if not
Appendix VII: Tables Demonstrating Theme Development

Tables 2-6 below demonstrate the process involved in moving from annotated transcripts to developing emergent themes, initial super and subordinate themes and eventually the final super and subordinate themes.

Table 2: Initial Emergent Themes:

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<th>Name</th>
<th>Temporality Present?</th>
<th>Emotional Pain Present?</th>
<th>Present in all Interviews?</th>
<th>Names of Emergent Themes Incorporated</th>
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Table 3: Development of Initial Super-Ordinate Themes:

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Table 4: Super and Subordinate Themes in Initial Analysis

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</tr>
</tbody>
</table>
Table 5: Progress from Initial Super-Ordinate Themes to Final Themes:

<table>
<thead>
<tr>
<th>Name</th>
<th>Temporality Present?</th>
<th>Emotional Pain Present?</th>
<th>Present in all Interviews?</th>
<th>Names of Initial Themes Incorporated</th>
<th>Fits With Metaphor As?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporality</td>
<td>-</td>
<td>✓</td>
<td>✓</td>
<td>-</td>
<td>The Journey</td>
</tr>
<tr>
<td>Revisiting the Trauma</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>The Image Itself</td>
<td>Opening the Suitcase</td>
</tr>
<tr>
<td>Process of Therapy</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Therapeutic Processes, Imagery as a Catalyst for Growth</td>
<td>Unpacking &amp; Re-Ordering the Contents</td>
</tr>
<tr>
<td>Therapeutic Outcomes</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Reintegration of Multiple Selves</td>
<td>Closing the Suitcase</td>
</tr>
<tr>
<td>Protection From Emotional Pain</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>Emotional Pain</td>
<td>Distancing</td>
</tr>
</tbody>
</table>
Table 6: Development of Final Super and Subordinate Themes:

<table>
<thead>
<tr>
<th>Super-Ordinate Theme Name</th>
<th>Subordinate Theme Names</th>
<th>Temporality Present?</th>
<th>Emotional Pain Present?</th>
<th>Present in all Interviews?</th>
<th>Names of Initial Themes Incorporated</th>
</tr>
</thead>
<tbody>
<tr>
<td>Revisiting the Trauma</td>
<td>Re-connecting with childhood self</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>The self growing over time, Reliving events — renamed as revisiting</td>
</tr>
<tr>
<td>Process of Therapy</td>
<td>Emotional control</td>
<td>✓</td>
<td>✓</td>
<td>×</td>
<td>Moving from isolation to connectedness in interpersonal relationships</td>
</tr>
<tr>
<td></td>
<td>Moving on versus being stuck in the past</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Moving on versus stagnating</td>
</tr>
<tr>
<td></td>
<td>The therapeutic relationship as characterized by trust, and meeting needs</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Therapist as providing what was needed, Moving from isolation to connectedness in interpersonal relationships</td>
</tr>
<tr>
<td>Therapeutic Outcomes</td>
<td>Healing the fractured self</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Fractured personality</td>
</tr>
<tr>
<td></td>
<td>Applying what has been learned</td>
<td>✓</td>
<td>✓</td>
<td>×</td>
<td>Putting learning into practice</td>
</tr>
<tr>
<td>Protection From Emotional Pain</td>
<td>N/A</td>
<td>✓</td>
<td>-</td>
<td>✓</td>
<td>Emotional Pain, Emotional responses, Emotional distance</td>
</tr>
</tbody>
</table>