AN EXPLORATION OF SCHEMA MODES IN PSYCHOSIS

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ABSTRACT

Schema focused therapy (SFT; Young et al., 2003), which includes schema mode work, was developed for people with a borderline personality disorder diagnosis, and more recently has expanded for use with other diagnoses. A research gap exists in relation to schema modes and psychosis. This study aims to explore the relevance of schema modes to people with a psychosis diagnosis.

Seven adults with a psychosis diagnosis took part in a semi-structured interview and completed the Schema Mode Inventory (SMI; Young et al., 2007) questionnaire. In the interview participants were presented with eight cards, each with a description of one of Young et al.'s (2003) original schema modes. Participants were asked a series of questions about each mode card. Following the interview, participants completed the SMI. Interviews were transcribed verbatim and interview data were organised into eight matrices, one matrix per schema mode. Data were analysed per matrix using thematic analysis. SMI scores were calculated and compared with interview transcripts.

A sense of separateness from others and feelings of shame, anger and difficulty regulating overwhelming emotion appeared common across the sample. Stigma was highlighted as a possible influencing factor. Whilst many descriptions of emotional and behavioural states given by participants may reflect some of Young's (2003) existing schema modes, and SMI data highlighted three modes of possible relevance to people with a psychosis diagnosis, findings were inconclusive. The findings suggested that if modes are found to be relevant to this population, experiences of voice-hearing and paranoia could influence the experience of a mode. Some discrepancies found between SMI and interview data highlighted the importance of using more than one method when assessing modes.

A critical review discussed the findings and highlighted limitations. Implications of the findings were considered in relation to clinical practice and at a wider service and societal level. Recommendations were made for future research.

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CONTENTS

1. INTRODUCTION

This chapter will examine current understanding of psychosis and its causes, including the context in which it is typically understood. The chapter includes a review of the literature on schema focused therapy (SFT) and schema modes, and an exploration of the relevance of schema modes to psychosis. In conclusion from the literature review, the chapter will end with a rationale for the research and will present the research questions. It will suggest that there is a research gap that could be useful to explore in terms of the relevance of schema modes to psychosis.

1.1. Literature Search Strategy

The literature review was initiated through conducting electronic searches using EBSCOHost (PsycINFO, PsychArticles, CINAHL Plus, Academic Search Complete), ScienceDirect and SCOPUS. Where possible, Boolean/phrase search was used, which utilises search operators AND, OR and NOT to search for specific combinations of key words, defining inclusion and exclusion criteria. Search terms included 'schema therapy', 'schema mode', 'psychosis', 'paranoia', 'hallucination', 'delusion' and 'voice' (see Appendix A for all search terms). No date parameters were set when searching and only articles and chapters published in English were included. A snowballing effect was used, whereby appropriate literature was identified on the publications' reference lists. Additional searches were conducted of literature written by academics known to contribute to research in the areas of psychosis and SFT. After an initial screening of the titles and abstracts of the literature generated by the searches, the most relevant literature for this research was selected. The selected papers and chapters were read in detail and incorporated into the following narrative review.

1.2. A Note on Terminology

Throughout this thesis the term 'psychosis' is used. The contested label of schizophrenia (e.g. Sarbin & Mancuso, 1980) has much stigma attached to it (Bentall, 2013) and has been argued to have low reliability and validity (Bentall, Jackson, & Pilgrim, 1988; Boyle, 2002). In a move of emphasis towards 'meaning'

not just 'symptoms', the term 'psychosis' is now commonly used, which can be viewed as less stigmatising (Johnstone, 2011). While it has been questioned whether the assumptions underpinning 'schizophrenia' have simply been transferred to 'psychosis', whereby experiences continue to be pathologised through use of the label (e.g. Boyle, 2006), the term 'psychosis' is used in this thesis in an attempt to minimise stigma.

The researcher also refers to 'people with a psychosis diagnosis' instead of 'people with psychosis'. The use of the biomedical conceptual framework and medicalised terminology is reductionist in that it fails to acknowledge external influences that substantial evidence now highlights as playing a significant role in the development of psychological distress (Boyle, 2002; Wong, 2014). The term 'people with psychosis' suggests that there is something inherently 'wrong' biologically with an individual, whereas the term 'people with a psychosis diagnosis' is a more descriptive term with fewer assumptions attached to it. The researcher also holds the understanding that not every individual will accept the term 'psychosis' as an accurate description of their experiences (British Psychological Society, 2017). The researcher also refers to experiences such as hearing voices as 'experiences' instead of 'symptoms'. This is to take a more neutral stance and to move away from an assumption that there is only one way of understanding such experiences.

1.3.   Understanding Psychosis

The following section examines definitions of psychosis and its related experiences, it's high prevalence and negative impact on functioning. The aetiology of psychosis is explored in detail, particularly in relation to voice-hearing and paranoia, on which most research is based. Consideration of the context surrounding psychosis can aid understanding around its relevance to schema focused therapy (discussed in section 1.3.4.)

1.3.1. The Framing of Psychosis According to Diagnostic Categories

The way psychosis is commonly understood has been influenced by DSM (Diagnostic Classification System) diagnostic criteria and the ICD (International Classification of Disorders). The DSM-V (American Psychiatric Association, 2013)

describes 'schizophrenia spectrum and other psychotic disorders' as including schizophrenia, schizoaffective disorder, schizophreniform disorder, delusional disorder and brief psychotic disorder. The ICD-10 (World Health Organisation, 2016) categorises under a similar umbrella term in the following way: schizophrenia, schizoaffective disorder, acute and transient psychotic disorder, schizotypal disorder, delusional disorder, other primary psychotic disorders, and unspecified primary psychotic disorders.

Experiences commonly thought of as 'psychotic' include believing things that other people find strange (labelled 'delusions' and also known as paranoia), hearing voices ('hallucinations'), appearing out of touch with reality ('acute psychosis'), and speaking in ways that other people find difficult to follow ('thought disorder') (British Psychological Society, 2017). Experiences tend to be separated into 'positive symptoms' (hearing voices; believing things others find strange) and 'negative symptoms' (e.g. emotional apathy, social withdrawal, speech poverty). Terminology used in this thesis includes voice-hearing, paranoia, and seeing things that others cannot see ('visual hallucinations').

1.3.2. <u>Prevalence</u>

An estimated 500,000 people in the UK – around one in a hundred – receive a diagnosis of schizophrenia at some point (Schizophrenia Commission, 2012). However, up to 10% of the general population hear a voice when nobody is there, at some point in their lifetime (Johns et al., 2014). Much variability exists in prevalence figures, with life circumstances and experiences affecting the likelihood of experiencing particular difficulties, and of subsequently receiving a particular diagnosis (Beavan, Read, & Cartwright, 2011). Many people in the general population have experiences that would be described as psychotic and are not distressed by these (Beavan et al., 2011; van Os, Kenis, & Rutten, 2010). Experiences appear to lie on a continuum; some people have intense and enduring experiences, whereas many others have only occasional experiences and to a lesser degree (e.g. Johns & van Os, 2001).

1.3.3. <u>Impact on Functioning</u>

Experiences seen as psychotic may cause distress and disruption to an individual's personal, social and occupational life. This includes increased ill physical health, higher levels of mortality (Smith, Langan, McLean, Guthrie, & Mercer, 2013), increased risk of suicide (Hor & Taylor, 2010) and high unemployment rates (Schizophrenia Commission, 2012). It is not only the symptoms of psychosis that contribute to these effects, but effects of medication, social adversity, poverty, and homelessness. Stigma and social exclusion linked to the diagnosis, are also known to worsen its effects (Sartorius, 2002; Thornicroft, 2006).

1.3.4. <u>The Aetiology of Psychosis</u>

Varying understandings are held around the aetiology of psychosis. The term psychosis covers several diagnoses, can mean different things to different people and can develop from a range of experiences.

1.3.4.1. Psychosis as a biological illness

Psychosis used to be considered a largely biological illness. Some believe that biological aspects increase the likelihood that experiences such as voice hearing will occur, and this belief is incorporated into psychological models (e.g. Zubin & Spring's 1977 stress-vulnerability model). However, much debate exists around the results of genetic studies and their methodology (e.g. Bentall, 2010; Crow, 2008; Hamilton, 2008; Joseph, 2006; Joseph, 2011; van Os, Rutten, & Poulton, 2008). To date firm evidence has not been found for a specific underlying biological mechanism of psychosis (British Psychological Society, 2017).

1.3.4.2. Psychosis as the result of adverse life experiences

A growing body of evidence now exists that suggests psychosis to be a natural reaction to stressful life circumstances and events, particularly abuse and other traumatic experiences (Johnstone, 2011; Read & Bentall, 2012; Varese et al., 2012). For example, Romme and Escher (1989) suggested voice hearing could be part of a coping process, after finding that 70% of a sample of voice hearers had started hearing voices following a traumatic event. Similarly, Honig et al. (1998) found that the onset of voice hearing can be preceded by a traumatic event or an event triggering an earlier trauma memory.

The overlap between experiences categorised as symptoms of post-traumatic stress disorder and experiences described as psychosis is much more than previously believed (Rudgeair & Farrelly, 2008). It has been suggested that they are fundamentally the same thing (Read, Fosse, Moskowitz, & Perry, 2014). For example, hearing voices and seeing things that others cannot see are suggested to be decontextualized trauma flashbacks, with some appearing to be strongly related to child abuse (Read, van Os, Morrison, & Ross, 2005).

Some experiences labelled as psychosis do appear to be associated with specific life experiences. For example, evidence suggests that voice hearing is more closely linked to childhood sexual abuse than other abuse experiences, and that paranoia is slightly more likely to be experienced by people raised in institutional care (Bentall, Wickham, Shevlin, & Varese, 2012). Paranoid or unusual beliefs are more commonly experienced by people who are poor, marginalised and immigrant; which may in part be due to victimisation and discrimination, contributing to vigilant or wary engagement with the world (Cromby & Harper, 2009). Research in the Netherlands found an increased likelihood that people who had experienced discrimination, including racism, would develop paranoid or unusual beliefs (Janssen et al., 2003). For some, the content of voices can have similar themes to abuse experienced in the past (e.g. Read, Agar, Argyle, & Aderhold, 2003).

Research indicates that deprivation, inequality and living in dense, urban environments are three major risk factors for developing psychosis (Kirkbride, Jones, Ullrich, & Coid, 2012). People from minority ethnic groups, predominantly those living in the UK and of African and African-Caribbean backgrounds, are also considerably more likely to be diagnosed with psychosis than white British people (Karlsen, Nazroo, McKenzie, Bhui, & Weich, 2005). Reasons include exposure to everyday racism (Boydell et al., 2001; Das-Munshi et al., 2012; Shaw et al., 2012), living in urban areas (Heinz, Deserno, & Reininghaus, 2013), and once in contact with mental health services, an increased likelihood of receiving a diagnosis of schizophrenia (Neighbors, Trierweiler, Ford, & Muroff, 2003; Schwartz & Blankenship, 2014). People from minority ethnic communities are also more likely to be sectioned, put in solitary confinement (Care Quality Commission, 2010; Commission for Healthcare

Audit and Inspection, 2007), given higher doses of medication and medicated against their will (Davies, 2014; Special Hospitals Service Authority, 1993).

1.3.4.3. Psychosis and childhood adversities

Studies are increasingly demonstrating links between childhood adversities and experiences such as paranoia and voice-hearing. Some of these are described below:

Evidence of a dose-response relationship has been reported, with findings from Varese et al.'s (2012) meta-analysis suggesting that the likelihood of developing psychosis significantly increased in those who had experienced adversity in childhood. For example, people who had suffered two types of adversity were five times more likely to receive a psychosis diagnosis, whereas for those experiencing three types the likelihood increased to 30-times (Shevlin, Houston, Dorahy, & Adamson, 2008).

At a biological level, the *traumagenic neurodevelopmental (TN) model* (Read, Perry, Moscowitz, & Connolly, 2001) has been proposed, having identified similarities in the brains of adults with a diagnosis of schizophrenia and children who were severely traumatised. Several structural and chemical similarities were identified, including damage to stress regulation mechanisms in the central nervous system. As a result, it was suggested that a heightened sensitivity to stress, considered a central aspect of psychosis, could be caused by childhood trauma, not necessarily inherited as originally thought. The model was tested on a sample of people with a diagnosis of schizophrenia; those with a history of childhood abuse experienced higher dysregulation of the hypothalamic-pituitary-adrenal (HPA) axis than those without an abuse history. Multiple studies have since provided support for the TN model (Read et al., 2014). For example, attachment difficulties in childhood are suggested to affect brain structures, connectivity and neurochemistry. Similar to effects in children who had experienced sexual or physical abuse, severe neglect in childhood was found to affect HPA dysregulation (Corbin, 2007; Strathearn, 2007).

Attachment theory describes how an individual's experiences and emotions are shaped by their early relationship with a primary caregiver. An individual's basic

patterns for relating to others are believed to develop within early infant-caregiver relationships (Harder & Lysaker, 2013; Shaver & Mikulincer, 2007). Through interaction with caregivers, infants develop internal working models (IWM); representations formed from beliefs, expectations and feelings of themselves and their caregivers in the relationship (Bowlby, 1969). IWMs provide implicit rules for understanding the self and other and shape one's experiences and emotions throughout life (Edwards & Arntz, 2012). The quality of interactions between a caregiver and infant contributes towards individual differences in the quality of IWMs, giving rise to attachment styles or mental states (Schwannauer, 2013). A healthy, secure attachment enables a secure base from which the infant can explore their environments with a sense of stability and freedom, more so than those whose attachment relationships have been troubled or threatening (Morgan & Shaver, 1999). Childhood adversities can impact on the ability to develop a secure attachment. Many people experiencing psychosis do not appear to have had a secure attachment to a primary caregiver during childhood (Read & Bentall, 2013).

One of the strongest predictors of secure attachment is the sensitivity of the caregiver to the child's intentional and emotional states (Slade, Belsky, Aber, & Phelps, 1999), enabling the child to develop the capacity to identify and relate to emotional and mental states in the self and others, referred to as 'mentalisation'. Deficits in this can result in an incoherent sense of self (Schwannauer, 2013) and difficulty regulating difficult emotions (Fonagy, Gergely, & Target, 2007). Garfield (1995) argued that at the core of psychosis is unbearable and unintegrated emotion, often originating from early development. Increasing evidence (e.g. Birchwood, 2003; Freeman & Garety, 2003) demonstrates the role of emotional distress in the onset and maintenance of psychosis (Gumley, Gillham, Taylor, & Schwannauer, 2013). Experiences such as paranoia and voice hearing are often linked to emotions, and some originate from experiences where overwhelming emotion was evoked (Gumley et al., 2013).

Psychosis is suggested to develop in the context of how a person understands oneself in relation to others (Schwannauer, 2013). Mentalisation is suggested to be a key mediating factor between attachment and psychosis (Gumley & Schwannauer, 2006; MacBeth, Gumley, Schwannauer, & Fisher, 2011; Read & Gumley, 2008). A

disrupted ability to understand others' mental states and intentions can lead to difficulties in social functioning, manifesting itself in 'positive symptoms' (Frith, 1992). More specifically, impaired mentalisation and insecure attachment are suggested to be potential underlying co-occurring mechanisms for paranoia (Bentall et al., 2009; Berry, Barrowclough, & Wearden, 2008). Insecure IWMs could prime individuals to expect hostility and threat from others (e.g. Gumley, Taylor, Schwannauer, & MacBeth, 2014).

In voice hearers, avoidant attachment has been demonstrated to be associated with feelings of rejection, criticism, or threat when hearing voices (Berry, Wearden, Barrowclough, Oakland & Bradley, 2011). Avoidant attachment and interpersonal distancing are suggested to be mediating factors in predicting voice hearing (MacBeth, Schwannauer, & Gumley, 2008).

Dissociation is a common trauma response, enabling one to provide distance from overwhelming experiences (Dell & O'Neil, 2009). Dissociation is described as "a partial or complete disruption of the normal integration of a person's conscious or psychological functioning" (Dell & O'Neil, 2009, p.xxi). Increasing attention is being given by researchers to the association between trauma, psychosis and dissociation (Longden, Corstens, Escher & Romme, 2012; Moskowitz, Read, Farrelly, Rudgeair, & Williams, 2009). Dissociative experiences in people with a diagnosis of psychosis have been found at high levels (Elhai, Frueh, Gold, Hamner, & Gold, 2003; Ross & Keyes, 2009; Schafer, Ross & Read, 2008).

It is argued that in a child's early years, a consistent and safe social environment is needed in order for the integration of different affective states. This integration can be inhibited by ongoing social stressors, which can damage the ability of the hippocampus to contextualise memories. This increases vulnerability to intrusions of each isolated state into another (Moskowitz et al., 2009; Read, Fink, Rudegeair, Felitti, & Whitfield, 2008). In relation to voice-hearing, the origins of decontextualised voices can be misconstrued by an individual as being external, yet are described as signals from one isolated state to another. With paranoia, decontextualised feelings of fear can be attributed to one's social environment. Disorganised thought can occur

when one state quickly shifts to another, which can arise when experiencing stress (Liotti & Gumley, 2008; Payne, Nadel, Britton, & Jacobs, 2004).

Another way of understanding voice hearing from a *psychodynamic perspective* that is also linked to childhood adversity, is that when a person hears the voice of the person who abused or traumatised them in childhood, one might defend oneself against the terror of the memory by repressing it, whilst projecting the voice into the external world so it can appear to be unrelated to one's own life (Silver, Koehler, & Karon, 2004).

Cognitive researchers have carried out extensive research into the processes involved in the development of psychosis, particularly paranoia and voice-hearing. Cognitive approaches acknowledge that people may become vulnerable to psychosis as a consequence of adversities. Adversities can contribute to the development of negative beliefs about the self (e.g. 'I am vulnerable'), others (e.g. 'others cannot be trusted') and the world (e.g. 'the world is dangerous'), which have been linked to psychosis (Garety, Kuipers, Fowler, Freeman, & Bebbington, 2001; Morrison, 2001). Negative appraisals of early experiences related to psychosis are believed to be more likely to occur if one has a history of trauma (Bak et al., 2005) with these negative appraisals likely to result in distress (Chadwick & Birchwood, 1994; Morrison, Nothard, Bowe, & Wells, 2004).

Confusion between inner and outer experience can occur for people who hear voices or see things that others cannot see. In relation to trauma, some people experience flashback memories of childhood abuse without awareness that these are memories and happened in the past. Instead these memories are experienced as external events occurring in the present. Described as 'faulty source monitoring' (misattributing an internal event to an external source), this process is central to many cognitive theories that attempt to understand psychosis (e.g. Bentall, 2004; Garety et al., 2001; Morrison, 2004).

Paranoia can involve an excessive estimation of personal threat (Bentall et al., 2009). Mechanisms suggested to contribute to paranoia include: a tendency to make decisions based on very little information ('jumping to conclusions'; Dudley & Over,

2003); difficulty understanding other people's mental states (poor 'theory of mind'; Frith, 1994); and an external locus of control where malevolent others are attributed as the cause of misfortunes in an attempt to protect oneself against feelings of low self-worth (Bentall, Kinderman, & Kaney, 1994).

The recently developed *Power Threat Meaning (PTM) Framework* (Johnstone & Boyle et al., 2018) proposes an alternative approach to diagnosis and acknowledges the crucial role of social and interpersonal adversities in contributing to distress. The PTM framework supports the idea that humans are social beings with core needs, and anything preventing these needs from being met might be experienced by an individual as a threat to their safety and survival, physically, emotionally, relationally and/or socially. Adversities include disrupted early attachment relationships, which "set the scene for biologically-mediated emotional responses to subsequent adversities" (p.23).

1.3.5. Currently Recommended Psychosis Interventions

Provision for psychosis in the NHS follows the National Institute for Health and Care Excellence (NICE) Guidelines for Psychosis and Schizophrenia in Adults (2014). NICE (2014) state that all adults diagnosed with psychosis should be offered psychological interventions (individual Cognitive Behaviour Therapy and Family Intervention). Those who have experienced an early episode of psychosis should be offered anti-psychotic medication in conjunction with psychological interventions.

1.3.5.1. Medication

A range of anti-psychotic medication is available (NICE, 2014). Many people find that experiences (e.g. hearing voices) become less frequent, intense and distressing when taking medication. However, some debate exists around how the medication works, appearing to have a general 'damping down' effect on thoughts and emotions (Mizrahi et al., 2006) rather than a specific effect. Little evidence exists to demonstrate that the medication corrects an 'underlying biochemical abnormality' (British Psychological Society, 2017), and as mentioned in Section 1.3.4.1., no firm evidence exists to show there to be such a thing.

Adverse effects are commonly experienced from anti-psychotic medication, some of which have a significant negative impact on quality of life. Long-term use can come with a high risk of health issues such as heart problems (Morrison et al., 2012), and may decrease life expectancy (Whitaker, 2002). Recent evidence suggests that adverse effects can outweigh benefits for many when medication is used long-term (Whitaker, 2010). Some people benefit, but others do not (British Psychological Society, 2017).

1.3.5.2. Cognitive Behaviour Therapy for Psychosis
NICE (2014) advise that Cognitive Behavioural Therapy for psychosis (CBTp) is offered to every individual diagnosed with psychosis. CBTp is based on theoretical cognitive models of 'positive symptoms' of psychosis developed by Garety et al. (2001) and Morrison (2001). The intervention aims to increase quality of life and reduce distress. The main assumption of CBT is that the way a person interprets and responds to events, contributes to the development of distress (Freeman & Garety, 2006). Through supporting clients in evaluating their appraisals of events and changing their cognitive, behavioural and emotional responses to these, distress can be reduced (Morrison & Barratt, 2010).

Many service users report finding CBTp helpful (van der Gaag, Valmaggia, & Smit, 2014; Wykes, Steel, Everitt, & Tarrier, 2008). Several meta-analyses have been conducted and, on average, people receiving CBTp are suggested to benefit to a similar degree as taking anti-psychotic medication (Burns, Erickson, & Brenner, 2014; Correll & Carbon, 2014; Pfammatter, Junghan, & Brenner, 2006; Turner, van der Gaag, Karyotaki, & Cuijpers, 2014; Wykes et al., 2008). The debatable effectiveness of anti-psychotic medication (mentioned above under section 1.3.5.1.) may bring to question the extent to which the above comparisons demonstrate the effectiveness of CBTp. Recent meta-analyses examining CBTp have indicated only small effect sizes in larger, more rigorous trials (e.g. Jauhar et al., 2014).

However, many service users with a psychosis diagnosis do appear to benefit from CBTp (Psychosis Research Unit, 2018). That said, other types of therapy may also be helpful, but have not been researched as intensively as CBTp (British Psychological Society, 2017) therefore may not have had the opportunity to

demonstrate effectiveness. Service users may need to try more than one type of therapy, as different types suit different people (British Psychological Society, 2017). It has been suggested that promoting and facilitating treatment choice for service users should be a priority (Psychosis Research Unit, 2018).

An ongoing debate in relation to CBT is that despite the model's acknowledgement that an individual's appraisals of an event are shaped by adverse childhood experiences, the focus of the intervention is on the cognitive present (Boyle, 2011). An increasing evidence base indicating that early adverse experiences contribute to the development of psychosis, suggests that interventions that also focus on these early experiences could be viable in the treatment of psychosis.

1.3.5.3. Family Intervention

NICE (2014) also recommend that Family Intervention (FI) is offered to all families of individuals with a psychosis diagnosis who are in close contact with the individual. FI can take various forms, that include behavioural family therapy, crisis-oriented family therapy, family and individual psycho-education. The intervention can take place in the family home or on NHS premises, and can involve one or multiple families at a time (Pilling et al., 2002).

The primary focus of FI is the behaviour of family members, to improve social functioning (Barrowclough & Tarrier, 1990) and decrease aggravation of positive symptoms (Kuipers, Bebbington, Pilling, & Orbach, 1999; Pharoah, Mari, & Streiner, 1999). Evidence for the impact of FI on relapse appears robust (e.g. Pfammatter et al., 2006; Pharoah, Mari, Rathbone, & Wong, 2010; Pilling et al., 2002; Pitschel-Walz et al., 2001) with relapse reducing by around 20% (Bustillo, Lauriello, Horan, & Keith, 2001) and some studies indicate treatment effects to continue for up to eight years following completion of FI (e.g. Tarrier, Barrowclough, Porceddu, & Fitzpatrick, 1994). However; in practice, implementation is poor (Schizophrenia Commission, 2012; Garety et al., 2008). FI is rarely taken up by families and cannot be accessed by the many service users who do not have close family (Garety et al., 2008).

Debates surrounding 'anti-psychotic' medication, CBTp, poor implementation and take-up of FI, along with the suggestion that people could be offered more treatment

choice, suggests a benefit in being open to exploring alternative interventions for people with a psychosis diagnosis. Psychologists' understanding of experiences associated with psychosis has changed fundamentally in the last two decades, including the importance of adverse life events and how people make sense of their experiences (British Psychological Society, 2017). Developing interventions that are more in line with new understandings, and NICE guidelines that reflect this and provide treatment choice for service users, could mean reduced reliance on medication and people feeling heard and understood by mental health services. Schema focused therapy is one such psychological intervention that could be considered and is explored in this research.

1.4.   Schema Focused Therapy

This section introduces schema focused therapy and schema modes. The origins of the therapy are explained, including its links to childhood adversities and attachment theory. Early maladaptive schemas, coping responses, and the development of schema modes as a means of conceptualising an individual's difficulties, are described. Schema focused therapy, including schema mode work, is described as an approach that was developed for people with a borderline personality disorder diagnosis, that in recent years has started to be used clinically with people with other diagnoses.

1.4.1. <u>Origins</u>

Schema focused therapy (SFT; Young, 1990; Young, Klosko, & Weishaar, 2003) was originally developed for people who were experiencing several psychological difficulties, displaying complex interpersonal patterns, and who were not responding to traditional cognitive behavioural therapy (CBT). CBT interventions have been developed for a range of mental health difficulties, such as anxiety and low mood, typically focusing on reducing 'symptoms', developing skills and problem solving in relation to one's current life. However, whilst many seem to benefit from CBT, many others do not. High relapse rates suggest that many people's difficulties are unsuccessfully addressed by CBT (Young et al., 2003).

SFT is an integrative therapy which significantly expands on CBT and integrates aspects of attachment, Gestalt, object relations, constructivist and psychoanalytic schools of therapy. SFT uses a cognitive behavioural framework and combines experiential and interpersonal techniques, using the therapeutic relationship and affective experience as a vehicle of change to a greater degree than the CBT model (Bamber, 2004). It is described as helping individuals and therapists to "make sense of chronic, pervasive problems, and to organise them in a comprehensible manner" (Young et al., 2003, p.6). SFT identifies schemas and schema modes originating in early childhood and continuing in the present, with a strong focus on interpersonal relationships (Young et al., 2003). These concepts are explained in the following sections.

1.4.2. <u>The Development of Early Maladaptive Schemas</u>

1.4.2.1. Origins / Core Emotional Needs

When emotional needs are met in childhood, healthy schemas develop which enable positive views to be formed about oneself, others, and the world. The basic needs of children include secure attachment to others: (e.g. stability, safety), autonomy, expression of needs and emotions, play and spontaneity, and realistic limits and self-control (Young et al., 2003).

If emotional needs are not met in childhood, early maladaptive schemas (EMS) develop (Young et al., 2003). Four types of early life experience are suggested to contribute towards the development of EMS:

- *Toxic frustration of needs*: A child's environment is missing something important, such as love, understanding, or stability.
- *Traumatisation or victimisation:* A child is harmed or victimised.
- *Too much of a good thing:* A child is provided with e.g. excessive amounts of freedom, or parents are overprotective.
- *Selective internalisation or identification with significant others:* A child identifies with and internalises a carer's thoughts, emotions, and behaviours (Young et al., 2003).

1.4.2.2. Young's Early Maladaptive Schemas

A comprehensive definition of an EMS is:

> *"A broad, pervasive theme or pattern; comprised of memories, emotions, cognitions, and bodily sensations; regarding oneself and one's relationships with others; developed during childhood or adolescence; elaborated throughout one's lifetime; and dysfunctional to a significant degree" (Young et al., 2003, p.7).*

Young et al. (2003) identified 18 EMS clustered into five domains (see Table 1 for a list, and Appendix B for more detailed descriptions of each EMS). For example, a person with a Mistrust/Abuse EMS will expect others to hurt, abuse, manipulate, lie or take advantage, which can develop from experiences of traumatisation or victimisation. The Entitlement/Grandiosity EMS involves the belief that one is superior, therefore entitled to special privileges, which can for some develop from having 'too much of a good thing' in childhood. An EMS will repeat during a person's life in response to particular situations, such as being criticised or rejected (Young et al., 2003).

Table 1: Early Maladaptive Schemas

<u>Schema Domains</u>

1) Disconnection and Rejection

2) Impaired Autonomy and Performance

<u>Early Maladaptive Schemas</u>

1) Abandonment/Instability
2) Mistrust/Abuse
3) Emotional Deprivation
4) Defectiveness/Shame
5) Social Isolation/Alienation

6) Dependence/Incompetence
7) Vulnerability to Harm or Illness
8) Enmeshment/Undeveloped Self
9) Failure

3) Impaired Limits

        10) Entitlement/Grandiosity
        11) Insufficient Self-Control/Self-
            Discipline

4) Other-Directedness

        12) Subjugation
        13) Self-Sacrifice
        14) Approval-Seeking/Recognition-
            Seeking

5) Overvigilance and Inhibition

        15) Negativity/Pessimism
        16) Emotional Inhibition
        17) Unrelenting
            Standards/Hypercriticalness
        18) Punitiveness

1.4.2.3. The Young Schema Questionnaire (YSQ; Young & Brown, 1990, 2001) and the EMS concept

The YSQ is a self-report measure widely used by clinicians in several countries, to assess an individual's EMS. The short version is commonly used because of its comparative psychometric properties and for convenience (Waller, Meyer, & Ohanian, 2001). Overall, studies have found the measure to possess very good internal consistency (Lee, Taylor, & Dunn, 1999; Schmidt, Joiner, Young, & Telch, 1995). A considerable amount of research has been conducted into EMS using the YSQ, offering support for the EMS concept. Rijkeboer and van den Bergh's (2006) study indicated that the YSQ measures clearly defined EMS constructs in people with and without significant mental health difficulties. Test-retest reliability of the YSQ was conducted with a non-clinical sample (Rijkeboer, van den Bergh, & van den Bout, 2005), with satisfactory test-retest correlation coefficients reported for all scales, providing support for Young et al.'s (2003) statement that EMS are deeply entrenched.

1.4.3. <u>Early Maladaptive Schema Perpetuation</u>

EMS are perpetuated in three main ways: cognitive distortions, self-defeating life patterns, and coping styles (Young et al., 2003).

1.4.3.1. Cognitive distortions

Situations are misperceived, resulting in reinforcement of the EMS, emphasising information that confirms the EMS and ignoring or minimising information that opposes it (Young et al., 2003).

1.4.3.2. Self-defeating life patterns

Emotions associated with the EMS are blocked, preventing opportunity to change the EMS. Relationships that could heal the EMS are avoided, instead remaining in relationships and situations that perpetuate the EMS. Interacting with others in ways that trigger negative responses reinforces the EMS (Young et al., 2003).

1.4.3.3. Coping styles

Early in life, coping styles develop unconsciously to enable avoidance of overwhelming emotions brought up in association with EMS. Young et al. (2003) describe three main coping styles as overcompensation, avoidance, or surrender. In general terms, each coping style maps onto the basic responses to threat, known as *fight* (overcompensation), *flight* (avoidance) and *freeze* (surrender). Coping styles are expressed through specific strategies or behaviours, referred to as c*oping responses*. People tend to use a combination of coping styles and responses. Different coping styles and responses will be used at different stages of one's life in varying situations, in an attempt to cope with the same EMS (Young et al., 2003).

Table 2: Coping Styles and Examples of Coping Responses (from Young et al., 2003, p.38-39)

Coping Styles	Examples of Coping Responses and related EMS
Surrender – accepting that an EMS is true, surrendering to it and behaving in ways that confirm it.	Putting self down, and selecting critical and rejecting friends (Defectiveness/Shame); giving a lot to others and asking for nothing in return (Self-Sacrifice)
Avoidance – Attempting to arrange one's life in order to avoid activating the EMS, avoiding thinking about the EMS and acting as though it does not exist.	Avoiding expression of true thoughts and feelings and not letting others get too close (Defectiveness/Shame); avoiding situations that involve giving and taking (Self-Sacrifice)

Overcompensation – Fighting the EMS, through thinking, feeling and behaving as though the opposite is true.	Criticising and rejecting others while appearing to be perfect (Defectiveness/Shame); giving as little to others as possible (Self-Sacrifice)

Young et al. (2003) criticise the DSM diagnostic system as fundamentally, conceptually flawed, with many diagnostic criteria for personality disorders simply being coping responses to core EMS (Young et al., 2003). In comparison, the schema model accounts for both EMS and coping responses, linking them both to their origins in early childhood. Rather than fitting into one diagnostic category, each individual is seen as having a unique profile consisting of multiple EMS and coping responses of varying strengths.

SFT was originally developed based only on the above concepts; of EMS, coping styles and coping responses. In some of the more complex cases presented by service users, the SFT approach was not found to be effective (Young, 2000, 2001; Young et al., 2003). Some individuals would have as many as 14 or 15 EMSs active at once, making it difficult to focus and identify clear therapy goals (Lobbestael, Van Vreeswijk, & Arntz, 2007). Frequent and rapid shifts in emotional states and coping responses could not be sufficiently explained by the EMS concept (Lobbestael et al., 2007).

1.4.4. The Development of Schema Modes

The concept of 'schema modes' was developed when it became apparent that particular EMS and coping responses would always be triggered together. Schema modes blend several EMS and coping responses together. Schema mode work is described as more manageable and an effective alternative for working with changing emotional states (Bamber, 2004; Young et al., 2003).

Schema modes are defined as "those schemas or schema operations – adaptive or maladaptive – that are currently active for an individual" (Young et al., 2003, p.37). A 'dysfunctional' mode is activated when an EMS or coping response erupts into distressing emotions, self-defeating or avoidance responses which affect behaviour and control emotional functioning (Young et al., 2003). Young et al. (2003) proposed

10 schema modes, arranged into four categories; Child, Dysfunctional Parent, Dysfunctional Coping, and Healthy Adult.

1.4.4.1. Child modes

If core needs were adequately met in childhood, a Happy Child mode develops, reflecting an ability to experience and express playful happiness. If core needs were *not* met, 'dysfunctional' Child Modes develop (Vulnerable, Angry, or Impulsive/Undisciplined), which are linked to intense negative emotions (e.g. sadness, anger, fear of abandonment).

1.4.4.2. Dysfunctional parent modes

Frequently displayed behaviour by a parent or other significant person (e.g. teacher, peer), towards a child can be internalised as a belief about the self. Categorised as Punitive or Demanding, these modes are centred around self-hatred, self-devaluation, or extremely high standards.

1.4.4.3. Dysfunctional coping modes

The coping styles of Avoidance, Surrender, and Overcompensation map directly onto these modes. Coping modes protect a person from activation of painful Vulnerable Child modes; however, in doing so access to needs and emotions is blocked, preventing development of healthy relationships.

1.4.4.4. Healthy adult mode

This mode involves functional thoughts, feelings and behaviours, displaying the ability to cope with emotions, solve problems and have healthy relationships. The Healthy Adult is aware of their needs and acts according to their needs, values and goals whilst also having awareness of their limitations.

(The above was adapted from Young et al., 2003 and Fassbinder, Schweiger, Jacob, & Arntz, 2014).

More detailed descriptions of schema modes, including linked EMS and coping styles, are below in Tables 3, 4, 5 and 6. For a more in-depth understanding of the

development of SFT including EMS, coping styles, and schema modes, please see Young et al. (2003).

Table 3. Child Modes (from Young et al., 2003 (p.273)

Child Mode	Description	Common Associated EMS
Vulnerable Child	Feel anxious, afraid, sad, and/or helpless, when associated schema activated.	Abandonment, Mistrust/Abuse, Emotional Deprivation, Defectiveness, Social Isolation, Dependence/Incompetence, Vulnerability to Harm or Illness, Enmeshment/Undeveloped Self, Negativity/Pessimism.
Angry Child	Experience anger when perceive core needs are not being met or when unfairly treated in relation to an EMS.	Abandonment, Mistrust/Abuse, Emotional Deprivation, Subjugation (or, at times, any of the schemas associated with the Vulnerable Child).
Impulsive/ Undisciplined Child	Act impulsively to meet immediate desire for pleasure without considering others' feelings or needs.	Entitlement, Insufficient Self-Control/Self-Discipline.
Happy Child	Feel loved, content, connected, satisfied.	No EMS are activated.

Table 4. Parent Modes (from Young et al., 2003, p.277)

Dysfunctional Parent Mode	Description	Common Associated EMS
Punitive/Critical Parent	Criticises, restricts or punishes the self or others.	Subjugation, Punitiveness, Defectiveness, Mistrust/Abuse (as abuser).
Demanding Parent	High expectations set for self. Feel high level of responsibility toward others. Put pressure on self or others to achieve these standards.	Unrelenting Standards, Self-Sacrifice.

Table 5. Coping Modes (from Young et al., 2003, p.275)

Dysfunctional Coping Modes	*Description*
Compliant Surrender	Dependence and compliance used as a means of coping.
Detached Protector	Disconnect, isolate from others, emotional withdrawal and behavioural avoidance employed as a means of coping.
Overcompensator	Control and counter-attack used as means of coping. Overcompensation may occur through means that are partially adaptive (e.g. over-working).

Table 6. Healthy Adult Mode (from Young et al., 2003, p.278)

The Healthy Adult mode acts like a good parent, with aims to: 1. Nurture, affirm and protect the Vulnerable Child mode. 2. Set limits for the Impulsive/Undisciplined Child and Angry Child modes (e.g. instilling self-discipline). 3. Challenges the unhealthy parent and coping modes.

1.4.4.5.   Modes as fragmented 'parts of the self'

Every individual experiences several schema modes. In its mildest form, a mode is like a 'mood'. Modes tend to be milder and more adaptive in 'healthy' individuals, where modes are suggested to be well-integrated (a 'unified self'), with seamless transitions between modes and the individual is aware of their modes (Young et al., 2003).

For some, modes are more rigid and extreme. The more severe an individual's psychological difficulties, the larger the dissociation between modes (Young et al., 2003). For example, with people with a diagnosis of borderline personality disorder, one mode becomes dominant, closing the others off, and moving between modes tends to be abrupt and sudden, described as 'flipping' from one mode to the next (Bamber, 2004). An individual with very distinct modes can have difficulty maintaining a unified sense of self. With different 'parts of the self' not having fully

integrated with other parts of the self, one can feel fragmented (Lobbestael et al., 2007).

Whilst EMS are trait constructs and therefore stable, modes are state concepts, changing depending on the situation one is in, and strongly linked to one's present emotional state (Lobbestael et al., 2007).

1.4.4.6.   The Schema Mode Inventory and the mode concept

The Schema Mode Inventory (SMI; Young et al., 2007) is a 269-item self-report questionnaire designed to assess the presence of schema modes. The short version (124 items; Young et al., 2007), commonly used in research and clinical practice, displays good psychometric properties with high internal consistencies (Lobbestael, van Vreeswijk, Spinhoven, Schouten, & Arntz, 2010) for identification of modes in borderline personality disorder and personality disorder. More information on the SMI is reported in section 2.7.1.3.

There appear to be strong correlations between borderline personality disorder and particular modes theorised for the borderline personality disorder diagnostic category; Vulnerable Child, Angry and Impulsive Child, Detached Protector, and Punitive Parent (Arntz, Klokman, & Sieswerda, 2005; Lobbestael, Arntz, & Sieswerda, 2005; Lobbestael, van Vreeswijk, & Arntz, 2008). The fast shifting pattern of modes has been indicated (Arntz et al., 2005; Lobbestael & Arntz, 2010, 2012; Lobbestael, Arntz, Cima, & Chakhssi, 2009) and the number of modes has been reported to positively correlate with the level of dissociation experienced in borderline personality disorder (Johnston, Dorahi, Courtenay, Bayles, & O' Kane, 2009).

Schema modes are a complex construct that comprise several aspects (Lobbestael et al., 2007). Overlap between modes reported by borderline personality disorder and other personality disorders has been observed (Lobbestael et al., 2008). Furthermore, the mode concept tends to be examined by self-report using the SMI, by individuals diagnosed with different personality disorders (e.g. Arntz et al., 2005; Bamelis, Renner, Heidkamp, & Arntz, 2011; Lobbestael et al., 2005, 2008). The use of self-report in testing the concept has been questioned, with researchers finding an underreporting of dysfunctional modes when comparing self-reports of modes with

service users' therapists' reports, particularly in those with a diagnosis of anti-social personality disorder (Lobbestael, Arntz, Lobbes, & Cima, 2009) who in another study reported a strong Healthy Adult mode (Lobbestael et al., 2005).

Despite these complexities and overlap, the concept of modes tends to be described by service users as "one of the most useful elements on the way to real change" (Bamelis et al., 2012, p.507).

1.4.5. <u>Schema Focused Therapy and Schema Mode Work</u>
All interventions within SFT fall under the aim of helping people to find adaptive ways to meet their core emotional needs. The therapist begins by helping the individual to identify their EMS and associated emotions, memories, bodily sensations, cognitions and coping styles (Young et al., 2003).

Two important therapeutic strategies in SFT are *limited reparenting* and *empathic confrontation* (Young et al., 2003, 2005) both of which contribute towards building a therapeutic alliance (van den Kieboom & Jonker, 2012). Limited reparenting refers to the therapeutic relationship being used as a secure base that can meet, at least partially, some of the core needs not sufficiently met in childhood (Dadomo et al., 2016; Young et al., 2003).

The therapeutic relationship conveys emotional regulation, following psychodynamic principles taken from Self Psychology and Object Relations theory (Clarkin et al., 2007; Maroda, 2009). Using cognitive, affective, behavioural and interpersonal techniques, the therapist joins the individual in the fight against their EMS. When unhelpful patterns are repeated, the therapist confronts the individual empathically with reasons for change.

Schema mode work was originally viewed as an advanced aspect of SFT, that a therapist can use when stuck (Bamber, 2004), but is now increasing in use. Young et al. (2003) outline criteria for the use of mode work; for example, chronic and rigid avoidance, high level of internal conflict, and high level of self-criticism. The identification of each mode gives rise to specific goals, and a 'roadmap' is developed which guides the interventions and is transferred to everyday life (Fassbinder et al.,

2014). Child modes are comforted and supported by the therapist, punitive parent modes are 'fought' against, dysfunctional coping modes are weakened, and healthier responses replace coping responses (Fassbinder et al., 2014).

In schema mode work, experiential techniques are used, including Gestalt methods; central to bringing needs, feelings and impulses to awareness and allowing full expression, are empty chair dialogues and imagery (Perls, 1973). Using the safety of the therapeutic relationship, intensive use of experiential techniques is suggested to result in corrective experiences in terms of needs, emotions and relationships (Fassbinder et al., 2014). Using experiential strategies enable access to emotional areas of the brain (e.g. the amygdala) where emotional memories are stored (LeDoux, 1995), where it is argued that change is more likely to occur. The schema mode model is said to summarise complex presentations in a clear, plausible and validating way (Fassbinder et al., 2014), and is argued to provide a less stigmatised view of psychological difficulties, as it proposes that *everybody* experiences modes (Young et al., 2003).

SFT can be short or longer term, depending on the individual's needs (Young et al., 2003), and can be delivered on a one-to-one basis (Giesen-Bloo et al., 2006) or in a group (Farrell, Shaw, & Webber, 2009).

1.5.   Critical Evaluation of Schema Focused Therapy and Mode Work

SFT is gaining widespread popularity (van Vreeswijk, Broersen, & Nadort, 2012). The mode concept has been extended to forensic populations (Bernstein, Arntz, & de Vos, 2007) and is being considered in relation to eating disorders (Pugh, 2015), chronic depression (Bordelon, 2007; Renner, Arntz, Leeuw, & Huibers, 2013) and obsessive-compulsive disorder (Gross, Stelzer, & Jacob, 2012).

Research findings indicate the efficacy and cost-effectiveness of SFT, including schema mode work[1], when used with people with a diagnosis of borderline

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[1] Some research is based on the original SFT model, and does not include schema mode work.

personality disorder (Giesen-Bloo et al., 2006). There is a general paucity of methodologically sound studies, particularly in relation to other personality disorders and mental health conditions; however, the evidence base is growing and reported findings are promising (Bamelis et al., 2011; Taylor, Bee, & Haddock, 2016).

Randomised control trials, open trials, and case-series studies have been used to evaluate SFT with borderline personality disorder and other personality disorders. Some large-scale controlled trials (e.g. Giesen-Bloo et al., 2006) and single-case series studies (e.g. Nordahl & Nysaeter, 2005) have been conducted regarding borderline personality disorder, providing evidence for SFT's effectiveness (Bamelis et al., 2011). For example, in Giesen-Bloo et al.'s (2006) randomised control trial comparing SFT with transference-focused psychodynamic therapy (TFP) in individuals diagnosed with borderline personality disorder, significant symptom reduction was demonstrated. On all outcome measures SFT demonstrated more positive results, along with a lower risk of dropout (of note, as risk of dropout is high with borderline personality disorder), and higher ratings by both service users and therapists regarding therapeutic alliance. Studies examining SFT and post-traumatic stress disorder (Cockram, Drummond, & Lee, 2010) and depression (Malogiannis et al., 2014) demonstrated promising results. Mixed evidence has so far been found in relation to eating disorders (e.g. George, Thornton, Touyz, Waller, & Beumont, 2004; Simpson, Morrow, & Reid, 2010).

Studies evaluating SFT vary in the outcomes they measure: schema, mode, and symptom change; dropout rates; and distress levels. Systematic reviews and meta-analyses have tended to examine symptom reduction in borderline personality disorder (Jacob & Arntz, 2013; Sempertegui, Karreman, Arntz, & Bekker, 2013). Taylor et al.'s (2016) systematic review focused on EMS and mode change across a range of diagnoses (borderline personality disorder, other personality disorders, anxiety disorders, post-traumatic stress disorder, and eating disorders). 12 studies met the criteria, and approaches varied, having used either the original manual or subsequent versions by Young (1990, 1996, 1999) and Young et al. (2003); the latter including mode work. Other manuals develop the approach further; for individual

(e.g. Arntz & van Genderen, 2009), and group mode work (e.g. Van Vreeswijk & Broersen, 2006, 2013).

11 of the 12 studies reported a decrease in EMS and significant reduction in symptoms across presentations. Schema change was not observed in a group intervention for eating disorders, where group numbers were small (George et al., 2004). In the seven studies examining borderline personality disorder and personality disorder, significant results were found for the effectiveness of SFT in both EMS reduction and symptom improvement (Taylor et al., 2016). Five of the studies measured modes, primarily in relation to personality disorders. Findings included studies that examined group SFT with mixed personality disorder groups (Renner et al., 2013; Skewes, Samson, Simpson, & van Vreeswijk, 2015; van Vreeswijk, Spinhoven, Eurelings-Bontekoe, & Broersen, 2014), and mixed personality disorder and mood disorders (Videler, Rossi, Schoevaars, van der Feltz-Cornelis, & van Alphen, 2014). These studies demonstrated reductions - some significant - in EMS and maladaptive schema modes, with medium to large effect sizes. Most demonstrated strengthening of the Healthy Adult mode, and those that measured distress reported improvements.

Evidence for the effectiveness of working with modes exists predominantly in relation to borderline personality disorder (Giesen-Bloo et al., 2006; Nordahl & Nysaeter, 2005) and is increasing in terms of other personality disorder presentations (Arntz & Jacob, 2013). Certain combinations of modes appear to be characteristic of particular personality disorders (Lobbestael et al., 2007) and mode models specific to most personality disorders have been described (Bamelis et al., 2011; Lobbestael et al., 2008). For example, a Self-Aggrandiser mode, a suggested subset of Overcompensator mode, is suggested to be common in narcissistic personality disorder (Young et al., 2003). Research into schema modes in other diagnoses is currently scarce and tends to be presented in the form of single case series.

Existing research indicates SFT's ability to achieve change in EMS and schema modes. Despite expansion of the use of SFT and mode work in clinical practice, in general good quality evidence for EMS and mode change in presentations other than personality disorders is currently very limited (Taylor et al., 2016). Existing research

varies in the method in which SFT is delivered, the length of intervention, and measurement and reporting of EMS and modes. Taylor et al. (2016) stated a need for studies to increase in robustness.

1.6. **A Case for Further Expansion**

The schema mode model is viewed as heuristic, open to being further developed and expanded (Arntz & Jacob, 2013). The recent expansion of the mode concept into diagnoses where other approaches such as CBT may not have been successful, indicates that SFT and modes could be considered in relation to psychosis intervention. There appear to be similarities in some of the processes leading to the development of voice-hearing and paranoia, when compared with the development of EMS (on which schema modes are based). The appropriateness for exploring modes in relation to psychosis and the potential benefits that SFT and schema mode work could bring to people with a psychosis diagnosis is discussed below.

1.6.1. Processes Contributing to Psychosis and Early Maladaptive Schemas
Similarities are apparent between processes believed to contribute to the development of voice-hearing and paranoia, and the development of a number of EMS. As outlined in section 1.3.5.2., increasing evidence now exists that demonstrates an association between childhood adversities and psychosis. This evidence has parallels with Young et al.'s (2003) descriptions of adverse childhood experiences (e.g. 'toxic frustration of needs', 'traumatisation and victimisation') as factors that can contribute to EMS development. The two areas mentioned above are discussed briefly below in relation to research in the field of psychosis.

One of the key theories underpinning SFT and schema modes is attachment theory. The *toxic frustration of needs* (when a child's environment is missing something important, such as love, understanding, or stability), links to attachment theory (see section *1.3.4.2*) with a suggestion that secure attachment is unlikely to occur without the provision of love, understanding or stability by a primary caregiver, reducing the likelihood of a child developing an understanding of one's own and other's mental states, and emotion regulation abilities. Considerable research has studied the relationship between attachment and psychosis (Korver-Nieberg, Berry, Meijer, & de

Haan, 2014), some of which is referred to in section *1.3.4.2*. Insecure attachment can increase vulnerability to psychosis and have a negative impact of the course of psychosis (Berry et al., 2008; Couture, Lecomte, & Leclerc, 2007).

Traumatisation or victimisation of a child can be linked to the TN model (Read et al., 2001; described in section *1.3.4.2)* which highlighted an association between severe childhood trauma and psychosis in brain structures and chemicals. Trauma and victimisation is likely to interfere with a child's ability to form secure attachment relationships, particularly if the person committing the abuse is the child's caregiver.

The limited reparenting provided by a therapist in SFT (described in section 1.4.5.) aims to meet some of the individual's unmet core emotional needs from childhood (Dadomo et al., 2016; Young et al., 2003). Many of these unmet needs will have origins in adversities including attachment relationships that were neglectful, inconsistent and/or abusive. Considering research suggesting that psychosis can develop as a consequence of such adversities, a therapy such as SFT could be seen to have value in providing limited reparenting appropriate to specific needs (i.e. EMS and modes identified as problematic).

1.6.2. The Role of Emotion

Emotions and emotion regulation are a central aspect of the schema mode concept (Dadomo et al., 2016). Research also highlights emotion as a core aspect of psychosis (Garfield, 1995; Gumley et al., 2013) and some links to psychosis were outlined in section *1.3.4.2.* Difficulty can be experienced by individuals with a psychosis diagnosis in regulating emotions in relationships (Docherty, 1996) and intimacy can be experienced as overwhelming and over-stimulating (Searles, 1965). Such difficulties are suggested to have origins in one's early attachment relationships. Compelling evidence exists in relation to 'high expressed emotion' (EE) in the family context and its influence on the course of psychosis (Burbach, 2013; Brown, Birley, & Wing, 1972).

SFT utilises experiential techniques in order to bring an individual's needs, emotions and impulses to awareness (see section 1.4.5.) within the context of a therapeutic relationship where the therapist acts as a secure base for the service user. Such an

approach could be viewed as useful for people with a psychosis diagnosis, considering research that suggests emotion is a core aspect of experiences such as voice-hearing and paranoia.

1.6.3. EMS and Psychosis

The small body of research conducted to date into EMS and psychosis, suggests some EMS to be associated with 'positive symptoms'[2] of psychosis. Bortolon, Capdevielle, Boulenger, Gely-Nargeot, & Raffard (2013) found that positive symptoms were significantly associated with six EMS (Enmeshment, Failure, Subjugation, Mistrust/Abuse, Social Isolation, Vulnerability to Harm). Significantly predicting positive symptoms after controlling for depression was the Mistrust/Abuse EMS.

Using the YSQ, Social Functioning Scale (SFS; Birchwood, Smith, Cochrane, Wetton, & Copestake, 1990), and Clinical Outcomes in Routine Evaluation (CORE; Evans et al., 1998), Taylor and Harper (2015) found preliminary evidence of several EMS being relevant to psychosis. Significant associations were found between emotional distress and eight EMS (Abandonment, Mistrust/Abuse, Social Alienation, Failure, Dependency, Vulnerability to Harm, Enmeshment, and Subjugation of Needs) in people with a psychosis diagnosis. The Dependency and Enmeshment EMS were significantly associated with lower social functioning.

Existing psychological models of psychosis have implicated schema, suggesting that negative schema develop as a result of early negative experiences (Garety et al., 2001; Morrison, 2001). Birchwood, Meaden, Trower, Gilbert and Plaistow (2000) suggested that paranoia and voice-hearing are fuelled by schemas surrounding social humiliation and subordination, developed following childhood social adversity.

Some similarities exist in experiences related to borderline personality disorder and psychosis, and trauma has been implicated as contributing to the development of such experiences (Allen, 2008; Crawford, Cohen, Chen, Anglin, & Ehrensaft, 2009; Liotti, Pasquini, & Cirrincione, 2000; van der Kolk, Hostetler, Herron, & Fisler, 1994;

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[2] this category was not broken down into the different experiences of psychosis.

Varese et al., 2012). For example, approximately 20-50% people with a diagnosis of borderline personality disorder report experiences associated with psychosis, particularly voice hearing (e.g. Pearse, Dibben, Ziauddeen, Denman, & McKenna, 2014). Although further research into possible mediators is required, evidence suggests that childhood trauma plays an important role in the development of these experiences (Schroeder, Fisher, & Schäfer, 2013).

1.6.4. Schema Modes and Psychosis

To date, no research has explored schema modes in relation to psychosis. However, in a recent study, interviewing adults with a diagnosis of psychosis and a history of childhood physical abuse, possible mode-like states were highlighted (Rhodes & Healey, 2016). A 'Paranoid' mode was proposed, involving scanning others for signs of threat. It was hypothesised that 'psychotic identity transformations' occur, with a possible continuum between 'psychotic' and 'non-psychotic' forms of modes. For example, during moments of heightened psychosis two participants reported feeling they had become children (possibly falling under Vulnerable Child mode), and another believed he was extremely rich (possibly linked to the Self-Aggrandiser mode and Entitlement/Grandiosity EMS). The sample of this study was small and specific to childhood physical abuse, therefore the findings may not extend to other groups. A need for further research was suggested, looking at other groups and using different methodology (Rhodes & Healey, 2016).

Khalily, Wota and Hallahan (2011) investigated schema modes across a range of mental health presentations. Fifty people completed the SMI and the Minnesota Multiphasic Personality Inventory (MMPI), a psychometric tool examining patterns of personality and emotional disorders on nine clinical scales. Significant positive correlations were found between modes and specific presentations, including paranoia and schizophrenia. Whilst findings highlighted possible links between psychosis and schema modes, the researchers reported limited power.

The literature presented above indicates schema modes could be identified in psychosis, and that SFT could be an appropriate therapy to consider for this population. Whilst the evidence base for SFT is currently limited, it is growing and has demonstrated promising findings regarding its effectiveness in EMS and mode

change. This thesis aims to add to the evidence base, by exploring schema modes in psychosis.

1.7. Aims and Research Questions

This research aims to explore the relevance of schema modes in the context of psychosis. Research has not previously covered this area; therefore, it is an exploratory study. The research questions are as follows:

1)   Do schema modes seem relevant for individuals with a diagnosis of psychosis?
2)   Does there appear to be a relationship between schema modes and psychosis?

1.8. Clinical Relevance and Rationale

As highlighted in section 1.4, with limitations to existing psychological interventions for psychosis, there may be a need for alternative approaches. It is highlighted as problematic that in theoretical models of psychosis, emotions and 'symptoms' have tended to be kept separate (Gumley et al., 2013). Emotion dysregulation should be addressed through psychological interventions (Smith et al., 2006). Indeed, many EMS develop during the preverbal stage; emotions, memories, or bodily sensations are stored before language has been acquired. It is therefore claimed that emotions can exist without cognitions (Zajonc, 1984) and that emotions have primacy over cognitions when working with EMS and schema modes (LeDoux, 1995; Young et al., 2003). Simple cognitive techniques cannot access parts of the brain where emotional memories are stored, which suggests an approach that accesses emotions is required.

Historically, there has been "a striking reluctance to keep people's life experience at the forefront of our theories" (Boyle, 2006, p.10). SFT draws upon theories that bring life experiences and a range of adversities to the forefront, and outlines ways in which they can be addressed. Shifting the focus in this way could help move further

away from individualising assumptions around psychosis being a consequence of genetic vulnerability and dysfunctional beliefs, and towards a recognition of the impact of early adverse experiences. If schema modes do appear relevant to psychosis, aspects of working with schema modes in SFT could be appropriately modified.

2.   METHODOLOGY

This chapter will describe the methodology chosen for this research. It will begin by stating the epistemological position taken and the rationale for why the methodological approach was chosen. The researcher will then reflect on her role in the process and the influence she had at every stage of the research. The study's procedure will be explained, detailing the recruitment method, the sample, data collection, and ethical issues. Finally, an outline will be given of how the data was analysed.

2.1.   Epistemological Position

A critical realist epistemological stance was taken to explore individuals' experiences of psychosis. Critical realism aims to attain an understanding of the 'truth' of what is happening in the world, whilst acknowledging that direct access to this reality may not be possible (Willig, 2013). It maintains that a real and knowable world exists, but that this is positioned behind a wall of socially-located, subjective knowledge, and it is only this that the researcher can access (Madill, Jordan, & Shirley, 2000).

The way that psychosis is experienced, talked about and interpreted is constructed within a wider social, cultural, historical and political context. This means there are a range of views and interpretations. Schema modes are constructs that were developed in a therapeutic context, arising from therapeutic discourses which in turn have been influenced by the wider social, cultural, historical and political context. Participants will have constructed the meaning of their experiences and the researcher will have interpreted these meanings through her lens as a researcher,

psychologist and individual with her own personal experiences and beliefs. Therefore, the researcher does not aim to uncover the 'truth' about psychosis or schema modes, yet instead acknowledges that accounts of individuals' stories will be elicited that, experienced and told by anyone else, are likely to produce different accounts.

2.2. Research Design

2.2.1. Qualitative Design

Previous research examining psychosis and Early Maladaptive Schemas (EMS) has been quantitative and focused on relationship between SMI scores and 'positive symptoms'. Modes have not been examined qualitatively apart from single case series, despite the reason for their development being to increase accessibility for service users and therapists. Therefore, not much is known about how people talk about the mode construct, and how relevant it might be to psychosis. As this was the main aim of the current research study, a qualitative design was deemed most appropriate.

Qualitative approaches aim to understand experiences and the contexts in which these are rooted and enable the collation of rich, descriptive data (Braun & Clarke, 2013). There is currently a paucity of qualitative research into schema modes. As clinicians are expanding the use of SFT and mode work, some using it with people with a diagnosis of psychosis, understanding the relevance of the mode concept in relation to psychosis could be useful.

Quantitative approaches might solely rely on the use of the SMI to explore which modes might be relevant to those with a psychosis diagnosis. However, it was felt that this might ignore the nuances of service users' difficulties. For example, although two people may score the same on a particular mode, there could be variance between their experiences that led to those responses. A quantitative method would not have enabled a more in-depth exploration of this area. However, it was considered important to include administration of the SMI in this research for comparison purposes. This was in order to compare the participants scores with their

accounts of modes during interview, and to increase comparability with other schema mode research studies.

In SFT, schema modes tend to be identified using a combination of three methods: in-session dialogue and observation; use of experiential techniques; and administering the SMI. In practice, it is advisable that all three methods are used (Lobbestael et al., 2007). For the purposes of this research, it was deemed ethically inappropriate to use experiential techniques; participants may have become distressed in a research as opposed to a therapeutically focused context. Therefore, the aim was to use two of the above methods, using dialogue in the form of an interview, alongside the SMI.

2.2.2. <u>Thematic Analysis</u>

Thematic analysis (TA) was chosen for this study, which proposes that exploration of a phenomenon is possible through direct and in-depth interviewing. This can produce rich and detailed data, from which identification and analysis of patterns of meaning is possible (Braun & Clarke, 2013) and clear descriptive themes can be generated (Braun & Clarke, 2006). TA aims to capture patterns of meaning whilst recognising that these can only be understood within the contexts in which they occurred (Braun & Clarke, 2013). Whilst enabling the identification of themes, it is argued that TA does not sacrifice depth of analysis (Joffe, 2012).

In addition to TA, Interpretative Phenomenological Analysis (IPA) was initially considered as a possible methodology. IPA aims to gain an in-depth understanding of one's lived experience and the meaning one attributes to this (Smith & Osborn, 2008). However, as Braun and Clarke (2013) state, it is important to match the theoretical framework and method with the research aims. This research was predominantly led by SFT theory, which meant that the methodology used would need to be more flexible than the IPA approach. Content analysis (CA) was also considered, as it could have enabled a clearer categorisation of whether a schema mode appeared relevant to each participant. However, it was felt that a wealth of important data indicating nuances in experiences would be lost by taking the CA approach.

TA can be used to generate new themes ('inductive') or to examine how existing concepts manifest in data (theory-led or 'deductive') (Braun & Clarke, 2006; Joffe, 2012). The approach taken in this research was predominantly theory-led, as it was driven by theoretical knowledge of schema modes, with research questions asking specifically about the relevance of schema modes. Like all qualitative research, prior exposure to theoretical knowledge and research will have some impact on the collection and analysis of data. As well as SFT, the process was also influenced by theoretical knowledge about psychosis. This theory-led approach heavily influenced the interview questions asked by the researcher.

As the researcher also wanted to remain as close to the data as possible, a more inductive approach was also taken during the analysis stage, allowing for the generation of new themes within a theory-led design/structure (the process of analysis is outlined in Section 2.8.). However, the researcher acknowledges that it will not be possible for her to remain independent of prior knowledge or theory when using this more inductive approach. The researcher's experience and existing knowledge shaped the design of the research and data collection stage, which will influence interpretation of the data.

TA can involve the direct observation of thematic patterns at the manifest level, or interpretation at the latent level (Boyatzis, 1998). It appealed to the researcher to approach the analysis at both levels, providing the opportunity to consider the experiences of participants at a deeper level. The first stage of the analysis (see Section 2.8. for an outline of the data analysis stages) took a semantic approach, whereby data were organised according to schema modes. Explicit surface meanings were necessary at this initial data organisation stage. Following this, the analytic process involved a progression from description to interpretation; interview data were organised to show patterns in semantic content, then summarised where interpretation occurred.

2.3.   Quality of the Research

There are several methods of evaluating and reviewing qualitative research. Yardley's (2000) four principles were used to assess the validity of the research findings. The principles are outlined and addressed below.

2.3.1. <u>Sensitivity to Context</u>

It is important that research is contextualised regarding relevant literature and theory. There must also be a sensitivity of research to participants' experiences and the socio-cultural context within which participants are located.

I conducted a literature search around the development of SFT and schema modes, in addition to the construction of psychosis. This, along with my own experiences of learning and working with service users who have received the diagnosis, informed my thinking.

Whilst the interview was theory-led and therefore structured around existing concepts, participants were asked open-ended questions as much as possible in order to encourage discussion about issues relevant and important to them.

During the analysis stage, I was aware of the importance of remaining sensitive to how the socio-cultural context shaped how experiences were spoken about. When writing up the Results chapter I attempted to maintain this sensitivity to social-cultural context. This was a difficult task, as the small sample of participants were from a mix of cultural backgrounds. At times the researcher felt that the process of thematic analysis of identifying themes across participants could lead to socio-cultural context being missed.

2.3.2. <u>Commitment and Rigour</u>

Commitment to the research can be demonstrated through methodological competence, thorough data collection, depth and breadth of data analysis and immersion in the topic. Each point is addressed below:

2.3.2.1. *Methodological competence*

Relatively new to qualitative research, the researcher's knowledge and skills had increased through the teaching received alongside reading and thinking critically about it. The unique design of this research led to much consideration and deliberation of the appropriate methodological approach to take.

2.3.2.2. *Thorough data collection*

Whilst this research was exploratory, the wide remit of the research (i.e. in exploring all eight schema modes) compromised the depth of the data collected. A more thorough data collection was enabled through the administration of the schema mode inventory in addition to the interview.

2.3.2.3. *Depth and breadth of data analysis/immersion in the topic*

The researcher fully immersed herself in the data, with initial familiarisation, followed by coding and organising the data into matrices, before refining codes and identifying themes and sub-themes. In qualitative research the triangulation process is complicated, particularly when taking a critical realist stance, as the aim is not to search for a knowable 'truth' (Braun & Clarke, 2006). Administration of the Schema Mode Inventory contributed to some form of triangulation, however as noted above, there were some limitations to this.

Credibility was assessed through the researcher's supervisor checking codes, themes and draft chapters.

2.3.3. <u>Transparency and Coherence</u>

There is a need for transparency in data collection methods and in the descriptions given of data, so that the fit between the research questions, theoretical framework, and methods can be examined. To enable transparency, examples of each stage of the analysis are included in the Appendices, which includes: an excerpt from a coded transcript; an example of a matrix template; and a table of quotes, codes and themes for a mode (see Appendices K, M, and N respectively). This attempts to provide a coherent story of the analysis and how interpretations were arrived at. It seems particularly important to provide such transparency because of the unique research design, alone with the view held by some that the flexibility of thematic

analysis can lead to a lack of coherence and an inconsistency when identifying themes (Holloway & Todres, 2003).

2.3.4. Impact and Importance

This principle can be evaluated in terms of the objectives of the analysis, the plans for how it would be applied and who the results would be considered relevant for. Implications of the research findings are outlined in section 4.3. This research is of clinical relevance to people with a psychosis diagnosis and therapists trained in SFT. It may also be of relevance to clinicians using approaches other than SFT. Findings will be disseminated to participants who communicated a wish to receive a summary of findings. Every effort will be made to disseminate the findings to wider academic forums.

2.4.   Researcher Reflexivity

In order to ensure data quality and transparency it was essential to maintain a reflexive stance throughout the research process. The researcher's assumptions, intentions and actions will impact on how she experiences the world. These can be influential throughout all stages of the research, from developing research questions to writing up the research (Yardley, 2000).

Throughout the research process, attention was paid to any biases that could influence the research (Thompson & Chambers, 2012). Prior to starting the research, the researcher had developed her own understanding around psychosis, that psychosis and related words such as 'delusions' and 'hallucinations' are socially constructed in their terms and experiences. The researcher was aware of the influence that her perspective regarding psychosis could have on the way questions were asked during interviews. There was the risk of confirmation bias, which involves the seeking of, and interpretation of, information according to one's own views (Nickerson, 1998). In order to try to limit bias, a reflective diary was kept during the research process. This enabled careful consideration of particular assumptions and why certain decisions were made.

Of note, this research was designed alongside a research project conducted by a fellow trainee clinical psychologist (exploring schema modes in relation to bipolar disorder), therefore it is possible that the researcher was also influenced by shared assumptions and biases held by her colleague. Because these assumptions were shared, they were also less identifiable. In addition, it was expected that the primary supervisor's experience in, and beliefs around, schema modes and SFT would influence the researcher's views. This may be particularly relevant as the researcher had not received training in SFT, therefore was was more reliant on her supervisor's knowledge.

2.5. Recruitment and Sample

2.5.1. <u>Recruitment</u>

Participants were recruited from three sites across one Borough in an inner London NHS Trust from whom research and development approval had been obtained. Participants were recruited predominantly from Community Mental Health Teams (CMHT) and one from an in-patient ward. Recruitment occurred with the assistance of healthcare team staff, along with the primary thesis supervisor who was employed in one of the CMHTs. The thesis supervisor approached psychologists and care-coordinators working across the borough, explained the research study and distributed recruitment information sheets (Appendix G) for staff to read, along with participant information sheets (Appendix E) for staff to hand out to potential participants. Recruitment also occurred through the researcher attending one CMHT to speak to staff running a depot clinic who handed out participant information sheets to anyone interested who attended the clinic. The researcher visited another CMHT and gave a presentation to staff about psychosis and requested support with recruitment.

Potential participants were identified by staff in the clinical teams and were informed verbally by staff about the study. Those who expressed an interest were given a participant information sheet to read and were asked for their consent for the researcher to contact them to give further information about the study, and to give the opportunity to ask questions. If potential participants continued to express an interest during initial contact with the researcher, they were given time to think before

the researcher made contact again to check for consent. If consent was given, an appointment was made to meet for the research interview.

2.5.2. Inclusion Criteria

Participants were considered for recruitment if they had been diagnosed with a non-affective psychotic disorder (e.g. Schizophrenia, Delusional Disorder, Schizoaffective Disorder, Schizophreniform Disorder or Brief Psychotic Disorder), and had not also been diagnosed with any additional major mental health conditions, with the exception of anxiety, given its prevalence. Participants were required to be aged 18 years or over and to understand and speak a good level of English. Participants needed to be considered by their clinical team to be in a mentally stable condition and to have the ability to give informed consent.

Homogeneity of characteristics (e.g. gender) was not sought, to avoid restricting the sample. Given this was exploratory research there were no theoretical grounds for a restrictive exclusion criterion regarding specific psychotic experiences.

2.5.3. The Sample

Seven individuals completed the research. The minimum recommended number of participants for small-scale research projects using TA is six (Braun & Clarke, 2013). An eighth person was interviewed, however was too tired to complete the SMI on the same day; further attempts to administer the questionnaire were unsuccessful. His data were therefore withdrawn from the study. The seven participants' pseudonyms* and demographic details are listed below in Table 7.

The sample reflected a range of ages (26-53 years old) and self-reported a diverse spread of ethnic background. The majority were male (male 5, female 2) and all but one had a diagnosis of paranoid schizophrenia. Experiences falling under these diagnoses varied, predominantly voice-hearing or paranoia, and for some a mixture of the two.

Table 7: Participant demographic details

Name*	Gender	Age	Ethnicity	Diagnosis	Experiences of Psychosis
Nasir	Male	40	Bangladeshi-British	Paranoid Schizophrenia	Paranoia, voice-hearing
Tom	Male	35	White-British	Paranoid Schizophrenia	Paranoia, voice-hearing
Mukhtar	Male	31	Asian-British	Paranoid Schizophrenia	Voice-hearing
Ali	Male	53	Asian-British	Paranoid Schizophrenia	Paranoia, voice-hearing
Sheila	Female	26	Black African-British	Schizoaffective disorder	Paranoia, voice-hearing
Jane	Female	31	White-British	Paranoid Schizophrenia	Paranoia
Kadir	Male	53	Turkish-British	Paranoid Schizophrenia	Paranoia, voice-hearing, seeing things others cannot see

Each participant was allocated a pseudonym at random.

2.6. Ethical Issues

Potential ethical issues were considered while referring to the British Psychological Society's (BPS) code of human research ethics (BPS, 2014). UEL ethics was not required for this study.

2.6.1. Ethical Approval

Ethical approval for the study was provided by the NHS Ethics panel on the 26th September 2017 (Appendix C)

2.6.2. Informed Consent

Prior to each interview commencing, each participant was given the participant information sheet to re-read and had the opportunity to ask any further questions before signing both copies of the consent form (one copy was kept by the participant, and the other by the researcher). The information sheet and consent form stated that

the participant was free to withdraw from the study at any point, without any disadvantage to them.

2.6.3. Confidentiality

Demographic information and interview and questionnaire data were kept securely. It was explained to participants that confidentiality would only be breached should there be concerns for their safety or that of another person, and that if this happened, where possible this would be discussed with the participant first and it would be discussed with my research supervisor. It was necessary to break confidentiality on one occasion, as a participant disclosed a deterioration of mental health. The researcher told the participant her concerns and gained consent to speak with their care coordinator.

Participants were requested to refrain from using identifiable information during the interview; however, they were also informed that any identifiable information given during the interview would be anonymised when the audio recording was transcribed. The audio files, transcripts and answers to the questionnaire were saved on a password-protected computer, in separate password protected files. Audio files were deleted from the audio recorder once uploaded. Paper-based information (consent forms, printed transcripts and completed questionnaires) was kept in a locked environment that could only be accessed by the researcher. Consent forms were kept separate from anonymised questionnaires and transcripts to prevent identification of participants.

All information (audio recording, written transcript, questionnaire responses) will be kept for five years following completion of the thesis, and then destroyed. During the five years, the information might be used for additional articles or publications based on the research.

2.6.4. Consideration of Possible Distress

The possibility of participants becoming distressed during or after the study was considered. The participant information sheet informed of the possibility of getting upset if talking about difficult experiences and outlined ways that the researcher could offer support (see Appendix E). Before, during and after the interviews, the

researcher remained sensitive to any signs of distress. The researcher arranged to speak with each participant's psychologist or care coordinator prior to and following each interview for safeguarding purposes. None of the participants appeared distressed as a result of any of the interview questions or content.

2.7.   Data Collection Process

2.7.1. Materials

2.7.1.1.   Digital audio recorder

A digital audio recorder (Philips Voice Tracer 1100) was used to record all interviews. The participant information sheet informed participants that the interview would be audio recorded. Participants were also verbally reminded of this immediately prior to commencement of the interview.

2.7.1.2.   Interview schedule

An interview schedule (Appendix H) was developed before the recruitment stage, following the literature review and discussion with both thesis supervisors. Interview questions were developed around the theory that schema modes are "the moment to moment emotional states and coping responses – adaptive and maladaptive – that we all experience" (Young et al., 2003, p.37.) and therefore questions related to experience of modes as well as possible triggers, duration and intensity. The schema modes themselves were presented on card, which provided brief descriptions of the modes. These were modified from more complex mode descriptions presented in (Young et al., 2003) to try to ensure that they were accessible to participants. Both supervisors have extensive knowledge and experience working with people with a diagnosis of psychosis, and the primary supervisor has experience of using SFT and mode work with service users. It was a semi-structured interview, whereby participants were asked the same number of basic questions, with flexibility for the researcher to ask prompts throughout the interview to follow avenues of enquiry as they arose. A pilot interview was conducted to gauge the appropriateness of the questions. The data from this interview was included in the analysis, as no major changes were made to the interview schedule.

2.7.1.3.   The Schema Mode Inventory – short version (SMI; Young et al., 2007)

The SMI was designed to assess for Young's schema modes and generates quantitative data. The short version was administered with each participant following their interview. The short SMI is a self-report measure comprising of 124 items and 14 scales and takes approximately 25 minutes to complete. A six-point scale, ranging from 'never or hardly ever' to 'always', is used to rate each item. The SMI is reported to display good psychometric properties with high internal consistencies (Lobbestael, van Vreeswijk, Spinhoven, Schouten, & Arntz, 2010) for identification of modes in personality disorder. The SMI is said to demonstrate reliability and validity, therefore is concluded to be a valuable tool to use in clinical practice and research (Lobbestael, 2012).

2.7.2. <u>Data Collection</u>

Interviews were conducted in a private room on NHS premises, lasting between approximately 50 minutes to 1.5 hours. At the beginning of the interview the participant was asked to describe, in their own words, their experience of psychosis (e.g. voice-hearing) so that the researcher could use the participants' own terminology throughout the interview. It also aided understanding around the type of experience that was being spoken about. The interview schedule (Appendix H) was then used as a guide to ask the participant questions. The way in which questions were asked depended on how the interview flowed. Using planned questions and prompts enabled the minimisation of any impact of personal biases; however, it was beneficial to not feel too constrained and able to follow up points that required clarification. Participants were given the chance after the interview to ask any questions and to reflect on the process.

Participants completed the SMI following the interview, a few of whom preferred the researcher to administer the questionnaire with them. Participants were asked to complete the questionnaire based on how things were for them generally.

2.8. Data Analysis

There were four stages to analysis: transcription of the interviews; organisation of interview data into matrices per schema mode; thematic analysis of the interview data by schema mode; and comparison of interview data with SMI data.

2.8.1. <u>Transcription of Interview Data</u>

The first stage in the data analysis process was transcribing the audio recordings, enabling the researcher to become familiar with the data (Braun & Clarke, 2013). The researcher transcribed at a semantic level, focusing on words that were said, not how they were said (e.g. emphasis, tone). This is referred to as the 'Jefferson Lite' (Potter & Heburn, 2005). Method of transcribing, which involves noting some of the gross linguistic components (e.g. laughter, pauses) but not additional detail. The inclusion of additional paralinguistic features is not generally viewed essential for TA, unlike some other qualitative analysis methods (Braun & Clarke, 2013). Transcription conventions used in this study were adapted from Braun and Clarke's (2013) notation system (Appendix J). As interviews were transcribed, identifiable information was removed and replaced with an appropriate equivalent word. Following transcription, the researcher listened to each audio recording in full to check against the transcripts for errors.

2.8.2. <u>Organisation of Data into Matrices</u>

The second stage of analysis involved organising the data according to schema mode. One format for displaying qualitative data was described by Miles and Huberman (1994) as a matrix, a table with defined rows and columns whereby large quantities of complex data can be presented ready for analysis. The researcher used Microsoft Excel to create eight matrices, one for each schema mode. Each matrix consisted of column headings, which were organised around SFT and literature. This was in order to try and determine whether participants unanimously spoke about, for example, modes being 'triggered off' by something in particular or the experience of 'switching' between modes. Column headings included: 'contributing factors', 'experience of mode', 'responses to mode' and 'mode influences psychosis?' and each participant's data were assigned to a row (see Appendix M for a matrix template).

2.8.2.1. *Familiarisation with the data*

The researcher immersed herself in the data. Each completed transcription was read and notes were made in the margins of initial observations.

2.8.2.2. *Coding*

Each transcript was again worked through systematically, labelling features of the data that appeared to reflect each schema mode. Each data item that seemed relevant to a mode was coded by typing notes in the margin (see Appendix K for an example of an annotated transcript). The left- and right-hand margins of the transcripts were used for coding: left-hand margin were codes of data extracts from the transcript that appeared to reflect the mode that the participant was being asked about at that point in the interview. The right-hand margin featured codes where the researcher identified examples of modes arising in the interview when the participant was not at that point being asked directly about that particular mode (e.g. was being asked about a different mode). A colour-coding system was used by the researcher when highlighting data for codes, so it was clear whether the data extract was linked to the left- (text highlighted in yellow) or right-hand (blue text) column. Distinguishing between the two helped the researcher to see how much data appearing to reflect schema modes arose when asked directly about modes.

A detailed definition of each category was used to ensure accurate coding into categories. Reliability of the coding was evaluated through computing coefficients of agreement (using Cohen's Kappa) between the researcher and her colleague conducting a similar study. After each researcher rated the extracts, they engaged in a dialogue around areas of disagreement. Initially, there was disagreement about three of the 16 extracts. At the end of the process, there was still disagreement on two of the sixteen extracts. This disagreement was regarding whether one quote was Demanding or Punitive Parent, and whether another was Impulsive Child or Overcompensator mode. At the end of the process k - .87 (*see* Appendix L for calculations). A Kappa of .70 is satisfactory.

2.8.3. Thematic Analysis Process

The third stage involved a TA being carried out on each matrix. The process of analysis was based on the phases detailed by Braun and Clarke (2006), adapted for the purposes of this study. Braun and Clarke's (2006) phases one (*familiarisation with the data*) and two (*coding*) refer to the processes described above in section 2.8.2.2. and involved the researcher becoming immersed in the transcripts and coding data according to each mode. The next phases described by Braun and Clarke (2006) were followed when TA was conducted on each matrix.

Phase three: Searching for themes

Themes are meaningful and coherent patterns across the data set that are relevant to the research question. This phase involved looking for similarity and relationships between codes within a matrix and across participants, making connections and creating broader codes. Consideration was given to relationships between codes, sub-themes and higher order themes. Themes are not simply discovered; it is acknowledged that themes are constructed by the person making the connections.

Phase four: Reviewing themes

The themes were checked, to ascertain whether they worked alongside coded extracts, matrices and the full transcripts. This phase involved two levels:

> *Level one*: To ensure the themes were coherent and appropriately supported, they were checked against the data. Themes with only a small amount of data attached to them were subsumed into broader themes, and those themes that were not distinctive enough were split. A thematic map was created (Braun & Clarke, 2006; see Section 3.1.).

> *Level two*: The themes were then checked again, through re-checking each matrix and transcript, to check that the thematic map was a consistent fit with the data, and to enable any missing data to be identified.

Phase five: Defining and naming themes

Consideration was given to the information that was conveyed by each theme, and how it related to its respective mode and also the whole data. Each theme was given a title.

Phase six: Writing up

The final phase involved drawing together the analysis into a narrative about the data, considering the findings within their context, and referring to existing theory and literature.

2.8.4. Comparison of SMI Scores with Interview Data

In the final stage of analysis, participants' scores from the SMI were checked against norms from a non-clinical adult population which provided ratings ranging from 'very low' to 'severe' (see Appendix O). This reflected how much an individual participant was perceived to experience each respective schema mode. Comparison of each participant's SMI ratings were made against the interview transcripts as a whole. Following this, the whole sample's SMI scores for each mode were considered in relation to each other, noting any similarities and patterns in the data.

3. RESULTS

Audio recordings from the seven interviews were transcribed. Each interview was analysed and coded according to each of the eight schema modes, following which a thematic analysis was undertaken of each mode. This chapter presents the overarching themes and sub-themes identified from the data for each mode. Participants' scores from the SMI questionnaire were compared to norms for a general adult population. A comparison was then made between these SMI ratings and what was talked about during the interviews. This chapter ends with this comparison and a summary of the findings.

Whilst interview transcriptions included word repetitions, connecting words and brief interjections, the analysis process did not include interpretation of these. Therefore, they have been removed from the quotes presented in this chapter. '…' refers to

words that have been removed, to reduce quote length. Each participant's pseudonym is used alongside their respective extracts.

It is important to note that due to interviews lasting a maximum of 90 minutes with no follow-up, to avoid causing undue distress to participants the interview schedules did not consist of questions about childhood experiences. This means that a fuller understanding of the child and parent modes, in terms of whether particular thoughts, feelings and behaviours were the response to unmet core needs or a reflection of an internalised parent, was not possible. At times participants spontaneously referred to childhood experiences, enabling a degree of insight, however this was not consistent and did not occur across all participants.

3.1. Summary of Themes

Insufficient data was available for a thematic analysis to be carried out on three of the modes – Demanding Parent, Impulsive/Undisciplined Child, and Overcompensator – therefore, these are not reported on this chapter. However, these modes are considered in Chapter 4. Although the research questions and interview schedule were theory-led, the researcher's aim was to remain close to the data during the analysis stage; therefore, the results and themes reported on below reflect the reported experiences of participants.

A thematic map displaying the five remaining schema modes with their superordinate themes and subordinate themes is displayed in Figure 1. Each mode's themes and sub-themes are then examined. The research questions are discussed and addressed in Chapter 4.

3.1.1. Punitive Parent Mode
Punitive Parent mode relates to thinking that oneself is bad or disliking oneself most of the time, feeling deserving of punishment, and/or feeling the urge to punish oneself or deprive oneself of pleasure. Six of the seven participants appeared to experience the Punitive Parent mode. An overarching theme for this mode was

identified as 'Think Badly of Self', with sub-themes of 'Self-Attack'; 'Mistakes a Threat to Self'; and 'Psychosis Exacerbates Sense of Self as Bad'.

3.1.1.1. Theme: Think badly of self

There were numerous examples across the six participants of thoughts, feelings, behaviours and beliefs about the self that appeared to reflect an overall sense of the self as 'bad', exacerbated in various ways by paranoia and voice-hearing. Self-criticism, self-blame and self-punishment were common and reported to be easily triggered.

Self-attack: Attacking the self was evident across the participants in varying forms. In general, participants spoke of self-blame and behaviours that appeared to reflect self-punishment (e.g. self-criticism, self-sabotage). Some self-attacking was described as occurring in response to making a mistake, which is examined in the below sub-theme of Mistakes as a Threat to Self.
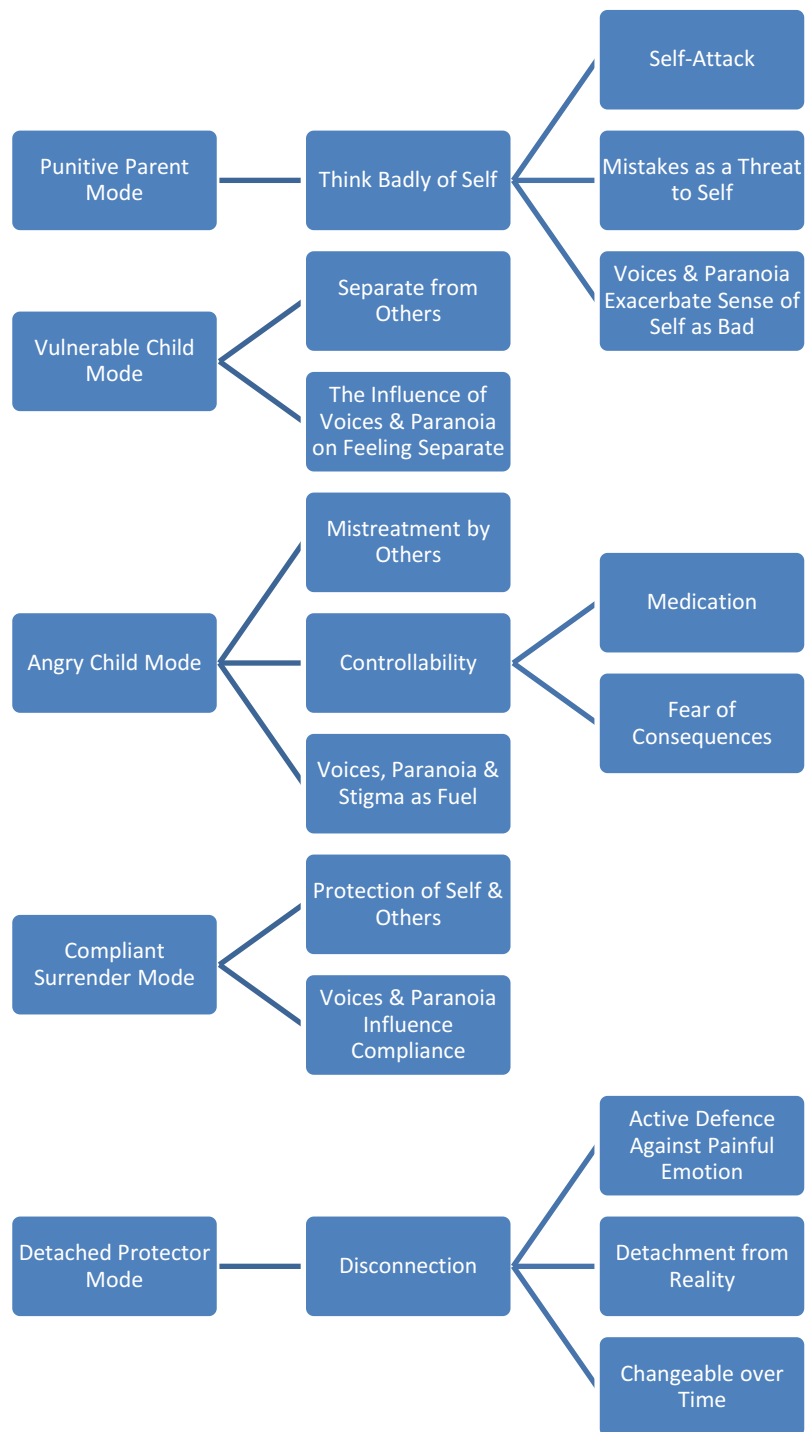
Figure 1. Thematic map of superordinate and subordinate themes for five schema modes

A common thread in the data involved self-criticism in relation to one's behaviour either in the past or present moment. Kadir mentioned regrets about not having done enough for his family, berating himself for this:

> I feel I could have done at least more for…my family...I feel like I
> could have done better really, you know (Kadir/331-337)

Sheila also spoke of berating herself, but for thinking negatively of others. Further criticism towards Sheila occurred in the form of voices, and the sense given in the interview was that this was where the majority of the self-attack came from for her. Therefore, this is examined in the below sub-theme of Psychosis Exacerbates Sense of Self as Bad.

Ali also spoke of being very self-critical and wanting this to change:

> I want to get over it, I don't want to be self-critical, I don't want to
> curse myself (Ali/597-598)

The above statement is, in itself, self-critical and is one example of several during the interview where Ali expressed his discontent at the status quo and his intentions to make changes and improve himself. In addition to self-criticising, Ali appeared to be punishing himself, in the form of self-sabotage. For example, he described spending money to reduce the guilt of having money: "you find a way to go and waste it" (Ali/360). He spoke of feeling undeserving of having money ("it's like a, guilt factor and, and that you don't deserve it" (Ali/340-341)) and referred to "seeing money as a root of all evil" (Ali/393-395). He related his feelings to changes in financial circumstances since childhood and current experiences of poverty.

Mistakes as a threat to self: For several participants the thought of, and response to, making mistakes can trigger intense negative feelings about the self which are often long-lasting. Making what may be viewed by most as a small mistake (e.g. losing at a game; dropping a cup) appeared to trigger very intense feelings for three participants. Ali talked about anger and frustration, and "beating myself" (Ali/62-63) over mistakes. He described feelings and thoughts in response to making a mistake

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as "My life is over...It's end of my life, I'm just worthless" (Ali/89-91). Kadir also described a strong reaction to everyday mistakes:

> If I make a mistake in anything I do, like even if I drop a cup or something…I think the world is going to come to an end (Kadir/155-158)

The same three participants described emotional responses to making mistakes as long-lasting. For example, Mukhtar mentioned that the anger at making a mistake whilst clothes shopping "ruins the whole day" (Mukhtar/113). For Kadir the feeling lasts at least a day or two, and Ali described the "suffering" (Ali/42) as lasting one to three days.

Three participants talked about trying to avoid making mistakes in order to avoid the negative emotions attached to it. For example, Kadir spoke of trying to avoid making mistakes because he will feel bad if he does make a mistake. For Jane there was so much worry about making mistakes, that she avoided everyday tasks (e.g. using herbs when cooking).

The impact - or anticipation - of making mistakes for the majority of participants in this sample gives the impression of being debilitating, significantly restricting one's ability to continue everyday life without being consumed with fear or other intense emotions. Such strong responses being triggered in response to making mistakes could potentially reflect a sense of the self as 'bad', with the act of making a mistake serving as a confirmation that this is true.

Voices and paranoia exacerbate sense of self as bad: Descriptions given of experiences by all six participants reflected a negative influence of psychosis on their sense of self. This included voice hearing and paranoia, and covered the content of what voices say, the presence of voices affecting one's ability to concentrate and achieve tasks, the meaning attributed to the content of paranoia, and reflection on one's behaviour that occurred during an episode of psychosis.

All participants who appeared to experience this mode who also hear voices, talked about voices triggering or exacerbating negative feelings about the self. Kadir described how voices make him feel really low and that he is bad in some way. One interpretation of voices is that they reflect one's thoughts and feelings about the self, voices appear to reflect self-attacking behaviour. Using this interpretation when considering Sheila's interview, would suggest that she experiences a large amount of prolonged self-attack. For example, she reported that the voices remind her of something she did in the past and "they call me a name" (Sheila/498-499) and a self-attacking process then seems to be prolonged by presence of the voices:

> then I say something mean and then they'll mirror it back to me, and
> then we start fighting…They cuss me for about two days, and we
> fight for about two days, it's horrible (Sheila/278-286)

Self-attack through voices was also apparent for Ali:

> But when I'm doing this, I'm doing that, I'm keeping myself, myself to
> myself, then, then my illness not happy, they're attacking me
> (Ali/920-925)

Ali appears to be in the position of having to meet standards set by the voices, then proceeds to be attacked when these standards are not met. This could potentially reflect a deep dissatisfaction with himself for who he is. As mentioned above under the sub-theme Self-Attack, at several points during the interview Ali said that he wanted to be different, and to improve himself (e.g. "I'm not really as social as I ought to be…and I will be more" (Ali/319-328). He seemed to be constantly striving to change his situation, with mocking and punishing voices appearing after he 'failed' to achieve something. Ali spoke of being laughed at by voices, for not managing to find the 'answer' to something. Mukhtar experienced the voices as "taking joy" (Mukhtar/360) in his misfortune, and as punishing, in telling him he is "going to hell" (Mukhtar/247). Mukhtar spoke of the voices having originally developed because "I wasn't religious anymore" (Mukhtar/254-255). In a similar vein to Ali, it is possible that Mukhtar's voices may be linked to not meeting standards set by himself or others.

Two of the three participants who experience paranoia spoke about the impact of their experiences of paranoia on feelings about the self. Tom spoke of hating himself and feeling guilty for how he had behaved during a paranoid episode, and Jane talked about the meaning she attributed to her experiences of paranoia:

> I do feel like, if all this bad stuff's happening, people reading my
> mind, they're out to hurt me, then, maybe I deserve it (Jane/278-279)

The feeling that has developed for Jane of possibly deserving such negative treatment by others reflects the ability of paranoia to exacerbate or even create a sense of oneself as 'bad' and worthy of punishment. Jane's feeling may reflect a type of paranoia that Trower and Chadwick (1995) termed 'bad me/punishment' paranoia, whereby individuals "tend to blame themselves and see themselves as bad, and view others as justifiably punishing them" (p.265).

Along similar lines, Tom spoke about feeling as though he was being punished through the paranoia, and linked this back to childhood experiences involving his father:

> I stepped into this horrible world where I thought that my dad…was
> tapping the phones here and at home to find out where I was
> because I hadn't seen him for a long time, to find out which cleaning
> company was working here to find the cleaner to pay her to steal
> stuff from me. So I started to get really worked up about it and then
> my uncle died recently…in my head I thought my dad had then
> murdered my uncle to get at me (Tom/44-52)

> I kept sort of thinking in my head well what happens with these
> things with my dad, that he didn't want me. So it was like, well that's
> what my head tells me, so that's why I think a lot of things is him
> punishing me for existing (Tom/437-441)

Elsewhere in the interview, Tom spoke of his childhood and times when he was berated and punished by his father. He talked about memories of his father telling him he had wrecked a weekend for everyone, after Tom had not wanted to dance at a family party. After a period of not seeing his father, Tom described his father pretending Tom did not exist: "I phoned him up and was like Happy Birthday dad it's Tom he was like Tom who?" (Tom/458-459). Much of Tom's experiences of paranoia appeared to originate from a belief that his father is out to get him and is turning everyone against him. Having given the researcher an insight into childhood experiences, it was powerful to see how his experiences in the present may reflect an internalised parent. Young et al. (2003) describes both Punitive Parent and Demanding Parent modes as internalised parents, therefore Tom's descriptions might be considered a reflection of the Punitive Parent mode.

In summary, the six participants all appeared to engage in self-attacking and self-critical behaviour, with voices and paranoia playing a role in exacerbating this behaviour and beliefs about the self as bad.

3.1.2. Vulnerable Child Mode

The Vulnerable Child Mode relates to often feeling completely alone, weak and helpless and unloved, or feeling frightened, sad, abandoned or anxious for no particular reason. All but one participant (Tom) identified with this mode in some way, and there was a sense that for most this had been a way of being for some time. Spontaneous discussion by a few participants of family and childhood experiences provided richer data. Two overarching themes of 'Separate from Others' and 'The Influence of Voices and Paranoia on Feeling Separate' were evident across participants.

3.1.2.1. Theme One: Separate from others

Six participants spoke in varying ways about a sense of feeling separate from others. Experiences underlying the feeling of separateness varied across participants; with descriptions of a distance between them and family and/or friends, feelings or experiences of hurt, rejection, betrayal and abandonment, and feeling different to others.

The way in which two participants talked about it suggested the feeling had been around for a long time. Mukhtar spoke of having "always had a picture of being…alone" (Mukhtar/500-501) and Kadir appeared to have never felt close to his family:

> like my family, you know, like, as I say I've always been sort of like, drifted away from them all the time, I've never been sort of like that really close bond (Kadir/332-334)

Betrayal of trust, rejection, and abandonment by friends and family were common threads. Mukhtar spoke about how having experienced racism throughout his life and being bullied at school, contributed to feeling alone. For Kadir there was a strong feeling of not being wanted or part of society, with a sense that he had been abandoned by his family. He used a striking metaphor to illustrate how this felt for him:

> I feel I've been…pushed on this roadside and left for dead while you know, they've all gone off you know, galavanting, off…I feel bad, I feel horrible (Kadir/882-884)

Kadir's choice of language has the effect of powerfully communicating the very strong feeling of rejection he has experienced, a sense of having been left behind and excluded.

Ali hinted at having been mistreated by his family, leaving him isolated and alone. He gave a sense that he now had only himself to rely on and trust:

> …what they [my family] did to me…finding me isolated and alone and they're all around and in [London Borough] and I'm the only one from my side then I'm isolated (Ali/266-269)

> So-called friends who's not really friends. And so-called family who's not really family. But only friend I have is me myself and my illness (Ali/881-883)

The above quote is striking in that it suggests that Ali feels so isolated that the only thing that resembles the company of another is his illness, perhaps his voices, represented here as a person (more is discussed under the following theme 'The influences of voices and paranoia on feeling separate').

Three participants spoke about feeling different to others (one participant's experiences, Mukhtar, are described under the theme 'The influence of voices and paranoia on feeling separate'). Nasir talked about others not having the same interests of playing computer games as him. When describing feeling "dumped" (Kadir/909) by his family, Kadir drew comparisons between himself and his siblings, feeling as though he is the only one with something 'wrong' with him, and has been treated as such:

> It's like we've got the plague or something, and they're going to
> catch a disease off us or something (Kadir/909-910)

3.1.2.2. Theme Two: The influence of voices and paranoia on feeling separate: The way that psychotic experiences were talked about by participants indicated an overall influence of voices and paranoia on feeling separate from others. Participants' experiences related to paranoia seemed to aggravate existing feelings of separateness. For example, Nasir talked about feeling more alone when something reminds him of times when stories were spread about him (a belief that may or may not have been true, that rumours were being spread about him):

> Whenever I hear something…either a family or relative says
> something that's related to the stories that are being spread about
> me basically...It does make me feel more alone (Nasir/559-567)

Jane spoke of people's reactions when telling them about her paranoid beliefs (e.g. that her neighbour can hear what she is thinking) and being told that it was not true:

I just feel like I'm on my own…I definitely feel helpless, because I'm speaking to people, I'm saying like 'they can hear what I'm thinking', everyone's like 'no they can't' (Jane/380-410)

Experiences such as Jane's, of holding paranoid beliefs in addition to not being believed by others, could be seen to understandably contribute towards a sense of difference and distance from others.

Experiences of voice-hearing, seeing things and believing things others find strange also appeared to exacerbate feelings associated with this mode. Mukhtar explained that because of his experiences of hearing voices and believing in supernatural powers, he feels different to others, and stigmatised and abandoned by friends. He talked about feeling betrayed when his friends took him for an exorcism as they believed he was "possessed by a demon people" (Mukhtar/459-460). It changed people's behaviour towards him and "it really caused a like a, big like space between like, yeah, distance between them and me" (Mukhtar/480-481). A strong sense of loss was communicated through the following quote:

I feel like I've been like abandoned…there was a time when like people used to look up to me and used to called out to help, but, call me out to help, but no longer you know, are like that anymore (Mukhtar/620-628)

Associated with both paranoia and voices, Sheila talked about a sense of feeling alone in not understanding her voices, which seemed to communicate a sense of feeling distant from her friends:

it feels like my friend can read my mind, and she knows what the voices are and she's done mind reading. And I feel like I'm alone because, my friends know what the voices are but I don't (Sheila/451-454)

Interestingly, Ali's reference (mentioned above under The Pain of Feeling Separate) to his illness as his 'friend', suggests that he gains a sense of comfort from the

presence of the 'illness' when he feels alone in other senses. It was unclear whether seeing his illness as a friend was a cause or response to isolation, or both. During the interview Ali also spoke about voices comprising both 'friends' and 'foes'. Hearing voices for Ali could potentially be experienced as a double-edged sword, with 'foes' perhaps exacerbating a sense of isolation, yet 'friends' acting to alleviate this. Sheila referred to 'missing' the voices when they went away on one occasion and of relief when they returned, despite an ambivalence regarding whether she wants the voices around.

In summary, the data suggests that these six participants suffer a sense of separateness and distance from other people. For some this appears to be associated with exclusion rather than an enduring sense of loneliness or isolation from childhood. Furthermore, the experience of psychosis itself has led to a sense of feeling different to – and/or disconnected from - other people.

3.1.3. Angry Child Mode

The Angry Child mode relates to feeling anger and rage, finding it difficult to control anger, becoming furious and shouting, or having violent thoughts and impulses. As mentioned at the beginning of this chapter, interview schedules did not consist of questions about childhood experiences, meaning an understanding of whether anger occurred in response to unmet core needs was not possible in this research. For this reason, the researcher made the decision to include under this mode all data referring to anger, with the caveat that it may be a tentative representation or version of the mode (i.e. the researcher may be including anger that was a proportionate response to a situation rather than enduring from childhood). Three overarching themes were identified for this mode: 'Mistreatment by Others', 'Controllability', and 'Voices, Paranoia and Stigma as Fuel'.

3.1.3.1. Theme One: Mistreatment by others

Experiences of having been mistreated by others were spoken about by five participants, ranging widely from thinking about past events where one felt badly treated, to occasions more recently that involved feeling misunderstood or not respected. Nasir's experiences of anger in relation to paranoia are described below

under theme three, but he distinguished between two types of anger – one related, and another unrelated, to paranoia:

> It's not always tied up with paranoia. There is um…I guess there is sort of like anger at the situation, being mistreated (Nasir/1034-1035)

Three participants talked about family or friends inducing anger. For example, Mukhtar and Kadir described feeling angry as a result of feeling misunderstood by family. Kadir spoke of anger being triggered by his sister's response to him feeling sad about his circumstances: "It makes me feel angry, when she says, 'stop feeling sorry for' you know, she talks about, it winds me up" (Kadir/432-434). Sheila talked about a friend she feels angry towards: "there's stuff that she's said to me and done...So I'm always angry at her" (Sheila/525-527).

Ali spoke metaphorically about forces operating at a higher level; feeling as though he is being looked down upon and mocked by those in power in society:

> like higher people, people up there…they want me to, this area to be supplied with this, filthy water…and so that's what they're doing. They're laughing, they talk ha ha ha ha, you come in and I can smell you, you come from the dirty water (Ali/776-781)

Ali's quote provides a sense of the impact of being on the receiving end of a lack of respect and power in society. It is possible that for Ali this brings up feelings of humiliation, powerlessness and/or helplessness, perhaps exacerbated by a sense of being controlled: "And somebody else is also stronger than that person, somebody else is pulling strings" (Ali/809-810).

Episodes of anger described by participants in relation to mistreatment by others generally appeared to be proportionate responses. This might indicate that these experiences, at least when individuals are not hearing voices or experiencing paranoia would not be categorised as Angry Child mode.

3.1.3.2. Theme Two: Controllability

The theme of Controllability is a reflection of how some participants' experiences of anger were changeable, particularly in terms of their ability to control anger, with two key influencing factors observed in the data; 'Medication' and 'Fear of consequences'.

Medication: Three participants brought up the experience of anger being influenced by their anti-psychotic medication. Tom reported that some medication had made him "really aggressive" (Tom/669-670), whereas Nasir and Mukhtar spoke of the opposite happening, with medication helping them to feel calmer. Nasir talked about anger occurring when he has forgotten to take a dose of Sulpiride, and he sometimes has to take extra doses if the anger is particularly severe. Mukhtar's experience of not being on medication affected the anger: "So I was off the medication and it was these, the anger and rage and trying to control myself" (Mukhtar/661-663). Later in the interview he stated that "because I'm on the medicine…it's calmed me down" (Mukhtar/1264-1265).

Fear of consequences: Three participants mentioned conscious attempts to not express or act on anger. Nasir talked about having stopped exercising through fear of harming others. He described a 'rage' triggered by a belief that people walking past his house were making comments about him:

> I'd get into a rage. I want to punch stuff, I punched the wall. I
> punched the doors, I think I put a few holes in a few doors. I literally
> stopped exercising after that because I was afraid...I was afraid I'd
> sort of catch one of these people and do them in (Nasir/656-661)

Experiences related to psychosis influence this sub-theme; Mukhtar and Jane both spoke of not wanting to be sectioned again. Mukhtar mentioned having been in fights in the past, but "I can't do that anymore" (Mukhtar/1301-1302) due to not wanting to be arrested or to end up in hospital. Jane explained "it's the difference between home treatment and being sectioned [laughter], innit?" (605-606).

3.1.3.3. Theme Three: Voices, paranoia and stigma as fuel

For six participants, experiences related to psychosis led to increased anger in various ways; ranging from voices triggering memories that induce anger, to paranoia contributing to rumination about past events, to anger around the stigma attached to psychosis.

The voices themselves triggered anger for Mukhtar and Sheila. Voices brought up memories of the past for Mukhtar, and Sheila spoke of voices doing something to make her angry at people. Voices served to exacerbate existing feelings of anger for Kadir; he spoke about the voices' response to his football team losing:

> they just, some take the piss like…'we beat you, we're better than
> you', and all this rubbish (Kadir/659-661)

The stigma attached to psychosis (having a diagnosis of psychosis and/or behaving in ways that others cannot understand) was brought up by two participants. Ali described stigma at a societal and community level reducing the likelihood that he will display anger:

> very rarely this society understand the mental health, the effects.
> Instead of helping them, the society, the community I'm from, they
> want to pounce on him and strangelise and…not physically but
> like… (Ali/671-675)

Mukhtar spoke of being viewed by people as a "psychopath" (Mukhtar/760). He described a "hatred" for the voices (Mukhtar/1564-1565) and anger at:

> Mainly what I've become, meaning what has happened to me, like
> my illness, I've ended up with an illness (Mukhtar/754-755)

Mukhtar's description invokes a sense of despair at the effect the voices have had on his life, along with a feeling of helplessness.

Paranoia was also talked about in terms of leading to increased anger. Jane spoke of feeling very irritable when unwell, and of what appeared to be frustration during an episode of paranoia, where she believed her neighbours could hear her thoughts and that she was upsetting them "I don't want to say angry, but I do sit there and think like, I'm doing everything I can" (Jane/394-395). Memories of the past triggered a "feedback loop" (Nasir/885) for Nasir, when thinking about the different things people had said about him in the past. When describing the feedback loop further, Nasir said that anger and paranoia for him are closely interlinked: "the paranoia will feed the anger and the anger will feed the paranoia" (Nasir/903-904).

In summary, the data suggest that participants in this sample experience anger for a range of reasons and that voices, paranoia and stigma influence anger in terms of fuelling it but also can lead to attempts to suppress it.

3.1.4. Compliant Surrender Mode

The Compliant Surrender mode relates to thinking about other people's needs, not one's own, doing things because others want or demand it, allowing others to treat oneself badly, and trying to please others to avoid conflict. Five participants talked about experiences that appeared to fall under this mode. Two themes were identified from the data: 'Protection of Self and Others', and 'Voices and Paranoia Influence Compliance'.

3.1.4.1. Theme One: Protection of self and others

All five participants commented on experiences that appeared to reflect this theme. There was a general sense of avoiding negative consequences for the self, which included not wanting to upset others. Three participants spoke about behaving differently in order to avoid negative consequences for themselves or others. An additional two participants discussed avoiding negative consequences in relation to past experiences of being sectioned; this is examined below under the theme Voices and Paranoia Influence Compliance.

It was apparent from the way that Tom and Kadir spoke about avoiding conflict, that for them it was perhaps an enduring state. For example. Tom gave several examples of how he likes to ensure others are happy:

I want to try and please everyone and make sure, um…no-one's
treating me badly (Tom/816-819)

Two participants talked about having changed their behaviour as they did not want to upset other people (see theme two below regarding Mukhtar's experience). Sheila does what her friends want to do without challenging them, due to guilt around her behaviour towards them when younger:

so with my friends, in school days, I was a bit horrible to them, but
nowadays I'm not horrible to them because I don't want to treat them
the way I did in school. So, I try to avoid conflict by just letting them
do what they want to do (Sheila/664-667)

3.1.4.2. Theme Two: Voices and paranoia influence compliance
From discussion with three participants it appeared that their levels of 'compliance' changed over time as a result of episodes of psychosis. Sectioning as a result of voices and paranoia, in addition to guilt related to one's behaviour during an episode, served to both increase and decrease levels of compliance.

For two participants this mode appeared more active now than in the past. Past negative experiences of being sectioned led to both changing their behaviour to be more submissive, in an attempt to avoid being sectioned again. Jane stated:

it's the difference between home treatment and being sectioned
[laughter], innit? (Jane/605-606)

For Mukhtar guilt relating to his past behaviour during psychotic episodes further exacerbated his now more compliant behaviour with his family; very different behaviour to the past, when he did not worry about avoiding conflict. Mukhtar spoke about pleasing his family; for example, by taking anti-psychotic medication, despite not wanting to:

> I take the medication…I don't want to take the medication
> (Mukhtar/1169-1170)

Three participants talked about how being caught up in psychosis (whether paranoia or hearing voices) led to a reduction in their ability to put others' needs before their own. Mukhtar's description of 'blocking' the voices through medication which has "calmed me down" (Mukhtar/1265), may be interpreted to suggest that the voices influence compliance. He described voices as interfering with his ability to function, whereas now that the voices are not so present he finds it easier to help his family with chores at home. Tom spoke about always doing whatever he can to help people when he is well, but that this can change during an episode of paranoia. Jane explained that:

> When I'm feeling paranoid I'm more likely to argue...when I'm
> paranoid that sort of tends to take over (Jane/724-727)

As Jane states, there is a sense from the descriptions that paranoia can 'take over' this mode or weaken its strength. Similarly, it is possible that hearing voices interferes with activation of the mode or weakens the mode's ability to operate.

Interestingly, Jane and Mukhtar both gave examples of compliance having increased *and* reduced as a consequence of psychosis. When not experiencing intense episodes of psychosis, both appear to go along with what other people want, to keep them happy or because of guilt, both due to negative past experiences of being sectioned or having upset family with behaviours acted out during an episode of psychosis. However, during the times of psychosis taking over or interfering, levels of compliance reduce.

In summary, the data suggest that several participants tend to avoid conflict with others for fear of causing hurt to themselves or others, and that for some this is influenced by experiences relating to voice-hearing or paranoia. The influence of voices and paranoia demonstrates the capacity for the Compliant Surrender mode to change what it looks like, and the extent to which it is experienced, over time.

3.1.5. Detached Protector Mode

The Detached Protector mode relates to avoiding things that one finds difficult, including social contact, painful emotions or thinking about oneself and one's problems, and can include feeling numb or empty. Five of the seven participants appeared to experience the Detached Protector mode in different guises and to varying degrees, which is reflective of Young et al.'s (2003) description that different coping styles will be used at different stages of one's life in varying situations, in an attempt to cope with the same EMS. An overarching theme of 'Disconnection' was identified, with three sub-themes of 'Active Defence Against Painful Emotions', 'Detachment from Reality' and 'Changeable over Time'.

3.1.5.1. Theme: Disconnection

The five participants all discussed experiences that highlighted a process of disconnecting from emotions. Participants each actively applied strategies to create distance from or reduce difficult emotions. A few participants also spoke of experiencing a form of disconnection that was less under their control.

Active defence against painful emotion: A range of strategies were actively used by the five participants to avoid or reduce negative emotions (e.g. working more, drinking alcohol, using porn) or to avoid situations that might trigger difficult emotions (e.g. social contact). Avoidance appeared to be commonly used, with Jane having previously avoided social contact for 15 years, and currently avoiding 'everything', including thinking about emotions:

> I don't really think about my emotions, I just, like experience
> something and try and get through it. I just carry on (Jane/755-757)

Jane had recently started drinking alcohol as a way of relaxing and calming herself down. Mukhtar talked about avoiding one of the triggers for critical voices telling him he will go to hell - hanging around with crows (Mukhtar believed he could communicate with crows). He explained that he did not want to put himself in a situation where he was vulnerable:

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you don't want to like, um put yourself in a situation where you will

have to…be helpless or insecure (Mukhtar/1428-1430)

For Mukhtar, allowing himself to feel helpless or insecure opened him up to criticism from the voices. The way that Mukhtar spoke throughout the interview suggested that he puts a lot of energy into 'blocking' the voices, almost putting up a barrier to prevent the voices from attacking and punishing. More around this is mentioned below.

Three participants discussed methods they use to reduce or cope with difficult feelings. Ali explained having to do something physical "to sweat myself out so it goes out of my system" (Ali/104-106). Nasir described how in the past he used porn to empty his mind and stop flashbacks of childhood abuse. Mukhtar spoke about self-harm as a way of blocking the voices and to deal with emotions:

Yeah, really hard, you have to hit yourself, you can either slap

yourself or you can hit yourself…it would straighten the emotions out

(Mukhtar/333-339)

Detachment from reality: Four participants talked about having had experiences where a detachment from reality appeared to occur that was not under their control. Nasir spoke of experiences during childhood; having 'blackouts' at school which he attributed to stress. The other three participants talked of detachment from reality occurring in the present day. Descriptions included "I don't feel any emotions…it's more like dead…there's nothing going on" (Mukhtar/1338-1341). Ali described feelings of being alone, weak and helpless subsequently changing into a state of being "frozen…nothing is registering" (Ali/987-988). Ali also described what it feels like when he makes a mistake in a computer game:

So when I'm not connected then it's not really, I'm not taking part.

Then even my skin is there…but it's out of reach (Ali/58-61)

It is apparent in Ali's description the distancing that seems to occur from the painful realisation of having made a mistake and potentially lost a game. The expression of

this distancing in a physical sense is striking. Jane also described at times feeling distant from her surroundings; despite reporting not normally feeling emotion, she explained that she sometimes becomes overwhelmed with emotion or thinks something really bad is going to happen, then goes into a 'bubble':

> I sort of like go in these…phases where I'm just like in a bubble or something…it's like everything's going on around me. There's nothing I can do (Jane/464-469)

Despite serving the purpose of cutting off from overwhelming emotions, other unsettling feelings arise, including helplessness. Jane also spoke of feeling unsafe when in the bubble:

> It feels like it doesn't hurt as much. It doesn't, things don't bother me, but…I don't feel safe when it's happening, just like I might miss something (Jane/514-517)

Changeable over time: Young et al. (2003) described the Detached Protector mode as changing its form depending on a variety of situational factors. All five participants who appeared to experience this mode also spoke of it changing over time, with most of these seemingly related to psychosis, either directly or indirectly (e.g. anti-psychotic medication).

Nasir talked about changes over time in his ability to function and to "forget the past" in which he was victim of childhood sexual abuse. He explained that following the abuse he threw himself into his schoolwork:

> I tried to ignore reality, and just sort of blocked out, blocked out, tried to force the memory away sort of thing, by trying to keep busy (Nasir/64-65)

As an adult, Nasir's attempts to forget the past and stop flashbacks continued through the use of porn. He described going to work in order to forget about the past, but at home without the distraction of work he would remember the past. More

recently, Nasir described having experienced a change in his functioning, feeling "lethargic…all the time" (Nasir/592-593). Nasir felt that no longer having "the same sort of get up and go" (Nasir/197) may be due to taking the anti-psychotic medication Sulpiride. Should this be the case, it would suggest that medication could, perhaps unsurprisingly, affect this coping mode. On the one hand, medication could induce a feeling of emotional detachment, however on the other hand for Nasir the medication potentially reduces his ability to defend himself against emotions and memories of abuse, taking more energy to do so. Mukhtar appeared to view the effects of anti-psychotic medication as positive, as he explained that it helped to block critical voices that told him he would go to hell.

The experience of paranoia and voice-hearing appeared to contribute to an increase in the experience of the Detached Protector mode for four participants. Tom and Ali, both of whom experience both paranoia and voice hearing, reported isolating themselves more during episodes of psychosis. Tom, who puts pressure on himself to achieve, also talked about how he tends to 'shut down' when the paranoia is intense:

> I suppose in that sense, I tend to shut down, so when I'm in that
> mode, I wouldn't be doing any art work, I wouldn't be doing work or
> anything, because, the way I reacted to that one, I literally hid my
> head under my desk and just curled up (Tom/347-350)

Jane spoke about how she was more likely to go into a 'bubble' when experiencing paranoia. For Mukhtar, the coping strategy of hitting or slapping himself is aimed at stopping the voices, therefore only occurs when the voices are present. These participants' accounts suggest that the presence of psychosis could impact on the form that the Detached Protector coping mode takes and whether it is activated.

In summary, the data indicate that most participants experience the Detached Protector mode in different ways and the way it presents can change over time. Paranoia and voice-hearing have the potential to influence whether the coping mode is present and the form that the mode takes.

3.2. Comparison of Schema Mode Inventory Scores with Norms

Participants completed the SMI following their interview, for the purposes of further exploring whether particular modes might be experienced by this sample. Each participant's SMI scores were calculated and their ratings in comparison to the norms, a non-clinical adult sample, are presented below in Table 8. The SMI norms provide ratings for each mode, ranging from 'very low' to 'severe'[3], which has been applied in this research to contextualise participants' scores and enable comparison. SMI scores were not reviewed until after the thematic analysis had been conducted, in order to reduce potential influence of the SMI scores on the analysis.

In comparing participants' scores with the norms, elevated SMI ratings were present for some schema modes. These elevated ratings would indicate that particular modes were present to a greater degree in the sample of participants than in the general population. Schema modes where four or more participants were rated as scoring either 'high' or 'very high' on the SMI, were Punitive Parent, Vulnerable Child, and Detached Protector. Interview data also suggested these three modes might be relevant to the sample. Taken at face value, this could indicate that these modes are prominent in people with a psychosis diagnosis. Interestingly, four participants scored 'very low' compared to the norms, in relation to the Self-Aggrandizer aspect of the Overcompensator mode. This could indicate (and is also reflected in the interview data) that this mode is not relevant for people with a psychosis diagnosis, or that it is *less* relevant than for the general population.

Further analysis of the SMI data is conducted below in section 3.3, where comparisons are made with the interview data. Considerations of potential limitations of using the SMI and interpretation of scores are discussed in section 3.3 and further in section 4.2.1.2.

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[3] NB. None of the participant scores fell into the 'severe' range.

Table 8: Participants' Schema Mode Inventory Scores

Participant	Demanding Parent	Punitive Parent	Vulnerable Child	Angry Child		Impulsive/Undisciplined Child		Compliant Surrender	Detached Protector		Overcompensator	
				Angry Child	Enraged Child	Impulsive Child	Undisciplined Child		Detached Protector	Detached Self-Soother	Self-Aggrandizer	Bully & Attack
Nasir	Average	Moderate	High	High	Moderate	Average	Average	Average	Very high	Moderate	Very low	Average
Tom	Very high	High	Moderate	High	High	Average	Average	High	Moderate	High	Moderate	Very low
Mukhtar	Average	Average	Very low	Very low	Very low	Very low	Average	Very low	Very low	Very low	Very low	Very low
Sheila	Very low	Moderate	Moderate	Moderate	Moderate	Average	Average	Average	Average	Moderate	Very low	Average
Ali	Very low	High	Very high	Very high	High	High	Moderate	High	Very high	Moderate	High	Very high
Jane	Average	High	Very high	Moderate	Moderate	Very low	Average	Average	Very high	Moderate	Very low	Average
Kadir	High	Very high	High	Moderate	Moderate	Moderate	Very high	Very high	Very high	High	High	High

The scoring key for the above categories, ranging from 'very low' to 'severe', can be found in Appendix O.

3.3. Comparison of Schema Mode Inventory Scores with Interview Data

Similarities and discrepancies between the interview data and SMI scores were also considered. This section provides a brief comparison between individual participants' SMI scores and the degree to which each respective mode was talked about or observed during the interview. Participants' whole transcripts were used to make the comparison with SMI scores. Whilst several SMI scores were consistent with interview responses, some discrepancy was evident. Of note, comparison was difficult, as this is an exploratory study and no particular means of assessing modes can be assumed to be correct.

3.3.1. Nasir

Nasir was the only participant whose ratings for the SMI appeared consistent with interview responses across all modes. One interpretation for this might be that his 'average' rating for Compliant Surrender may have reduced any need to please the researcher. Alternatively, he was no less compliant than the general population.

3.3.2. Tom

Tom's scores were consistent across several modes. He displayed a 'very high' score in relation to Demanding Parent mode, and 'high' for Punitive Parent and Compliant Surrender all of which came through very clearly during the interview. Tom scored 'high' on the SMI for Angry Child mode, however the anger he spoke about during the interview did not appear to be as strong as this score suggests. It could be hypothesised that Tom's high scores for Compliant Surrender mode meant he did not feel able to open up to the researcher about the anger he experiences.

3.3.3. Mukhtar

Interestingly, the majority of Mukhtar's ratings on the SMI appeared to reflect an under-reporting, when compared with what he talked about during the interview. For example, Mukhtar's scores for Vulnerable Child fell into the 'very low' range, despite describing to the researcher 'always' having been alone and his experiences of bullying and feeling betrayed and abandoned by friends. An alternative hypothesis might be that Mukhtar's responses in the interview were exaggerated, for reasons

that might include wanting to please the researcher by agreeing with the mode cards presented to him.

3.3.4. Sheila

Sheila's scores were consistent across several modes. Her 'moderate' score for Punitive Parent did not seem consistent with the potentially self-attacking nature of the voices that she spoke about during the interview and appeared to occur a lot. Sheila's 'moderate' score for Angry Child may not have reflected the amount of anger she described towards others and the voices; however, it is possible that because the wording of the SMI statements are not specific to voices, this may have influenced Sheila's responses.

3.3.5. Ali

For Ali, there was a general consistency between SMI and interview responses, apart from a discrepancy with regards to Impulsive/Undisciplined Child and Overcompensator modes. Ali's 'high' SMI score for Compliant Surrender was consistent with his descriptions of power in society with an associated sense of helplessness. On multiple occasions during the interview, Ali made reference to wanting to improve himself. One way of interpreting this could be that Ali felt ashamed about his situation and so wanted to prove to the researcher that he was going to change.

3.3.6. Jane

For Jane there was a general consistency between SMI scores and interview responses. For example, her 'very high' score for the Detached Protector mode appeared to reflect what Jane spoke about during the interview about trying not to feel emotion and occasionally going into a 'bubble'. Jane's SMI score for Compliant Surrender fell in the 'average' range; at points during the interview she appeared to display compliance in response to the researcher's questions. For example, Jane responded to a question but then asked "is that the sort of answer you want…?... I didn't know if I was answering right" (Jane/255-261).

3.3.7. Kadir

Kadir displayed consistency across a few modes. What did not seem to come across in interview was Kadir's 'high' SMI score for Demanding Parent and 'very high' score for Detached Protector. On closer look at the SMI, items under Detached Protector mode included 'I feel detached (no contact with myself, my emotions, or other people)' (item 34) and 'I feel distant from other people' (item 39). Kadir rated each as occurring 'all of the time' and 'most of the time' respectively, and during the interview Kadir spoke a lot about feeling alone and abandoned by his family. These two SMI items might be viewed by some as reflective of the Vulnerable Child mode, as might be interpreted in Kadir's case.

3.3.8. Comparison Across Participants

As may be evident above, participants tended to vary in terms of how consistent their SMI and interview responses were. Several factors are likely to have contributed to these differences (e.g. medication, mood, rapport with the researcher) and the sample was not homogenous (e.g. differences in age, culture, experiences of paranoia or voice-hearing).

Of note, when examining the sample as a whole, participants scoring 'high' or 'very high' for Compliant Surrender (Tom, Ali and Kadir) also scored highly on other schema modes that might be viewed as the more 'negative' modes (Impulsive/Undisciplined Child, Angry Child, and Overcompensator). Interestingly, in the interview these three modes did not come across as present for these participants, particularly Impulsive/Undisciplined Child and Overcompensator. This might be interpreted as some participants finding it easier to respond openly via a questionnaire about aspects of themselves that might be viewed by others as negative, whereas the thought of talking about such things face-to-face may have triggered embarrassment or shame. In addition, the items on the SMI might have picked up on particular factors that were not brought up during the interview.

It might also be notable that four participants (Nasir, Ali, Jane and Kadir) all scored 'Very High' on the SMI for Detached Protector mode. It might be surmised that these participants were less able to access and describe their emotions, which could subsequently impact on the quality and accuracy of data.

The discrepancies illustrated above between SMI scores and interview responses highlights the importance of triangulation of methods when assessing for schema modes. The viability of the methods used in this research are examined in Chapter 4.

4. DISCUSSION

This chapter examines findings from the study, referring to the research questions and relevant literature. Methodological limitations are discussed and a professional and personal reflexive account of the research process is given. Implications of the findings on clinical practice are then discussed, along with recommendations for future research and consideration of wider implications.

4.1. Summary of Findings

By gaining an understanding of schema modes in relation to psychosis, this study aimed to explore the possibility of whether SFT could be considered for expansion, for use with people with a diagnosis of psychosis. Thematic analysis of five of the eight schema modes identified nine themes. A discussion in relation to some of the themes and a review of the data in relation to the research questions is presented below.

4.1.1. Research Question One

Do schema modes seem relevant for individuals with a diagnosis of psychosis?

The first research question seeks to understand whether schema modes might seem relevant for this specific population. There is a limit to the extent to which this question can be answered using interview data. As mentioned in the Results chapter, as the interview schedule did not consist of questions about childhood experiences, a fuller understanding of some of the modes was limited as it was generally not possible to know whether a thought, feeling or behaviour was in response to an unmet core need. For this reason, the modes commented on are a version of Young et al.'s (2003) original schema modes (i.e. a more adult and

present focus), therefore there are limits as to how much can be concluded from the interview data. Some participants made reference to their childhood and these data were included in the analysis, which proved beneficial in providing some context to their current experiences.

Analysis of the interview data highlighted a few themes and areas of interest which are examined below. In the next section, the modes that were not subject to analysis due to insufficient data are discussed. The relevance of modes to people with a psychosis diagnosis is then explored, with reference to the SMI data collected from participants.

4.1.1.1. General themes

Some general themes seemed relevant for this sample of participants – shame, feeling separate to others, and difficulty coping with overwhelming emotions - and are examined below. Their relevance to schema modes is also discussed.

The examples of how the theme of the sense of self as bad played out in participants appeared to reflect an amount of *shame*. Shame is an emotion commonly spoken about in relation to insecure attachment and is generally viewed as involving two components: external and internal shame. External shame (Gilbert, 1997, 1998) refers to thoughts and feelings around how one exists negatively (e.g. with anger or contempt, or that the self is viewed as having unattractive qualities) in the minds of others (Gilbert & Procter, 2006). Internal shame develops with self-awareness and the understanding of how one exists for others (Lewis, 1992, 2003). Attention is focused on the self which is viewed as flawed, inadequate or bad. Self-devaluation and self-criticism are key aspects of internal shame.

External and internal shame can fuse together, meaning that when an instance triggering shame occurs, such as failing at a task, one might feel the world is turning against oneself (e.g. others being shaming and rejecting), whilst also internally being self-critical, persecutory and hostile (Gilbert & Procter, 2006). There were several examples of participants being self-attacking, indicating internal shame may have been present. The way that participants described seemingly disproportionate

responses to making mistakes may have reflected a combination of both external and internal shame.

Since shame was potentially experienced by most participants, it is important to consider that some questions asked during the interview may have induced shame, and thus influenced responses. For example, being presented with the Overcompensator and Impulsive/Undisciplined Child mode cards on which more negative statements about the self were written.

This research highlighted what appeared to be a difficulty *coping with overwhelming emotion*, with a range of emotion regulation strategies used, including suppression and detachment. Previous research suggested that people with a psychosis diagnosis may have difficulty regulating emotion, using unhelpful strategies such as suppression or rumination (Hutchins, Rhodes, & Keville, 2016; Livingstone, Harper, & Gillanders, 2009). This builds on increasing evidence (e.g. Birchwood, 2003; Freeman & Garety, 2003) that demonstrates the role of emotional distress in the onset and perpetuation of psychosis (Gumley et al., 2013). As mentioned in chapter 1, Garfield (1995) argued that at the core of psychosis is unbearable and unintegrated emotion, often originating from early development. Dissociative experiences have been found to occur at high levels in people with a psychosis diagnosis (Elhai et al., 2003; Ross & Keyes, 2009; Schafer, Ross & Read, 2008).

There are possible ways of understanding how emotion regulation difficulties might develop. For example, a compassion-focussed approach would suggest that some people who are highly threat-focused, internally and externally, will not have had the chance to develop abilities to understand the reasons for their distress or to self-soothe (Gilbert & Procter, 2006). A range of childhood adversities could contribute to this; for example, a person who experienced physical or sexual abuse may become very alert to danger, as this was an essential survival mechanism during the period of abuse. Drawing on both the TN model's suggestion of a heightened sensitivity to stress following trauma in childhood, and attachment theory where the adversities present a barrier to the forming of secure attachments and therefore the ability to self-soothe, it would be understandable that difficulty regulating emotions might follow.

Attachment theory states that through secure attachment, internal working models are developed around others being safe and supportive, which in turn helps to develop self-evaluation and self-soothing skills (Baldwin, 2005; Mikulincer & Shaver, 2004, 2005). Insecurely attached children are more likely to view others as a threat and can become focused on the power others have to cause them emotional and physical pain (Gilbert, 2005; Irons & Gilbert, 2005; Sloman, Gilbert, & Hasey, 2003). This is understandable if a child has experienced neglect and therefore might have developed a view that others are not reliable or trustworthy, or was abused by a caregiver thus developing a belief that others cannot be a source of safety but instead a danger. SFT and the mode concept are strongly influenced by attachment theory. It is possible that participants in this research who experienced a strong, long-lasting, negative response to a mistake may not have been helped in their early years to develop self-soothing abilities. However, this link cannot be made from the data.

There was a strong sense of *feeling separate from others* for most participants. Some of the feelings of separateness and distance appeared to be more enduring (e.g. Mukhtar having 'always' seen himself as being alone), but other experiences (e.g. of loss of family and friends) seemed to be linked to particular experiences that included feeling mistreated by others (e.g. racism, betrayal of trust, and stigma surrounding the diagnosis). Paranoia has been described as a "profound form of social alienation" (Mirowsky & Ross, 1983, p.236). If the belief is persecutory, this does not simply reflect a sense of detachment from others, but a feeling of hostility and antagonism in one's relationships (Mirowsky & Ross, 1983). Whether the belief is true or not, it serves as a self-fulfilling prophecy (Kohn, 1973; Lemert, 1962). The suspicious or paranoid individual may not seek social support and may feel uncomfortable accepting offers of support, therefore maintaining the conditions that appear to justify their beliefs (Lemert, 1962). See section 4.1.2.1. where stigma is discussed further.

4.1.1.2. Modes excluded from thematic analysis
Thematic analysis was not performed on three of the modes (Demanding Parent, Impulsive/Undisciplined, Overcompensator) due to an insufficient number of

participants appearing to experience these modes. It may be that these modes do not tend to be prevalent in the psychosis population, however consideration has been given to whether there is anything specific about these three modes that might have made them less identifiable.

There appeared to be some overlap between the Demanding Parent and Punitive Parent modes and at times the researcher had difficulty determining which mode participants might experience. Young et al. (2003) acknowledge that there is overlap and they report that it is common for people to experience both modes.

Impulsive/Undisciplined Child and Overcompensator are two modes which might be seen as having the most negative connotations attached to them. Although the researcher attempted to design the mode cards to be the least threatening in this respect, the mode descriptions may still have influenced whether participants agreed with these mode cards. The SMI scores suggested these two modes were relevant for a couple of participants, with Ali and Kadir receiving high scores. Ali and Kadir both also scored highly for Punitive Parent mode; one possible interpretation of this might be that an element of shame was present, with a potential threat of being viewed negatively by the researcher. It might be hypothesised that this shame is likely to have influenced face-to-face responses more than questionnaire responses where in the latter there may be less fear of judgement by others. Another interpretation might be that Ali and Kadir's high SMI scores for Detached Protector mode affected their ability to access or put into words the more shameful aspects of themselves. In addition to the above considerations, another possibility is that the mode card descriptions did not fully reflect Young et al.'s (2003) modes (examined in more detail in section 4.2.1.3.)

4.1.1.3. Relevance of modes
The researcher aimed to gain an understanding of the intensity and duration of particular states; for example, whether presentation was similar or different to a 'flipping' from one mode to another (Bamber, 2004) as is reportedly prevalent for people with a diagnosis of borderline personality disorder.

It was difficult to understand the *intensity* and *duration* of participants' different states using an interview. If these modes are indeed relevant to these participants, it was unclear whether any states 'flipped' to another state as Young describes in relation to borderline personality disorder. At times it seems anger may feel overwhelming for a few participants, however whether the anger itself can be described as a mode as opposed to a proportionate emotional response is another debate. Within the theme of 'Think Badly of Self' under Punitive Parent mode, the seemingly disproportionate response to making a mistake or doing something 'wrong' appeared for many participants to lead to a long-lasting response. This could potentially be viewed as individuals staying in the Punitive Parent mode for lengthy periods of time (1-4 days) therefore not seeming to reflect 'flipping', however it is difficult to tell from the data whether this is in fact the case.

Through the interview the researcher also aimed to understand the triggers of particular emotional and behavioural states, in an attempt to distinguish between what might be considered a 'normal' mood and proportionate response to a trigger, and what may be an enduring aspect of one's personality. With the limited amount of time available for the interview this was not possible. For several participants, experiences that might be perceived to reflect a mode were variable and some had changed over time. This is reported by Young et al. (2003) to be a feature of modes, yet can add to the difficulty in identifying them. There was some evidence of what appeared to be disproportionate responses, for example self-attack and anger, which might, with more research be considered variations of the Angry Child and Punitive Parent modes.

Further contributing to the difficulty in understanding the relevance of modes to psychosis, is that it was unknown how much each participant was able to report on their experiences (i.e. were they fully aware of their emotional and behavioural states). As mentioned in Chapter 1, 'healthy' individuals tend to be aware of their generally well-integrated modes (Young et al., 2003). It might be argued that individuals with a psychosis diagnosis may not have well-integrated modes and therefore may also not be aware of some of these modes. This again illustrates the importance of not relying solely on self-report when assessing modes. In this research, there were several occasions where participants were presented with a

mode card, yet what they spoke about appeared to relate to a different mode. However, this may not reflect a lack of awareness; rather, there is a strong possibility that the wording on the mode cards and the overlap between modes contributed to this.

Overall, participants could relate to the mode card descriptions. However, the researcher was aware of the possible influence of the Barnham effect (Meehl, 1956), whereby people give high accuracy ratings to descriptions of personality that they believe describes them, whereas in reality the descriptions apply to almost everyone. Therefore, it is possible that any individual reading a mode card could have related the description to themselves in some way.

Participants' SMI scores provided an insight into the potential relevance of three schema modes to people with a psychosis diagnosis. These modes – Punitive Parent, Vulnerable Child, and Detached Protector - were also highlighted by interview data as modes that may be experienced by this sample.

4.1.1.4. Summary

The three modes highlighted by the SMI data that may be of relevance to people with a psychosis diagnosis, could be worthy of further exploration in future research. There was a limit to the extent to which research question one could be answered by the interview data alone, for reasons that are explored above in section 4.1.1.3. and below in section 4.2.1. The SMI data could go some way to bridging this gap in terms of understanding what participants' modes might look like, with careful consideration of possible limitations of its use. Limitations surrounding the interview data and use of the SMI are discussed further in section 4.2.1.

Many of the mode card descriptions appeared to resonate with participants and generated some interesting data. Many descriptions of emotional and behavioural states given by participants could potentially reflect some of Young's (2003) existing schema modes. However, more extensive research would be required in order to understand more about whether modes might be relevant to people with a psychosis diagnosis.

4.1.2. Research Question Two

Does there appear to be a relationship between schema modes and psychosis?

Research question two asked whether there appears to be a relationship between schema modes and psychosis. The research findings indicate that voice-hearing and paranoia could exacerbate and prolong experiences where guilt, shame, anger, or a sense of separateness from others, is involved. Whether these experiences appear to be reflective of Young's schema modes was examined above in Section 4.1.1.3. As the findings were inconclusive, this section will explore whether there appeared to be a relationship between particular themes and psychosis.

Participants varied in terms of how much their everyday lives were currently affected by voice-hearing and paranoia. For example, Sheila's voices were present all of the time yet Nasir's seemed blocked out by medication. Despite these differences, it was apparent that should modes be identified in an individual with a diagnosis of psychosis, how the mode presented itself was likely to be impacted by any voice-hearing or paranoia.

4.1.2.1. General themes

There were several ways in which it seemed voice-hearing and paranoia could potentially influence schema modes. Some of the key findings are highlighted and discussed below.

Self-attack in the form of voices was an interesting finding. As described in section 4.1.1.1, shame appeared common in the sample. Internal shame can involve self-to-self relating in the form of hostility and self-criticism, which can occur through self-talk and/or hostile inner voices (Gilbert, 2000; Whelton & Greenberg, 2005). Several participants talked about voices triggering or exacerbating negative feelings about the self, with many examples given of self-criticism and attack. It is possible, therefore, that if the Punitive Parent mode is relevant to people with a psychosis diagnosis it is likely that voice-hearing could exacerbate the experience and lengthen its duration.

Anger was prevalent in the sample, with participants talking about anger increasing in response to experiences related to psychosis; ranging from voices triggering memories that induce anger, to paranoia contributing to rumination about past events, to anger around the stigma attached to psychosis. A link between paranoia and anger has previously been suggested whereby powerlessness and anger is felt in response to experiencing persecutory delusions (Fornells-Ambrojo & Garety, 2009). Cromby and Harper (2005) suggest that feelings that arise in response to paranoid beliefs can influence one's social interactions, which can serve to (further) isolate or stigmatise the person.

Indeed, the research highlighted *stigma* related to the diagnosis of psychosis and interpretations made by others of experiences related to psychosis. Stigma was mentioned by Ali and Mukhtar. Stigma involves negative social attitudes communicated to a person, who often then internalises these into a sense of difference and shame (Corrigan & Kosyluk, 2013; Pyle & Morrison, 2013). Johnstone and Boyle et al., (2018) suggest that for a member of a 'devalued' group "Being ascribed the identity of 'mentally ill' may increase and amplify existing experiences of shame, exclusion and marginalisation, as well as being a significant source of stigma and discrimination in itself." (p.321).

Interview data suggested that stigma contributed towards anger and feeling separate from others. It may therefore be reasonable to assume that the modes of Angry Child and Vulnerable Child that involve these components would be impacted in some way for individuals subjected to stigma. This finding is consistent with research demonstrating that stigma and social exclusion linked to the diagnosis, further worsen the effects (Sartorius, 2002; Thornicroft, 2006). It is also important to consider that shame in participants may have been triggered or exacerbated by stigma. It might therefore be hypothesised that stigma may influence how a person experiences the Punitive Parent mode. A possible limitation of SFT may be that it does not explicitly consider culture and stigma in the development of EMS and modes.

Participants described particular states or experiences as *changeable* depending on whether they were hearing voices or experiencing paranoia. The findings suggest

that paranoia or voice-hearing may prevent activation of the Compliant Surrender mode for individuals who might normally experience this mode. For example, it could be hypothesised that heightened emotion (e.g. fear, anger) that may result from paranoia overrides one's ability to make use of one's cognitive abilities and think before acting as one might usually do. Similarly, during an episode of paranoia or voice-hearing, anger can increase and feel less controllable. Jane's description of the paranoia 'taking over' appears consistent with previous research that suggested emotions during an episode of psychosis can seem all-encompassing leading to reduced use of coping strategies (Hutchins et al., 2016).

Research findings were consistent with previous research by Hutchins et al. (2016) demonstrating that *guilt, self-criticism and self-blame* can occur following an episode of psychosis. Tom and Mukhtar talked about feeling 'bad' or 'guilty' after episodes of psychosis due to how they behaved during the episode. It is possible this is closely associated with shame (see section 4.1.1.1), with paranoia and voice-hearing further exacerbating both internal and external shame.

The study was not able to confirm whether a 'paranoid' mode involving scanning others for signs of threat, as suggested by Rhodes and Healey (2016) might apply. While the research findings appeared to suggest some influence of paranoia and voice-hearing on an individual's emotional and behavioural state, there was not enough data to confirm that 'psychotic identity transformations' with a possible continuum between 'psychotic' and 'non-psychotic' forms of modes (Rhodes & Healey, 2016) occur.

4.1.2.2. Summary

In response to research question two, without a fuller understanding around the relevance of schema modes to this population, this research question is difficult to answer. The findings suggest that if modes are relevant to people with a psychosis diagnosis, experiences of voice-hearing and paranoia could exacerbate an individual's experience of a mode, whether during an episode of psychosis or as part of the aftermath. It is possible that this may contribute to some modes being longer in duration.

4.2. Critical Review

<u>4.2.1. Limitations</u>

4.2.1.1. The complexity of the schema mode concept

Schema modes are complex, consisting of several elements and there is considerable overlap between modes. Accurately identifying an individual's modes is typically a process that occurs over several sessions (Young et al., 2003). Whilst some themes were identified in the sample used for this research, there were also many differences. It could be argued that the complexity of the schema mode construct reflects the uniqueness of each person's experiences. No individual's experiences – or responses to these experiences - are the same as another person's (Gelder, 1983). Therefore, it would be logical to assume that each person's formulation (or schema mode model) would be different, regardless of diagnosis. However, it seems that because schema modes attempt to account for individual differences, the mode concept is therefore complex, meaning that conducting research into modes can be difficult. Some of the limitations are discussed below in section 4.2.1.5.

4.2.1.2. Data collection methods

The researcher used a combination of an interview and questionnaire and, to a limited extent, her own observations during the interviews. The importance of not relying on only one method when exploring schema modes was highlighted in section 2.2.1. The SMI alone is likely to obscure nuances in an individual's experiences and an interview alone cannot capture the complex range of experiences that comprise a mode. The use of self-report in testing the mode concept has previously been questioned, with researchers finding an underreporting of modes when comparing self-report with therapist-report, particularly in relation to people with a diagnosis of anti-social personality disorder (Lobbestael et al., 2009b; Lobbestael et al., 2005). Asking participants to complete a Social Desirability Scale (e.g. Crowne & Marlowe, 1960) could have aided understanding around this. Instead, during the analysis stage the researcher made decisions regarding whether a particular mode was being spoken about. Whilst limitations are also associated with that method, the triangulation of data seemed crucial in capturing as much information about a participant's experiences as possible. Using this method in a

standalone piece of research is, however, still unlikely to be enough to gain a clear enough idea surrounding whether a mode might be relevant for an individual.

The SMI was completed by participants following their interview, to reduce the likelihood of priming effects. The question might arise regarding whether the SMI can provide a true reflection of a person's modes. The SMI was unable to provide an understanding of the nuances of a participant's experiences; for example, the differences in experiences when hearing voices versus not. It could also be argued that the SMI does not take into account the uniqueness of voice-hearing and how voices might reflect a person's own thoughts. For example, items on the SMI such as 'I'm hard on myself' (item 7) and 'I'm quite critical of other people' (item 81) are unlikely to capture circumstances whereby a person's *voices* are hard on the person, and the *voices* are critical of other people. Another possible limitation was illustrated in section 3.2.7. when examining Kadir's responses to items for Detached Protector mode, which might be perceived as more relevant for Vulnerable Child mode.

4.2.1.3. Schema mode cards

The mode cards presented to participants during their interview were developed using more than one source (Jacob, van Genderen, & Seebauer, 2015; Young et al., 2003). An attempt was made to provide summarised and easy-to-understand descriptions of each of the eight selected modes. The language was adjusted for particular modes (Impulsive/Undisciplined Child, and Overcompensator) so the descriptions did not sound too abrasive. How well the descriptions matched each schema mode (e.g. there was some crossover) and how consistent the descriptions are with the items on the SMI is debatable. However, with each mode comprising many elements, it was impossible to develop a simple description that encompassed everything.

4.2.1.4. Considerations of alternative methods

Mood inductions have been suggested to be "the techniques par excellence" (Lobbestael et al., 2007, p.82) to provide insight into association between modes and displayed emotional and behavioural responses. Unfortunately, this was beyond the scope of this research. Similarly, Garfield (1995) argued that affective attunement is a key means of enabling understanding of psychotic experiences, and their

integration. However, "emotional experiences and meanings have their roots in often difficult experiences containing powerful affects which are not necessarily readily accessible verbally" (Gumley et al., 2013, p.3). There is a limit therefore, to how much participants would have been able to access and put to words their experiences.

4.2.1.5. *The utility of the mode concept*

Perhaps due to its complexity the schema mode model can be viewed as heuristic, open to being further developed and expanded (Arntz & Jacob, 2013). Lobbestael et al. (2007) question what the ultimate aim of mode conceptualisation ought to be, and has named the "risk of forming a never-ending list of modes" (p.82). Modes were developed in order to simplify the conceptualisation of people's difficulties, however with modes ever-expanding the question arises around whether this is the case (Lobbestael et al., 2007). It has in fact been suggested that one cannot ever be 'finally right' about how the self is divided. There is multiplicity not only in the personality, but in ways of conceiving this multiplicity (e.g. Rappoport, Baumgardner, & Boone, 1999).

4.2.1.6. *A theory-led design*

The findings from this research were heavily influenced by the research being theory-led. e.g. participants were presented with mode cards, therefore there is a strong possibility that much of what they discussed was guided by these. It is therefore important that the identified themes are considered in relation to this method (i.e. these themes were not generated entirely by participants).

4.2.1.7. *The potential influence of medication*

As the majority of participants mentioned they were currently taking anti-psychotic medication, the possible impact of side effects on the quality of the interviews and responses to the SMI questionnaire is acknowledged. The sometimes 'damping down' effect of medication on thoughts and emotions (Mizrahi et al., 2006) may have impacted on participants' ability - and perhaps motivation - to access their thoughts and emotions. Side effects can also include restlessness and agitation (Mind, 2018), which could, for example, reduce one's ability to concentrate for long periods of time. Side effects such as anxiety could lead to an inaccurate picture of a schema mode

being developed (e.g. describing feeling anxious for no particular reason is an experience that would fall under the Vulnerable Child mode; however, if anxiety is caused by medication, not unmet core emotional needs, the mode may be falsely identified).

4.2.2. The Sample

Participants who took part volunteered to do so, which may mean that particular experiences were captured over others. Consideration has been given to the potential influence of the offer of a voucher on participants' responses in terms of compliance. In an attempt to minimise this risk, participants were told that they could withdraw at any point, and that they did not have to answer all questions. The majority of participants were male. Most were unemployed and lived in an area of London with high levels of deprivation. The sample comprised a few different cultural backgrounds which added richness to the data. Most had been given a diagnosis of 'paranoid schizophrenia' with participants experiencing paranoia, voice-hearing or both. This meant the sample was not homogenous, which has its advantages and disadvantages. The benefits were that a range of interesting experiences were discussed. However, with the already small sample size it further limited any possibility of generalisation of findings. As the study was exploratory, it had not been deemed crucial to ensure homogeneity.

4.2.3. Researcher Reflexivity

The researcher's assumptions, intentions and actions influence their experience of the world, and these are also likely to affect the research process (Yardley, 2000). The research was approached from a critical realist perspective; therefore, where the researcher has suggested links to theory, this ought to be viewed as one way of understanding something, rather than making claims about the 'truth'.

Qualitative research is criticised by some as being based on small sample sizes with a risk of researcher bias in the collection of data and interpretation of themes (Willig, 2013). However, Braun and Clarke (2006) argue that it can provide more in-depth accounts than quantitative data, along with unexpected insights. This study's objective was to gain an understanding around a complex phenomenon (Willig, 2013), whilst being aware of the limits of the transferability of the findings. The

combined use of matrices and thematic analysis enabled the organisation and analysis of a large amount of complex data.

Although the primary thesis supervisor had received training in SFT, the researcher had not, which will have influenced decisions made throughout the research process. There is a possibility that others may not agree with how the modes were described on the mode cards, or decisions made regarding whether participants were talking about a particular mode. It is acknowledged that the analysis conducted in this research is only one interpretation of the data, and throughout the whole process will have been influenced by the researcher's own beliefs and values.

A crucial part of the research process was for the researcher to reflect on how her own experiences contributed to an interest in this topic (Yardley, 2000). Hearing from colleagues in a previous role about their use of SFT and their belief in its clinical utility led to an interest in the approach. With regards to psychosis, the researcher understands it to be a socially constructed concept, with teaching received as part of the doctoral training at the University of East London significantly contributing to this belief. The teaching received has also raised questions for the researcher around the effectiveness of standalone CBT approaches and she believes that integrative approaches to intervention have potential to have more utility.

The power held by the researcher in relation to the participants was considered. Whilst participating in an interview for research can help give a voice to the marginalised and subjugated (Hutchinson, Wilson, & Skodol Wilson, 1994), the researcher was aware of the influence of her power could have on participants' experience of the process. The power of her role as a psychologist and being in a perceived position of 'knowing' or 'having' the 'answer', in addition to approving or disapproving of their experiences or views, may have impacted on participants' ability to talk freely. Attempts were made to level any power imbalance by taking a non-judgemental stance and it was hoped that not being part of the service could enable more openness. However, the researcher was also aware of the disadvantages of not knowing participants, as there was limited time to build a rapport prior to the interviews.

The researcher was keen not to fall into the pattern of referring to people as 'having' psychosis, therefore tried to be careful with the use of language throughout the write up of this research. The use of such a label brings with it many assumptions developed by society and includes individualising and blaming discourses. The researcher brought her own assumptions about the label of psychosis, and participants would have held their own assumptions about how they might be viewed by the researcher, as 'owners' of this label. The researcher attempted to be sensitive in using the term when talking with participants. At the beginning of each interview it was stated that there are many different types of experience that fall under the term psychosis and that people tend to find it helpful to put their experiences into words that make sense for them. It was hoped that this would help participants to feel more comfortable and less judged.

The researcher felt uncomfortable using the diagnostic category of psychosis as a means of selecting participants for this research. Despite a rationale of following suit of previous research that examines schema modes according to diagnostic categories, the researcher worried that by approaching the research in this way, it was further strengthening the idea that this way of labelling people is acceptable. However, the research was designed in this way because it was felt that a common frame of reference was required as a starting point in carrying out some potentially meaningful research. Mental health services tend to be set up according to diagnostic categories; therefore, if this set up is to continue, it would make sense to attempt to conduct research that could have an impact in services specifically designed around psychosis.

4.3. Implications

Implications for clinical practice and future research are considered below. In relation to clinical practice consideration was given not only to implications for therapists using SFT, but in a wider sense, thinking about whether the findings might have implications for clinicians using other approaches.

4.3.1. Clinical Practice

Despite the limitations of this study, some clinical implications can be drawn from the findings. If clinicians were to conduct schema mode work with people with a psychosis diagnosis, the potential influence of paranoia and voice-hearing on an individual's modes would need to be considered. The already changeable nature of modes (Young et al., 2003) interacting with paranoia and voices would bring an additional layer of complexity. Clinicians would need to consider whether current methods of assessing a person's modes would be appropriate for people with a psychosis diagnosis.

One finding from this research was that anti-psychotic medication could reduce one's ability to feel emotions, potentially making it more difficult to function and behave in ways that could help with recovery. This may raise questions around the effectiveness of schema mode work in such cases if medication is obscuring one's 'real' modes and preventing access to one's emotions. Anti-psychotic medication could therefore present a barrier to mode work.

The findings appeared to reflect overwhelming emotion experienced by participants, consistent with previous research that has suggested unbearable and unintegrated emotion to be at the core of psychosis (Garfield, 1995). This finding supports suggestions that emotion should become more of a focus in interventions for psychosis (Gumley et al., 2013; Smith et al., 2006). For example, shame appeared to be common across participants, highlighting a potential need for interventions that can address shame. One such example may be compassionate mind training, developed for people experiencing high shame and self-criticism (Gilbert, 1992, 1997, 2000; Gilbert & Irons, 2005).

The research highlighted the influence that stigma can have on experiences and emotions. These are areas that do not tend to be considered in mainstream CBT approaches and it is unclear whether schema mode work does. It might therefore be important for clinicians working with people with a psychosis diagnosis to ensure that service users are asked about such potential influences. Clinicians might consider using the power-threat-meaning framework (Johnstone & Boyle et al., 2018) mentioned in section 1.3.4.2. when formulating an individual's distress. This could

ensure a focus on not only stigma, but other wider influencing factors, including power and culture.

Approaches such as SFT that place an emphasis on the role of adversities in shaping an individual's experiences (e.g. emotional, behavioural) and relationship to the self and others, arguably merit further attention. The increasing amount of research indicating a link between adversities and psychosis, suggests that an intervention that takes into account early adverse experiences could be beneficial for people with a psychosis diagnosis. Further research would need to be conducted in order to clarify whether SFT could be an appropriate alternative to interventions for psychosis currently in wide use, such as CBTp (see section 4.3.2. for research suggestions).

4.3.2. Future Research

Due to difficulties in answering the research questions using the interview data, future research exploring schema modes would need to consider the methodology used. The limitations in exploring modes in a standalone piece of research such as the present study highlight the potential advantages of alternative approaches, such as case series. The case series benefits from longer-term contact with participants, allowing for more in-depth exploration with the use of experiential techniques including mood induction. Other research might benefit from focusing on a smaller number of modes, providing the opportunity to acquire richer data. It would also be important to consider asking about childhood experiences, to better enable identification and understanding of modes. If mode cards were to be used in future research, decisions would need to be made around the most appropriate descriptions to use. Future research would also benefit from using a large sample of participants, in order to account for heterogeneity and increase the potential to generalise the findings.

For reasons discussed in section 2.2.1. it is recommended that the SMI is not solely relied upon in research, and that a triangulation of methods is always used. Should the SMI be used with people with a psychosis diagnosis, researchers might consider administering it more than once; for example, asking participants to complete it based on when paranoia or voices are present vs absent. This could enable an

increased understanding around a person's experiences and give some insight into possible variations in schema modes in relation to psychosis. However, there are limitations to using the SMI, particularly if one hears voices. This might mean that future research explores how the SMI could be modified to account for voice-hearing. There may be merit in future research exploring whether there might be schema modes for voices. If this is pursued, the above methodological considerations would need to be taken into account.

Theories on EMS and modes are based are embedded in Western values and assumptions. For example, attachment theory is argued to make assumptions that one (female) primary caregiver raises a child, whereas traditionally in some cultures two or more people take the caregiver role, and in modern Western society, roles have changed. Attachment theory is also said to obscure the diversity and richness of early relationships by placing emphasis on the importance of small number of behaviours (Cromby, Harper, & Reavey, 2013). In addition, some cultures hold the belief of a collective rather than individual 'self' (Geertz, 1984). This raises questions around the cross-cultural relevance of the schema mode concept, which holds assumptions around the fragmented 'self' and the need for its integration.

Future research would ideally take into consideration service users' experiences and views. Consultation with service users is recommended, as an exploration of views regarding existing psychological interventions for psychosis that are recommended by the NICE guidelines, and the choice of interventions offered. The development or adaptation of interventions will need to be based on a careful assessment of the needs of people with a psychosis diagnosis; this could go some way to considering issues such as many interventions on offer being based on Westernised theories.

4.3.3. Wider Implications

When issues such as stigma and power are being raised through research, focusing research and clinical intervention at the individual level will never be enough. Questions may arise around whether mental health services are doing enough to reduce the stigma and shame that can be attached to psychosis. At a societal and community level, attention could be focused on developing initiatives that address

social isolation, trust-building within neighbourhoods to tackle victimisation, and policies that challenge injustice and discrimination (Cromby & Harper, 2005).

4.4. Conclusions

The research findings were inconclusive, yet highlighted a few schema modes that might be relevant to people with a psychosis diagnosis. The research also illustrated the importance of taking into account the possible impact of experiences of voice hearing and paranoia on the presentation of modes in a small sample of participants. This may be particularly important for clinicians who are practicing schema mode therapy with individuals with a psychosis diagnosis. The research also raised questions around the utility of the SMI with people with a psychosis diagnosis. The research highlighted shame and anger as emotions that psychological interventions might benefit from focusing on. The impact of stigma could warrant further attention in clinical practice and at a wider service and societal level.

Despite reports that the schema mode model summarises complex presentations in a clear, plausible and validating way (Fassbinder et al., 2014) for service users, researching the mode concept is in itself complex. Recommendations for future research have been made.

5. REFERENCES

Allen, D. M., 2008. Panic, rage and family discord in borderline personality disorder. *Directions in Psychiatry 28*, 103-111.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorder (5th ed.)*. Washington DC: American Psychiatric Association.

Arntz, A., & Jacob, G. (2013). *Schema therapy in practice: An introductory guide to the schema mode approach.* West Sussex: Wiley-Blackwell.

Arntz, A., Klokman, J., & Sieswerda, S. (2005). An experimental test of the schema mode model of borderline personality disorder. *Journal of Behavior Therapy and Experimental Psychology, 36,* 229-239.

Arntz, A., & van Genderen, H. (2009). *Schema therapy for borderline personality disorder*. Sussex: Wiley.

Bak, M., Krabbendam, L., Janssen, I., Graaf, R. D., Vollebergh, W., & Os, J. V. (2005). Early trauma may increase the risk for psychotic experiences by impacting on emotional response and perception of control. *Acta Psychiatrica Scandinavica*, *112* (5), 360-366.

Baldwin, M. W. (2005). *Interpersonal cognition*. New York: Guilford.

Bamber, M. (2004). 'The good, the bad and defenceless Jimmy' - A single case study of Schema Mode Therapy. *Clinical Psychology & Psychotherapy*, *11* (6), 425-438.

Bamelis, L. L. M., Renner, F., Heidkamp, D., & Arntz, A., (2011). Extended schema mode conceptualisations for specific personality disorders: An empirical study. *Journal of Personality Disorders, 25* (10), 41-58.

Barlow, D. H. (2001). *Clinical handbook of psychological disorders* (3rd ed.). New York: Guilford Press.

Barrowclough, C., & Tarrier, N. (1990). Social functioning in schizophrenic patients: I. The effects of expressed emotion and family intervention. *Social Psychiatry and Psychiatric Epidemiology, 24*, 125–129.

Beavan, V., Read, J., & Cartwright, C. (2011). The prevalence of voice-hearers in the general population: A literature review. *Journal of Mental Health, 20* (3), 281–292.

Bentall, R. P. (2004). *Madness explained: Psychosis and human nature*. London: Penguin.

Bentall, R. (2010). *Doctoring the mind: Why psychiatric treatments fail*. London: Penguin Books.

Bentall, R. P. (2013). Would a rose, by any other name, smell sweeter? *Psychological Medicine, 43* (7), 1560-1562.

Bentall, R. P., Jackson, H. F., & Pilgrim, D. (1988). Abandoning the concept of 'schizophrenia': Some implications of validity arguments for psychological research into psychotic phenomena. *British Journal of Clinical Psychology, 27* (4), 303–324.

Bentall, R., Kinderman, P., & Kaney, S. (1994). The attributional processes and abnormal beliefs: Towards a model of persecutory delusions. *Behaviour Research and Therapy, 32,* 331–41.

Bentall, R. P., Rowse, G., Shryane, N., Kinderman, P., Howard, R. H., Blackwood, N., & Corcoran, R. (2009). The cognitive and affective structure of paranoid delusions. A transdiagnostic investigation of patients with schizophrenia spectrum disorders and depression. *Archives of General Psychiatry, 66*, 236-247.

Bentall, R. P., Wickham, S., Shevlin, M., & Varese, F. (2012). Do specific early-life adversities lead to specific symptoms of psychosis? A study. *Schizophrenia Bulletin, 38* (4), 734–740.

Bernstein, D. P., Arntz, A., & de Vos, M. (2007). Schema focused therapy in forensic settings: Theoretical model and recommendations for best clinical practice. *International Journal of Forensic Mental Health, 6* (2), 169-183.

Berry, K., Barrowclough, C., & Wearden, A. (2008). Attachment theory: A framework for understanding symptoms and interpersonal relationships in psychosis. *Behaviour Research and Therapy, 46,* 1275–1282.

Berry, K., Wearden, A., Barrowclough, C., Oakland, L., & Bradley, J. (2012). An investigation of adult attachment and the nature of relationships with voices. *British Journal of Clinical Psychology*, *51* (3), 280-291.

Birchwood, M., Smith, J. O., Cochrane, R., Wetton, S., & Copestake, S. O. N. J. A. (1990). The Social Functioning Scale: The development and validation of a new scale of social adjustment for use in family intervention programmes with schizophrenic patients. *The British Journal of Psychiatry*, *157* (6), 853-859.

Birchwood, M. (2003). Pathways to emotional dysfunction in first-episode psychosis. *British Journal of Psychiatry, 182,* 373-375.

Birchwood, M., Meaden, A., Trower, P., Gilbert, P., & Plaistow, J. (2000). The power and omnipotence of voices: Subordination and entrapment by voices and significant others. *Psychological Medicine, 30* (2), 337-344.

Bordelon, S. K. (2007). Comorbidity of chronic depression and personality disorders: Application of schema mode therapy. In T. Ronen & A. Freeman (Eds.), *Cognitive behavior therapy in clinical social work practice (*pp.447-465*).* New York: Springer.

Bortolon, C., Capdevielle, D., Boulenger, J. P., Gely-Nargeot, M. C., & Raffard, S. (2013). Early maladaptive schemas predict positive symptomatology in schizophrenia: A cross-sectional study. *Psychiatry Research, 209* (3), 361-366.

Bowlby, J. (1969). *Attachment, vol. 1 of Attachment and loss*. London: Hogarth Press.

Boyatzis, R. E. (1998). *Transforming qualitative information: Thematic analysis and code development*. Thousand Oaks, CA: Sage.

Boydell, J., van Os. J., McKenzie, K., Allardyce, J., Goel, R., McCreadie, R. G., et al. (2001). Incidence of schizophrenia in ethnic minorities in London: Ecological study into interactions with environment. *British Medical Journal, 323*, 1336–1338.

Boyle, M. (2002). Schizophrenia: A scientific delusion? (2nd ed.). London: Routledge.

Boyle, M. (2006). *From 'Schizophrenia' to 'Psychosis': Paradigm Shift or More of the Same?* Paper presented at BPS Division of Clinical Psychology Annual Conference, London, December.

Boyle, M. (2011). Making the world go away, and how psychology and psychiatry benefit. In M. Rapley, J. Moncrieff & J. Dillon (Eds.), *De-medicalizing mental illness. Psychology, psychiatry and the human condition* (pp. 27-43). Basingstoke: Palgrave Macmillan.

Bramber, M. (2004). 'The good, the bad and defenceless Jimmy' – A single case study of schema mode therapy. *Clinical Psychology and Psychotherapy, 11,* 425-438.

British Psychological Society. (2014). *Code of human research ethics*. Leicester: British Psychological Society.

British Psychological Society. (2017). *Understanding psychosis and schizophrenia*. Leicester: British Psychological Society.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*, 77-101.

Braun, V., & Clarke, V. (2013). *Successful qualitative research: A practical guide for beginners*. London: Sage.

Brown, G. W., Birley, J. L. T., & Wing, J. K. (1972). Influence of family life of schizophrenic disorders: A replication. *British Journal of Psychiatry, 121* (562), 241-258.

Burbach, F. R. (2013). Towards a systemic understanding of family emotional atmosphere and outcome after psychosis. In A. Gumley, A. Gillham, K. Taylor, & M. Schwannauer (Eds.), *Psychosis and emotion: The role of emotions in understanding psychosis, therapy and recovery* (pp. 116-135). Hove: Routledge.

Burns, A. M., Erickson, D. H., & Brenner, C. A. (2014). Cognitive-behavioral therapy for medication-resistant psychosis: A meta-analytic review. *Psychiatric Services, 65* (7), 874-880.

Bustillo, J. R., Lauriello, J., Horan, W. P., & Keith, S. J. (2001). The psychosocial treatment of schizophrenia: An update. *American Journal of Psychiatry*, *158*, 163–75.

Care Quality Commission. (2010). *Count me in 2010. Results of the 2010 national census of inpatients and patients on supervised community treatment in mental health and learning disability services in England and Wales*. London: Care Quality Commission.

Chadwick, P., & Birchwood, M. (1994). The omnipotence of voices: A cognitive approach to auditory hallucinations. *The British Journal of Psychiatry*, *164* (2), 190-201.

Clarkin, J. F., Yeomans, F. E., & Kernberg, O. F. (2007). *Psychotherapy for borderline personality: Focusing on object relations*. Washington, DC: American Psychiatric Press.

Cockram, D. M., Drummond, P. D., & Lee, C. W. (2010). Role and treatment of early maladaptive schemas in Vietnam veterans with PTSD. *Clinical Psychology and Psychotherapy, 17* (3), 165-182.

Commission for Healthcare Audit and Inspection. (2007). *Count me in. Results of the 2006 national census of inpatients in mental health and learning disability services in England and Wales*. London: Commission for Healthcare Audit and Inspection.

Corbin, J. (2007). Reactive attachment disorder: A biopsychosocial disturbance of attachment. *Child and Adolescent Social Work Journal, 24*, 539–52.

Correll, C.U., & Carbon, M. (2014). Efficacy of pharmacologic and psychotherapeutic interventions in psychiatry: To talk or to prescribe: Is that the question? *JAMA Psychiatry, 71* (6), 624–626.

Corrigan, P., & Kosyluk, K. (2013). Erasing the stigma. *Basic and Applied Social Psychology, 35,* 131–140.

Couture, S., Lecomte, T., & Leclerc, C. (2007). Personality characteristics and attachment in first episode psychosis: Impact on social functioning. *Journal of Nervous and Mental Disease, 195,* 631-639.

Crawford. T. N., Cohen, P. R., Chen. H., Anglin, D. M., & Ehrensaft. M. (2009). Early maternal separation and the trajectory of borderline personality disorder symptoms. *Development and Psychopathology, 21*, 1013-1030.

Cromby, J., & Harper, D. J. (2005). *Paranoia and social inequality*. British Psychological Society.

Cromby, J., & Harper, D.J. (2009). Paranoia: A social account. *Theory and Psychology, 19* (3), 335–361.

Cromby, J., Harper, D., & Reavey, P. (2013). *Psychology, mental health and distress*. New York: Palgrave Macmillan.

Crow, T. (2008). The emperors of the schizophrenia polygene have no clothes. *Psychological Medicine, 38*, 1681-1685.

Crowne, D. P., & Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology*, *24* (4), 349.

Dadomo, H., Grecucci, A., Giardini, I., Ugolini, E., Carmelita, A., & Panzeri, M. (2016). Schema Therapy for emotional dysregulation: Theoretical implication and clinical applications. *Hypothesis and Theory, 7*, 1-16.

Das-Munshi, J., Bécares, L., Boydell, J.E., Dewey, M. E., Morgan, C., Stansfeld, S. A., & Prince, M. J. (2012). Ethnic density as a buffer for psychotic experiences: Findings from a national survey (EMPIRIC). *The British Journal of Psychiatry, 201*, 282–290.

Davies, S. C. (2014). *Annual report of the Chief Medical Officer 2013, public mental health priorities: Investing in the evidence*. London: Department of Health.

Dell, P. F., & O'Neil, J. A. (2009). Dissociation and the dissociative disorders: DSM-V and Beyond. *Journal of Trauma & Dissociation, 11* (4), 491-493.

Docherty, N. M. (1996). Affective reactivity of symptoms as a process discriminator in schizophrenia. *Journal of Nervous and Mental Diseases, 184,* 535-541.

Dudley, R. E. J., & Over, D. E. (2003). People with delusions jump to conclusions: A theoretical account of research findings on the reasoning of people with delusions. *Clinical Psychology & Psychotherapy*, *10* (5), 263-274.

Edwards, D., & Arntz, A. (2012). In M. van Vreeswijk, J. Broersen , & M. Nadort (Eds.), *The Wiley-Blackwell handbook of schema therapy: Theory, research, and practice* (pp. 1-26). Sussex: John Wiley & Sons Ltd.

Elhai, J., Frueh, C., Gold, P., Hamner, M., & Gold, S. (2003). Postraumatic stress, depression and dissociation as predictors of MMPI Scale 8 scores in combat veterans with PTSD. *Journal of Trauma and Dissociation, 4*, 51–64.

Evans, C., Connell, J., Barkham, M., Mellor-Clark, J., Mergison, F., McGrath, G., & Audin, K. (1998). *The CORE outcome measure*. Leeds: Core System Group.

Farrell, J. M., Shaw, I. A., & Webber, M. A. (2009). A schema-focused approach to group psychotherapy for outpatients with borderline personality disorder: A

randomized controlled trial. *Journal of Behavior Therapy and Experimental Psychiatry, 40,* 317–328.

Fassbinder, E., Schweiger, U., Jacob, G., & Arntz, A. (2014). The schema mode model for personality disorders. *Die Psychiatrie*, *11,* 1-9.

Fonagy, P., Gergely, G., & Target, M. (2007). The parent-infant dyad and the construction of the subjective self. *Journal of Child Psychology and Psychiatry, 48,* 288-328.

Fornells-Ambrojo, M., & Garety, P. (2009) Understanding attributional biases, emotions and self-esteem in poor me paranoia: Findings from an early psychosis sample. *British Journal of Clinical Psychology, 48* (2), 141-162.

Freeman, D., & Garety, P. A. (2003). Connecting neurosis and psychosis: The direct influence of emotion on delusions and hallucinations. *Behaviour Research and Therapy*, *41* (8), 923-947.

Freeman, D., & Garety, P. A. (2006). Helping patients with paranoid and suspicious thoughts. *Advances in Psychiatric Treatment, 12*, 404–415.

Frith, C. D. (1992). *The cognitive neuropsychology of schizophrenia*. Hillside NJ: Lawrence Erlbaum and Associates Inc.

Frith, C. (1994). Theory of mind in schizophrenia. In A. S. David & J. C. Cutting (Eds.), *Brain damage, behaviour and cognition series. The neuropsychology of schizophrenia* (pp. 147-161). Hillsdale, NJ, US: Lawrence Erlbaum Associates, Inc.

Garety, P. A., Fowler, D. G., Freeman, D., Bebbington, P., Dunn, G., & Kuipers, E. (2008). Cognitive–behavioural therapy and family intervention for relapse prevention and symptom reduction in psychosis: Randomised controlled trial. *The British Journal of Psychiatry, 192* (6), 412-423.

Garety, P. A., Kuipers, E. K., Fowler, D., Freeman, D. & Bebbington, P. E. (2001). A cognitive model of the positive symptoms of psychosis. *Psychological Medicine, 31,* 189-195.

Garfield, S. (1995). *Unbearable affect: A guide to the psychotherapy of psychosis.* Oxford: John Wiley and Sons.

Geertz, C. (1984). Distinguished lecture: Anti anti-relativism. *American anthropologist, 86* (2), 263-278.

Gelder, M., Gath, D., & Mayou, R. (1983). *Oxford textbook of psychiatry.* Oxford: Oxford University Press.

George, L., Thornton, C., Touyz, S. W., Waller, G., & Beumont, P. J. V. (2004). Motivational enhancement and schema-focused cognitive behaviour therapy in the treatment of chronic eating disorders. *Clinical Psychologist, 8,* 81–85.

Giesen-Bloo, J., van Dyck, R., Spinhoven, Ph., van Tilburg, W., Dirksen, C., van Asselt, Th., Kremers, I., Nadort, M., & Arntz, A. (2006). Outpatient psychotherapy for borderline personality disorder: Schema focused therapy versus transference focused therapy, a randomized clinical trial. *Archives of General Psychiatry, 63* (6), 649-58.

Gilbert, P. (1992). *Depression: The evolution of powerlessness.* Hove: Lawrence Erlbaum Associates.

Gilbert, P. (1997). The evolution of social attractiveness and its role in shame, humiliation, guilt and therapy. *British Journal of Medical Psychology, 70,* 113–147.

Gilbert, P. (1998). What is shame? Some core issues and controversies. In P. Gilbert, & B. Andrews (Eds.), *Shame: Interpersonal behavior, psychopathology and culture* (pp. 3–36). New York: Oxford University Press.

Gilbert, P. (2000). Social mentalities: Internal 'social' conflicts and the role of inner warmth and compassion in cognitive therapy. In P. Gilbert, & K.G. Bailey

(Eds.), *Genes on the couch: Explorations in evolutionary psychotherapy* (pp. 118–150). Hove: Brunner-Routledge.

Gilbert, P. (2005). Compassion and cruelty: A biopsychosocial approach. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 9–74). London: Routledge.

Gilbert, P., & Irons, C. (2005). Focused therapies and compassionate mind training for shame and self-attacking. In P. Gilbert (Ed.), *Compassion: Conceptualisations, research and use in psychotherapy* (pp. 263–325). London: Routledge.

Gilbert, P., & Procter, S. (2006). Compassionate mind training for people with high shame and self-criticism: Overview and pilot study of a group therapy approach. *Clinical Psychology & Psychotherapy*, *13* (6), 353-379.

Gross, E. N., Stelzer, N., & Jacob, G. A. (2012). Treating obsessive-compulsive disorder with the schema mode model. In M. van Vreeswijk, J. Broersen & M. Nadort (Eds.), *The Wiley-Blackwell handbook of schema therapy: Theory, research and practice (pp.173-184).* Sussex: John Wiley & Sons Ltd.

Gumley, A. I., Gillham, A., Taylor, K., & Schwannauer, M. (2013). Psychosis and emotion: The role of emotions in understanding psychosis, therapy and recovery. In A. I. Gumley, A. Gillham, K. Taylor & M. Schwannauer (Eds.), *Psychosis and emotion: The role of emotions in understanding psychosis, therapy and recovery* (pp. 1-8). Hove: Routledge.

Gumley, A., & Schwannauer, M. (2006). *Staying well after psychosis: A cognitive interpersonal approach to recovery and relapse prevention*. Hove: Wiley.

Gumley, A. I., Taylor, H. E. F., Schwannauer, M., & MacBeth, A. (2014). A systematic review of attachment and psychosis: measurement, construct validity and outcomes. *Acta Psychiatrica Scandinavia, 129* (4), 257–274.

Hamilton, S. P. (2008). Schizophrenia candidate genes: Are we really coming up blank? *American Journal of Psychiatry, 165* (4), 420-423.

Harder, S., & Lysaker, P. (2013). Narrative coherence and recovery of self-experience in integrative psychotherapy. In A. I. Gumley, A. Gillham, K. Taylor, & M. Schwannauer (Eds.), *Psychosis and emotion: The role of emotions in understanding psychosis, therapy and recovery* (pp. 56-67). Abingdon: Routledge.

Heinz, A., Deserno, L., & Reininghaus, U. (2013). Urbanicity, social adversity and psychosis. *World Psychiatry, 12* (3), 187–197.

Holloway, I., & Todres, L. (2003). The status of method: Flexibility, consistency and coherence. *Qualitative Research*, *3* (3), 345-357.

Honig, A., Romme, M. A., Ensink, B. J., Escher, S. D., Pennings, M. H., & deVries, M. W. (1998). Auditory hallucinations: A comparison between patients and nonpatients. *Journal of Nervous and Mental Disease, 186,* 646-651.

Hor ,K., & Taylor, M. (2010). Suicide and schizophrenia: A systematic review of rates and risk factors. *Journal of Psychopharmacology, 24*, 81–90.

Hutchins, J., Rhodes, J., & Keville, S. (2016). Emotional earthquakes in the landscape of psychosis: An interpretative phenomenology. *The Cognitive Behaviour Therapist*, *9.* doi:10.1017/S1754470X16000167

Hutchinson, S. A., Wilson, M. E., & Skodol Wilson, H. (1994). Benefits of participating in research interviews. *The Journal of Nursing Scholarship, 26* (2), 161-166.

Irons, C., & Gilbert, P. (2005). Evolved mechanisms in adolescent anxiety and depression. The role of attachment and social rank systems. *Journal of Adolescents, 28*, 325–341.

Jacob, G. A., & Arntz, A. (2013). Schema therapy for personality disorders: A review. *International Journal of Cognitive Therapy, 6*, 171–185.

Jacob, G., van Genderen, H., & Seebauer, L. (2015). *Breaking negative thought patterns: A schema therapy self‑help and support book*. Malden, MA: Wiley-Blackwell.

Janssen, I., Hanssen, M., Bak, M., Bijl, R. V., De Graaf, R., Vollebergh, W., ... & van Os, J. (2003). Discrimination and delusional ideation. *The British Journal of Psychiatry, 182* (1), 71–76.

Jauhar, S., McKenna, P. J., Radua, J., Fung, E., Salvador, R., & Laws, K. R. (2014). Cognitive-behavioural therapy for the symptoms of schizophrenia: Systematic review and meta-analysis with examination of potential bias. *British Journal of Psychiatry, 204* (1), 20-29.

Joffe, H. (2012). Thematic analysis. *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners*, *1*, 210-223.

Johns, L. C., Kompus, K., Connell, M., Humpston, C., Lincoln, T. M., Longden, E., et al. (2014). Auditory verbal hallucinations in persons with and without a need for care. *Schizophrenia Bulletin, 40* (4), 255–264.

Johns, L. C., & van Os, J. (2001). The continuity of psychotic experiences in the general population. *Clinical Psychology Review, 21* (8), 1125-1141.

Johnston, C., Dorahi, M. J., Courtenay, D., Bayles, T., & O' Kane, M. (2009). Dysfunctional schema modes, childhood trauma, and dissociation in borderline personality disorder. *Journal of Behavior Therapy and Experimental Psychiatry, 40* (2), 248-255.

Johnstone, L. (2011). Can traumatic events traumatize people? Trauma, madness and 'psychosis'. In M. Rapley, J. Moncrieff & J. Dillon (Eds.), *De-medicalizing mental illness. Psychology, psychiatry and the human condition* (pp. 99-109). Basingstoke: Palgrave Macmillan.

Johnstone, L. & Boyle, M. with Cromby, J., Dillon, J., Harper, D., Kinderman, P., Longden, E., Pilgrim, D., & Read, J. (2018). *The Power Threat Meaning Framework: Towards the identification of patterns in emotional distress,*

unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. Leicester: British Psychological Society.

Joseph, J. (2006). *The missing gene: Psychiatry, heredity and the fruitless search for genes*. New York: Algora Publishing.

Joseph, J. (2011). The crumbling pillars of behavioral genetics. *GeneWatch*, *24* (6), 4-7.

Karlsen, S., Nazroo, J. Y., McKenzie, K., Bhui, K., & Weich, S. (2005). Racism, psychosis and common mental disorder among ethnic minority groups in England. *Psychological Medicine, 35* (12), 1795–1803.

Khalily, M. T., Wota, A. P., & Hallahan, B. (2011). Investigation of schema modes currently activated in patients with psychiatric disorders. *Irish Journal of Psychological Medicine, 28* (2), 76-81.

Kirkbride, J. B., Jones, P. B., Ullrich, S., & Coid, J. W. (2012). Social deprivation, inequality, and the neighborhood-level incidence of psychotic syndromes in East London. *Schizophrenia Bulletin, 40* (1), 169-180.

Kohn, M. (1973). Social class and schizophrenia: A critical review and reformulation. *Schizophrenia Bulletin, 7*, 60-79.

Korver-Nieberg, N., Berry, K., Meijer, C. J., & de Haan, L. (2014). Adult attachment and psychotic phenomenology in clinical and non-clinical samples: A systematic review. *Psychology & Psychotherapy: Theory, Research & Practice, 87* (2), 127-154.

Kuipers, E., Bebbington, P., Pilling, S., & Orbach, G. (1999). Family intervention in psychosis: who needs it. *Epidemiologie e Psichiatria Sociale, 8*, 169–173.

LeDoux, J. E. (1995). Emotion: Clues from the brain. *Annual Review of Psychology*, *46* (1), 209-235.

Lee, C. W., Taylor, G., & Dunn, J. (1999). Factor structures of the Schema Questionnaire in a large clinical sample. *Cognitive Therapy & Research, 23* (4), 421-451.

Lemert, E. M. (1962). Paranoia and the dynamics of exclusion. *Sociometry, 25*, 2-20.

Lewis, M. (1992). *Shame: The exposed self*. New York: Free Press.

Lewis, M. (2003). The role of the self in shame. *Social Research, 70*, 1181–1204.

Liotti, G., & Gumley, A. (2008). An attachment perspective on schizophrenia: The role of disorganized attachment, dissociation and mentalization. In A. Moskowitz, I. Schafer & M. Dorahy (Eds.), *Psychosis, trauma and dissociation: Emerging perspectives on severe psychopathology* (pp. 117–33). Chichester: Wiley-Blackwell.

Liotti, G., Pasquini, P., & Cirrincione, R. (2000). Predictive factors for borderline personality disorder: Patients' early traumatic experiences and losses suffered by the attachment figure. *Acta Psychiatrica Scandinavia, 102*, 282-289.

Livingstone, K., Harper, S., & Gillanders, D. (2009). An exploration of emotion regulation in psychosis. *Clinical Psychology & Psychotherapy, 16* (5), 418-430.

Lobbestael, J. (2012). Validation of the schema mode inventory. In M. van Vreeswijk, J. Broersen & M. Nadort (Eds.), *The Wiley-Blackwell handbook of schema therapy: Theory, research, and practice* (pp. 541-551). Sussex: John Wiley & Sons Ltd.

Lobbestael, J., & Arntz, A. (2010). Emotional, cognitive and physiological correlates of abuse-related stress in borderline and antisocial personality disorder. *Behaviour Research and Therapy, 48* (2), 116-124.

Lobbestael, J., & Arntz, A. (2012). The state dependency of cognitive schemas in antisocial patients. *Psychiatry Research, 198* (3), 452-456.

Lobbestael, J., Arntz, A., Cima, M., & Chakhssi, F. (2009a). Effects of induced anger in patients with antisocial personality disorder. *Psychological Medicine, 39* (4), 557-568.

Lobbestael, J., Arntz, A., Lobbes, A., & Cima, M. (2009b). A comparative study of patients and therapists' reports of schema modes. *Journal of Behaviour Therapy and Experimental Therapy, 40*, 571-579.

Lobbestael, J., Arntz, A., & Sieswerda, S. (2005). Schema modes and childhood abuse in borderline and antisocial patients. *Journal of Behavior Therapy and Experimental Psychology, 36,* 240-253.

Lobbestael, J., van Vreeswijk, F., & Arntz, A. (2007). Shedding light on schema modes: A clarification of the mode concept and its current research status. *Netherlands Journal of Psychology, 63*, 76-85.

Lobbestael, J., van Vreeswijk, M., & Arntz, A. (2008). An empirical test of schema mode conceptualisations in personality disorders. *Behavior Research and Therapy, 46,* 854-860.

Lobbestael, J., van Vreeswijk, M., Spinhoven, P., Schouten, E., & Artntz, A. (2010). Reliability and validity of the short schema mode inventory (SMI). *Behavioural and Cognitive Psychotherapy, 38* (4)*,* 437-458.

Longden, E., Corstens, D., Escher, S., & Romme, M. (2012). Voice hearing in a biographical context: A model for formulating the relationship between voices and life history. *Psychosis, 4* (3), 224–34.

Lynch, D., Laws, K. R., & McKenna, P. J. (2010). Cognitive behavioural therapy for major psychiatric disorder: Does it really work? A meta-analytical review of well-controlled trials. *Psychological medicine*, *40* (1), 9-24.

MacBeth, A., Gumley, A., Schwannauer, M., & Fisher, R. (2011). Attachment states of mind, mentalization, and their correlates in a first-episode psychosis sample. *Psychology and Psychotherapy: Theory Research and Practice, 84*, 42-57.

MacBeth, A., Schwannauer, M., & Gumley, A. (2008). The association between attachment style, social mentalities, and paranoid ideation: An analogue study. *Psychology and Psychotherapy: Theory Research and Practice, 81*, 79-93.

Madill, A., Jordan, A., & Shirley, C. (2000). Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies. *British Journal of Psychology, 91* (1), 1-20.

Malogiannis, I. A., Arntz, A., Spyropoulou, A., Tsartsara, E., Aggeli, A., Karveli, S., ... & Zervas, I. (2014). Schema therapy for patients with chronic depression: a single case series study. *Journal of Behavior Therapy and Experimental Psychiatry*, *45* (3), 319-329.

Maroda, K. J. (2009). *Psychodynamic Techniques: Working with Emotion in the Therapeutic Relationship*. New York: The Guilford Press.

McKenna, P., & Kingdon, D. (2014). Has cognitive behavioural therapy for psychosis been oversold? *British Medical Journal,* 348.

Meehl, P. E. (1956). Wanted – a good cookbook. *American Psychologist, 11* (6), 263-272.

Mikulincer, M., & Shaver, P. R. (2004). Security-based self-representations in adulthood: Contents and processes. In N.S. Rholes & J.A. Simpson (Eds.), *Adult attachment: Theory, research, and clinical implications* (pp. 159–195). New York: Guilford.

Mikulincer, M., & Shaver, P. R. (2005). Mental representations of attachment security: Theoretical foundations for a positive social psychology. In M. W. Baldwin (Ed.), *Interpersonal cognition* (pp. 233–266). New York: Guilford.

Miles, M. B., & Huberman, A. M. (1994). *Qualitative data analysis: An expanded sourcebook (2nd ed.).* London: Sage.

Mind (2018). *Antipsychotics*. Retrieved from: https://www.mind.org.uk/information-support/drugs-and-treatments/antipsychotics/side-effects/#.W27fD-hKjIU

Mirowsky, J., & Ross, C. E. (1983). Paranoia and the structure of powerlessness. *American Sociological Review*, *48* (2), 228-239.

Mizrahi, R., Kiang, M., Mamo, D.C., Arenovich, T., Bagby, R.M., Zipursky, R.B. et al. (2006, December). The selective effect of antipsychotics on the different dimensions of the experience of psychosis in schizophrenia spectrum disorders. *Schizophrenia Research, 88* (1–3), 111–118.

Morgan, H. J., & Shaver, P. R. (1999). Attachment processes and commitment to romantic relationships. In J. M. Adams & W. H. Jones (Eds.), *Handbook of Interpersonal Commitment and Relationship Stability* (pp. 109-124). New York: Plenum.

Morrison, A. (2001). The interpretation of intrusions in psychosis: An integrative cognitive approach to hallucinations and delusions. *Behavioural and Cognitive Psychotherapy, 29,* 257-276.

Morrison, A. (2004). *Cognitive therapy for psychosis: A formulation-based approach.* Hove: Brunner-Routledge.

Morrison, A. P., Nothard, S., Bowe, S. E., & Wells, A. (2004). Interpretations of voices in patients with hallucinations and non-patient controls: a comparison and predictors of distress in patients. *Behaviour research and therapy*, *42* (11), 1315-1323.

Morrison, A. P., & Barratt, S. (2010). What are the components of CBT for psychosis? A Delphi study. *Schizophrenia Bulletin, 36* (1), 136-142.

Morrison, A. P., Hutton, P., Shiers, D., & Turkington, D. (2012). Antipsychotics: Is it time to introduce patient choice? *British Journal of Psychiatry, 201*, 83–84.

Moskowitz, A., Read, J., Farrelly, S., Rudgeair, T., & Williams, O. (2009). Are psychotic symptoms traumatic in origin and dissociative in kind? In P.F. Dell &

J.A. O'Neill, *Dissociation and the dissociative disorders: DSM-V and beyond* (pp.521–534). New York: Routledge.

Neighbors, H. W., Trierweiler, S. J., Ford, B. C., & Muroff, J. R. (2003). Racial differences in DSM diagnosis using a semi-structured instrument: The importance of clinical judgment in the diagnosis of African Americans. *Journal of Health and Social Behavior, 44* (3), 237–256.

National Institute for Health and Care Excellence (2014). *Psychosis and schizophrenia in adults: Prevention and management* (NICE Quality Standard No. 178). Retrieved from: https://www.nice.org.uk/guidance/cg178

Nickerson, R. S. (1998). Confirmation bias: A ubiquitous phenomenon in many guises. *Review of General Psychology*, *2* (2), 175.

Nordahl, H. M., & Nysæter, T. E. (2005). Schema therapy for patients with borderline personality disorder: A single case series. *Journal of Behavior Therapy and Experimental Psychiatry, 36* (3), 256–266.

Payne, J. D., Nadel, L., Britton, W. B., & Jacobs, W. J. (2004). The biopsychology of trauma and memory. In D. Reisberg & P. Hertel (Eds.), *Series in affective science. Memory and emotion* (pp. 76-128). New York: Oxford University Press.

Pearse, L. J., Dibben, C., Ziauddeen, H., Denman, C., & McKenna, P. J. (2014). A Study of Psychotic Symptoms in Borderline Personality Disorder. *The Journal of Nervous and Mental Disease, 202* (5), 368-371.

Perls, F. (1973). *The Gestalt approach and eye witness to therapy*. Science & Behavior Books.

Pfammatter, M., Junghan, U.M., & Brenner, H.D. (2006). Efficacy of psychological therapy in schizophrenia: Conclusions from meta-analyses. *Schizophrenia Bulletin, 32* (1), S64-S80.

Pharoah, F. M., Mari, J. J., & Streiner, D. (1999). Family intervention for
      schizophrenia (Cochrane Review). *Cochrane Library*, *Issue 2*. Update
      Software: Oxford.

Pharoah, F., Mari, J., Rathbone, J., & Wong, W. (2010). Family intervention for
      schizophrenia. *The Cochrane database of systematic reviews*, *12*, CD000088.

Pilling, S., Bebbington, P., Kuipers, E., Garety, P., Geddes, J., Orbach, G., &
      Morgan, C. (2002). Psychological treatments in schizophrenia: I. Meta-
      analysis of family intervention and cognitive behaviour therapy. *Psychological
      Medicine, 32,* 763–782.

Pitschel-Walz, G., Leucht, S., Bäuml, J., Kissling, W., & Engel, R. R. (2001). The
      effect of family interventions on relapse and rehospitalization in schizophrenia:
      A meta-analysis. *Schizophrenia Bulletin*, *27* (1), 73-92.

Potter, J., & Hepburn, A. (2005). Qualitative interviews in psychology: Problems and
      possibilities. *Qualitative Research in Psychology, 2* (4), 281-307.

Psychosis Research Unit (2018). *Treatment choice.* Retrieved from:
      http://www.psychosisresearch.com/treatment-choice/

Pugh, M. (2015). A narrative review of schemas and schema therapy outcomes in
      the eating disorders. *Clinical Psychology Review, 39*, 30-41.

Pyle, M., & Morrison, A. (2013). 'It's just a very taboo and secretive kind of thing':
      Making sense of living with stigma and discrimination from accounts of people
      with psychosis. *Psychosis: Psychological, Social and Integrative Approaches,
      6*, 195–205.

Rappoport, L., Baumgardner, S., & Boone, G. (1999). Postmodern culture and the
      plural self. In J. Rowan & M. Cooper (Eds.), *The plural self. Multiplicity in
      everyday life* (pp. 93-106). London: Sage.

Read, J., Agar, K., Argyle, N., & Aderhold, V. (2003). Sexual and physical abuse
      during childhood and adulthood as predictors of hallucinations, delusions and

thought disorder. *Psychology and Psychotherapy: Theory, Research and Practice, 76* (1), 1–22.

Read, J., & Bentall, R. P. (2012). Negative childhood experiences and mental health: Theoretical, clinical and primary prevention implications. *British Journal of Psychiatry, 200*, 89-91.

Read, J., & Bentall, R. (2013). Madness. In J. Cromby, D. Harper, & P. Reavey, *Psychology, Mental Health, and Distress* (pp. 249-282). New York: Palgrave Macmillan.

Read, J., Fink, P.J., Rudegeair, T., Felitti, V., & Whitfield, C.L. (2008). Child maltreatment and psychosis: A return to a genuinely integrated bio-psycho-social model. *Clinical Schizophrenia & Related Psychoses, 2* (3), 235–254:

Read, J., Fosse, R., Moskowitz, A., & Perry, B. (2014). The traumagenic neurodevelopmental model of psychosis revisited. *Neuropsychiatry, 4* (1), 65–79.

Read, J., & Gumley, A. (2008). Can attachment theory help explain the relationship between childhood adversity and psychosis. *Attachment: New Directions in Psychotherapy and Relational Psychoanalysis, 2*, 1-35

Read, J., Mosher, L. R., & Bentall, R. P. (Eds.). (2004). *Models of madness: Psychological, social and biological approaches to schizophrenia*. Psychology Press.

Read, J., Perry, B. D., Moscowitz, A., & Connolly, J. (2001). The contribution of early traumatic events to schizophrenia in some patients: A traumagenic neurodevelopmental model. *Psychiatry, 64* (4), 319-345.

Read, J., van Os, J. V., Morrison, A. P., & Ross, C. A. (2005). Childhood trauma, psychosis and schizophrenia: a literature review with theoretical and clinical implications. *Acta Psychiatrica Scandinavica*, *112* (5), 330-350.

Renner, F., Arntz, A., Leeuw, I., & Huibers, M. (2013). Treatment for chronic depression using schema therapy. *Clinical Psychology: Science and Practice, 20* (2), 166-180.

Rhodes, J. E., & Healey, L. J. (2016). 'Many die in the hurricane': An interpretative phenomenological analysis of adults with psychosis and a history of childhood physical abuse. *Clinical Psychology and Psychotherapy.* doi:10.1002/cpp.2043

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

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

Romme, M. A. J., & Escher, A. D. M. A. C. (1989). Hearing voices. *Schizophrenia Bulletin, 15,* 209-216.

Ross, C., & Keyes, B. (2009). Clinical features of dissociative schizophrenia in China. *Psychosis: Psychological, Social and Integrative Approaches, 1* (1), 51–60.

Rudgeair, T., & Farrelly, S. (2008). Pharmocotherapy in the collaborative treatment of trauma induced dissociation and psychosis. In I. Moskowitz, I. Schafer & M. J. Dorahy (Eds.), *Psychosis, trauma and dissociation: Emerging perspectives on severe psychopathology* (pp.307–318). Oxford: Wiley-Blackwell.

Sarbin, T. R., & Mancuso, J. C. (1980). *Schizophrenia: Medical diagnosis or moral verdict?* New York: Pergamon Press.

Sartorius, N. (2002). Iatrogenic stigma of mental illness: Begins with behaviour and attitudes of medical professionals, especially psychiatrists. *British Medical Journal, 324,* 1470–1471.

Schafer, I., Ross, C., & Read, J. (2008). Childhood trauma in psychotic and dissociative disorders. In A. Moskowitz, I. Schafer, M. J. Dorahy (Eds.), *Psychosis, trauma and dissociation: Emerging perspectives on severe psychopathology* (pp. 137–50). Chichester: Wiley-Blackwell.

Schizophrenia Commission. (2012). *The abandoned illness: A report from the Schizophrenia Commission*. London: Rethink Mental Illness.

Schmidt, N. B., Joiner, T. E., Young, J. E., & Telch, M. J. (1995). The Schema Questionnaire: Investigation of psychometric properties and the hierarchical structure of a measure of maladaptive schemata. *Cognitive Therapy and Research, 19* (3), 295-321.

Schroeder, K., Fisher, H. L., & Schäfer, I. (2013). Psychotic symptoms in patients with borderline personality disorder: Prevalence and clinical management. *Current Opinion in Psychiatry, 26* (1), 113-119.

Schwannauer, M. (2013). Attachment, mentalisation and reflective function in psychosis. In A. I. Gumley, A. Gillham, K. Taylor & M. Schwannauer (Eds.), *Psychosis and emotion: The role of emotions in understanding psychosis, therapy and recovery* (pp. 68-83). Abingdon: Routledge.

Schwartz, R. C., & Blankenship, D. M. (2014). Racial disparities in psychotic disorder diagnosis: A review of empirical literature. *World Journal of Psychiatry, 4* (4), 133-140.

Searles, H. (1965). *Collected papers on schizophrenia and related subjects*. New York: International Universities Press.

Sempertegui, G. A., Karreman, A., Arntz, A., & Bekker, M. H. J. (2013). Schema therapy for borderline personality disorder: A comprehensive review of its empirical foundations, effectiveness and implementation possibilities. *Clinical Psychology Review, 33*, 426–447.

Shaver, P. R., & Mikulincer, M. (2007). Adult attachment strategies and the regulation of emotion, in J. J. Grass (Ed.), *Handbook of Emotion Regulation,* New York: Guilford Press, 446-465.

Shaw, R. J., Atkin, K., Bécares, L., Albor, C. B., Stafford, M., Kiernan, K. E., ... & Pickett, K. E. (2012). Impact of ethnic density on adult mental disorders: Narrative review. *The British Journal of Psychiatry, 201* (1), 11–19.

Shevlin, M., Houston, J., Dorahy, M., & Adamson, G. (2008). Cumulative traumas and psychosis: An analysis of the National Comorbidity Survey and the British Psychiatric Morbidity Survey. *Schizophrenia Bulletin, 34,* 193–199.

Silver, A., Koehler, B., & Karon, B. (2004). Psychodynamic therapy of schizophrenia: Its history and development. In J. Read, L. Mosher & R. Bentall (Eds), *Models of Madness: Psychological, Social and Biological Approaches to Schizophrenia* (pp. 209–22). London: Routledge.

Simpson, S. G., Morrow, E., & Reid, C. (2010). Group schema therapy for eating disorders: A pilot study. *Frontiers in Psychology*, *1*, 182.

Skewes, S. A., Samson, R. A., Simpson, S. G., & Van Vreeswijk, M. (2015). Short-term group schema therapy for mixed personality disorders: a pilot study. *Frontiers in psychology*, *5* (1592), 1-9.

Slade, A., Belsky, J., Aber, J. L., & Phelps, J. L. (1999). Mothers' representations of their relationships with their toddlers: Links to adult attachment and observed mothering. *Developmental Psychology, 35,* 611-619.

Sloman, L., Gilbert, P., & Hasey, G. (2003). Evolved mechanisms in depression: The role and interaction of attachment and social rank in depression. *Journal of Affective Disorders, 74*, 107–121.

Smith, B., Fowler, D. G., Freeman, D., Bebbington, P., Bashforth, H., Garety, P., & Kuipers, E. (2006). Emotion & psychosis: Links between depression, self-esteem, negative schematic beliefs and delusions and hallucinations. *Schizophrenia Research, 86* (1-3), 181-188.

Smith, D. J., Langan, J., McLean, G., Guthrie, B., & Mercer, S.W. (2013). Schizophrenia is associated with excess multiple physical-health comorbidities but low levels of recorded cardiovascular disease in primary care: Cross-sectional study. *British Medical Journal, 3* (4). doi: 10.1136/bmjopen-2013-002808

Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 51–80). Los Angeles, CA: Sage.

Special Hospitals Service Authority (SHSA) (1993). *Report of the Committee of Inquiry into the Death in Broadmoor Hospital of Orville Blackwood and a Review of the Deaths of Two Other Afro-Caribbean Patients: 'Big, black and Dangerous?'* (Chairman: Professor H. Prins) London: SHSA.

Strathearn, L. (2007). Exploring the neurobiology of attachment. In L. Mayes, P. Fonagy & M. Target (Eds), *Developmental Science and Psychoanalysis: Integration and Innovation* (pp. 117-130). London: Karnac.

Tarrier, N., Barrowclough, C., Porceddu, K., & Fitzpatrick, E. (1994). The Salford Family Intervention Project: Relapse rates of schizophrenia at five and eight years. *The British Journal of Psychiatry*, *165* (6), 829-832.

Taylor, C. D. J., Bee, P., & Haddock, G. (2016). Does schema therapy change schemas and symptoms? A systematic review across mental health disorders. *Psychology and psychotherapy: Theory, research and practice, 90* (3), 456–479.

Taylor, C. D. J., & Harper, S. F. (2015). Early maladaptive schema, social functioning and distress in psychosis: A preliminary investigation. *Clinical Psychologist*. doi:10.1111/cp.12082

Thompson, A. R., & Chambers, E. (2012). Ethical issues in qualitative mental health research. In D. Harper & A. Thompson (Eds.) *Qualitative Research Methods in Mental Health and Psychotherapy: A Guide for Students and Practitioners* (pp. 23-37). Chichester: John Wiley & Sons.

Thornicroft, G. (2006). *Shunned: Discrimination against people with mental illness*. Oxford and New York: Oxford University Press.

Trower, P., & Chadwick, P. (1995). Pathways to defense of the self: A theory of two types of paranoia. *Clinical Psychology: Science and Practice, 2*, 263–278.

Turner, D.T., van der Gaag, M., Karyotaki, E., Cuijpers, P. (2014). Psychological interventions for psychosis: a meta-analysis of comparative outcome studies. *American Journal of Psychiatry*, *171* (5), 523-538.

van den Kieboom, P., & Jonker, D. (2012). Individual schema therapy: Practical experience with adults. In M. van Vreeswijk, J. Broersen & M. Nadort (Eds.), *The Wiley-Blackwell handbook of schema therapy: Theory, research and practice* (pp. 311-322). Sussex: John Wiley & Sons Ltd.

van der Gaag, M., Valmaggia, L.R., & Smit, F. (2014). The effects of individually tailored formulation-based cognitive behavioural therapy in auditory hallucinations and delusions: A meta-analysis. *Schizophrenia Research, 156* (1), 30-37.

van der Kolk, B. A., Hostetler, A., Herron, N., & Fisler, R. E. (1994). Trauma and the development of borderline personality disorder. *Psychiatric Clinics of North America, 17*, 715-730.

van Os, J., Kenis, G., & Rutten, B.P. (2010). The environment and schizophrenia. *Nature, 468* (7321), 203–212.

van Os, J., Rutten, B.P., & Poulton, R. (2008). Gene environment interactions in schizophrenia: review of epidemiological findings and future directions. *Schizophrenia Bulletin, 34,* 1066–1082.

van Vreeswijk, M., & Broersen, J. (2006). Schemagerichte Therapie in Groepen. Cognitieve Groepspsychotherapie bij Persoonlijkheidsproblematiek. Handleiding voor Therapeuten [Schema therapy in groups: A manual for therapists]. Houten, the Netherlands: Bohn Stafleu van Loghum.

van Vreeswijk, M., & Broersen, J. (2013). Kortdurende Schemagroeps-Therapie: Cognitief Gedragstherapeutische Technieken Deel Handleiding [Short-term group schema therapy schedule: Cognitive behavioural therapy techniques] (Reved.). Houten, the Netherlands: Bohn Stafleu van Loghum.

van Vreeswijk, M., Broersen, J., & Nadort, M. (2012). *The Wiley-Blackwell handbook of schema therapy: Theory, research and practice*. Sussex: John Wiley & Sons Ltd.

van Vreeswijk, M., Spinhoven, P., Eurelings-Bontekoe, E. H. M., & Broersen, J. (2014). Changes in symptom severity, schemas and modes in heterogeneous psychiatric patient groups following short-term schema cognitive–behavioural group therapy: A naturalistic pre-treatment and post-treatment design in an outpatient clinic. *Clinical Psychology & Psychotherapy*, *21* (1), 29-38.

Varese, F., Smeets, F., Drukker, M., Lieverse, R., Lataster, T., Viechtbauer, W., Read J., van Os, J., & Bentall, R. P. (2012). Childhood adversities increase the risk of psychosis: A meta-analysis of patient-control, prospective and cross-sectional cohort studies. *Schizophrenia Bulletin, 38* (4), 661-671.

Videler, A. C., Rossi, G., Schoevaars, M., van der Feltz-Cornelis, C. M., & van Alphen, S. P. J. (2014). Effects of schema group therapy in older outpatients: A proof of concept study. *International Psychogeriatrics*, *26* (10), 1709-1717.

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

Whelton, W.J., & Greenberg, L.S. (2005). Emotion in self-criticism. *Personality and Individual Differences, 38*, 1583–1595.

Whitaker, R. (2002). *Mad in America*. Cambridge, MA: Perseus Publishing.

Whitaker, R. (2010). *Anatomy of an epidemic: Magic bullets, psychiatric drugs, and the astonishing rise of mental illness in America*. New York: Crown.

Willig, C. (2013). *Introducing qualitative research in psychology (3rd Ed.).* Berkshire: Open University Press.

Wong, S. E. (2014). A critique of the diagnostic construct schizophrenia. *Research on Social Work Practice, 24* (1), 132-141.

World Health Organisation. (2016). Schizophrenia, schizotypal and delusional disorders. In *International statistical classification of diseases and related health problems* (10th ed.). Geneva: World Health Organisation.

Wykes, T., Steel, C., Everitt, B., & Tarrier, N. (2008) Cognitive behavior therapy for schizophrenia: Effect sizes, clinical models, and methodological rigor. *Schizophrenia Bulletin, 34* (3): 523-537.

Yardley, L. (2000). Dilemmas in qualitative health research. *Psychology & Health, 15,* 215-228.

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

Young, J. E. (1996). *Outline for schema-focused cognitive therapy for borderline personality disorder*. New York: Cognitive Therapy Center of New York.

Young, J. E. (1999). *Cognitive therapy for personality disorders: A schema-focused approach* (Revised ed.). Sarasota, FL: Professional Resources Press.

Young, J. E. (2000). *Workshop on Schema Mode Therapy for borderline personality disorders,* London, 2000.

Young, J. E. (2001). *Workshop on Schema Mode Therapy for narcissistic personality disorders,* Manchester, 2001.

Young, J. E., Arntz, A., Atkinson, T., Lobbestael, J., Weishaar, M. E., van Vreeswijk, M. F., & Klokman, J. (2007). *The schema mode inventory*. New York: Schema Therapy Institute.

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

Young, J. E., & Brown, G. (2001). *Young Schema Questionnaire: Special Edition*. New York: Schema Therapy Institute.

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

Young, J. E., Weinberger, A. D., & Beck, A. T. (2001). Cognitive therapy for depression. In D. Barlow (Ed.), *Clinical handbook of psychological disorders (3rd ed., pp.264-308).* New York: Guilford Press.

Zajonc, R. B. (1984). On the primacy of affect. *American Psychologist, 39* (2), 117-123.

Zubin, J., & Spring, B. (1977). Vulnerability: A new view on schizophrenia. *Journal of Abnormal Psychology, 86,* 103-126.

6. APPENDICES

Appendix A. Literature Review Searches

<u>Search criteria</u>
When using Boolean/phrase searches, search terms were refined using 'abstract, title, keywords' within Science Direct and 'title' and 'subjects' in PsychINFO. The search terms were aligned to my research questions and were as follows:

<u>Key words</u>

Psychosis	Schema therapy	Attachment	Emotion
Schizophrenia	Schema mode	Object relations	Relationship
Voice			
Paranoia			
Delusion			
Hallucination			

In some cases, connectors and parentheses were used to create search phrases and connect key words. The PsycInfo Thesaurus was also used to generate searches.

Appendix B. Early Maladaptive Schemas (from Young et al., 2003, p.14-17)

1)   Disconnection and Rejection
        1)   Abandonment/Instability – the perceived instability or unreliability of those available for support and connection.
        2)   Mistrust/Abuse – the expectation that others will hurt, abuse, humiliate, cheat, lie, manipulate, or take advantage.
        3)   Emotional Deprivation – the expectation that one's desire for a normal degree of emotional support will not be adequately met by others.
        4)   Defectiveness/Shame – the feeling that one is defective, bad, unwanted, inferior, or invalid in important respects or that one would be unlovable to significant others if exposed.
        5)   Social Isolation/Alienation – the feeling that one is isolated from the rest of the world, different from other people, and/or not part of any group or community.

2)   Impaired Autonomy and Performance
        6)   Dependence/Incompetence – the belief that one is unable to handle one's everyday responsibilities in a competent manner, without considerable help from others.
        7)   Vulnerability to Harm or Illness – exaggerated fear that imminent catastrophe will strike at any time and that one will be unable to prevent it.
        8)   Enmeshment/Undeveloped Self – excessive emotional involvement and closeness with one or more significant others (often parents) at the expense of full individuation or normal social development.
        9)   Failure – the belief that one has failed, will inevitably fail, or is fundamentally inadequate relative to one's peers in areas of achievement.

3)   Impaired Limits
        10) Entitlement/Grandiosity – the belief that one is superior to other people; entitled to special rights and privileges; or not bound by the rules of reciprocity that guide normal social interaction.
        11) Insufficient Self-Control/Self-Discipline – pervasive difficulty or refusal to exercise sufficient self-control and frustration tolerance to achieve one's personal goals or to restrain the excessive expression of one's emotions and impulses.

4)   Other-Directedness

      12) Subjugation - excessive surrendering of control to others because one feels coerced – submitting in order to avoid anger, retaliation, or abandonment.

      13) Self-Sacrifice - excessive focus on voluntarily meeting the needs of others in daily situations at the expense of one's own gratification.

      14) Approval-Seeking/Recognition-Seeking - excessive emphasis on gaining approval, recognition, or attention from other people or fitting in at the expense of developing a secure and true sense of self.

5)   Overvigilance and Inhibition

      15) Negativity/Pessimism – a pervasive, lifelong focus on the negative aspects of life while minimising or neglecting the positive or optimistic aspects.

      16) Emotional Inhibition - the excessive inhibition of spontaneous action, feeling, or communication, usually to avoid disapproval by others, feelings of shame, or losing control of one's impulses.

      17) Unrelenting Standards/Hypercriticalness - the underlying belief that one must strive to meet very high internalised standards of behaviour and performance, usually to avoid criticism.

      18) Punitiveness – the belief that people should be harshly punished for making mistakes. Involves the tendency to be angry, intolerant, punitive, and impatient with those people (including oneself) who do not meet one's expectations or standards.

Appendix C. Ethical Approval

Below is the first page of the NHS Ethics approval letter received on 26th September 2017.

NHS
Health Research Authority

Email: hra.approval@nhs.net

26 September 2017

Dear

Letter of HRA Approval

Study title:	An Exploration of Schema Modes in Psychosis (including Bipolar conditions).
IRAS project ID:	222790
Protocol number:	N/A
REC reference:	17/LO/1407
Sponsor	University of East London

I am pleased to confirm that **HRA Approval** has been given for the above referenced study, on the basis described in the application form, protocol, supporting documentation and any clarifications noted in this letter.

Participation of NHS Organisations in England

The sponsor should now provide a copy of this letter to all participating NHS organisations in England.

Appendix B provides important information for sponsors and participating NHS organisations in England for arranging and confirming capacity and capability. **Please read *Appendix B* carefully**, in particular the following sections:

- *Participating NHS organisations in England* – this clarifies the types of participating organisations in the study and whether or not all organisations will be undertaking the same activities
- *Confirmation of capacity and capability* - this confirms whether or not each type of participating NHS organisation in England is expected to give formal confirmation of capacity and capability. Where formal confirmation is not expected, the section also provides details on the time limit given to participating organisations to opt out of the study, or request additional time, before their participation is assumed.
- *Allocation of responsibilities and rights are agreed and documented (4.1 of HRA assessment criteria)* - this provides detail on the form of agreement to be used in the study to confirm capacity and capability, where applicable.

Further information on funding, HR processes, and compliance with HRA criteria and standards is also provided.

Appendix D: Recruitment Sheet

SEEKING PARTICIPANTS FOR A RESEARCH STUDY

Research Title: Exploration of Schema Modes in Psychosis

I am seeking to recruit participants for my doctoral thesis study. This study aims to explore whether people who experience psychosis describe being in different modes of functioning (i.e. have different combinations of thoughts, emotions and behavioural responses) at different times. If so, what kind of things affect these modes of functioning and cause them to change? Participants will be asked to take part in an interview and complete a questionnaire. Participation in the study will last approximately 1.5 hours. Participants will be given a £10 Love2Shop voucher for their time.

I am seeking to recruit approximately 8-10 participants who meet the following criteria:

A. Has a diagnosis of a non-affective psychotic disorder (e.g. schizophrenia, delusional disorder, schizoaffective disorder, schizophreniform disorder or brief psychotic disorder)

B. Has not also been diagnosed with any additional major psychiatric conditions, with the exception of anxiety (given its prevalence)

C. Is aged 18 or over

D. Understands and speaks English

E. Is considered by their clinical team to be in a mentally stable condition and to have the ability to give informed consent

If you have anyone on your caseload at ████████████████ who meets the above criteria, I would be extremely grateful if you could **ask for their consent to be contacted by the researcher for more information about the study**.

Please ask for:

1) Their preferred method of contact (e.g. email, telephone)
2) Their contact details
3) Their preferred day of week and time of day to be contacted

Note that prior to commencement of each interview I will discuss with you the service user's emotional state, to check that they are at present stable. I will also check how the service user responded in recent interviews to any questions that may have been upsetting: if there are any indications that the service user may not be stable, I will not proceed.

After the interview I will speak to you and share information concerning any distress that may have been displayed by the service user. Whether the service user appeared distressed or not, I will ask you to check directly with the service user.

This study is being carried out under the supervision of ██████████ (Clinical Psychologist). We hope that this research will help us to better understand experiences of Psychosis and how existing therapies can be appropriately modified for working with this client group. Recruiting for research studies can be challenging and I am therefore very grateful in advance for your support with this.

Please do not hesitate to email myself ████████████████████████████ or ██████████ ████████████████ securely for more information about the study; or with the details of any potential participants who have consented to being contacted.

Your support with recruitment is very much appreciated!

Hannah Whitehead
Trainee Clinical Psychologist
University of East London

Appendix E. Participant Information Sheet

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

<u>**UNIVERSITY OF EAST LONDON**</u>

The Principal Investigators
Hannah Whitehead, ██████████████████████
██████████████████████████

Information Sheet about a Research Study

This letter is giving you some information to help you think about whether you would like to take part in this research study. The study is part of my Professional Doctorate in Clinical Psychology at the University of East London.

Title of research study
An exploration of schema modes in psychosis

What is the study about?
The aim of this study is to interview people who have been referred to the ████████████ ████████████████████████████ about their experiences. I would like to investigate whether there are particular ways of responding to or coping with serious mental health problems. It is hoped that this study will help to develop psychological therapies.

The completed study will be written in the form of an academic thesis. I may use the research to write more articles that might appear in academic or practice journals.

Why am I being asked to take part?
As you have been referred to the ██, you might have had some experiences associated with psychosis and I believe that speaking directly to people who have had these types of experiences is the best way to understand it.

What am I being asked to do?
I am interested in meeting with you for an interview that would last for about one hour. I would ask a number of questions and make an audio recording of the interview, which I would type up afterwards. After the interview I would also ask you to complete a questionnaire, which would take 20-30 minutes.

What are the benefits of taking part?

In being interviewed you will have the chance to speak about your experiences and give your understanding in relation to these. You will also be helping to give researchers and professionals some understanding about psychosis and therapies that could be developed to help people in similar positions to you in the future.

Where would it take place?

Interviews would take place in a private room at the ███████████████████████ ████████████████

What information will you have about me and how will you keep it safe?

I would record each interview using an audio recorder. Only I would listen to the recordings and type them up into transcripts. Any names that were mentioned and anything that would make you or anyone else identifiable would be changed in the transcript. As this research study is part of my University course, two supervisors will be supporting me with the study and I will be discussing information from the interviews and questionnaires with them. The typed transcript will be read by my research supervisor █████████, a Clinical Psychologist at ███████████████████████████████ and may be read by my other research supervisor █████████, Clinical Psychologist at the University of East London. The examiners who test me when the thesis is assessed may request to see the transcript. No one else will have access to the transcript or questionnaire.

The final thesis will include a small number of quotes from interviews. I will make sure that these quotes do not identify who you are or anyone you are talking about.

The audio file, transcript and answers to the questionnaire will be saved on a computer that is password protected, in separate password protected files. Any paper-based information (consent forms, questionnaires) will be kept in locked drawers or filing cabinets on NHS premises.

How long would you keep my information for?

All information (audio recording, written transcript, questionnaire responses) will be kept for five years following completion of the thesis, and then destroyed. During the five years, the information might be used for additional articles or publications based on the research.

Are there any risks in taking part?

There are no risks or dangers involved in taking part, although it is possible you might get upset during or after the interview, if you were talking about difficult experiences. If you did get upset, there are some ways I could offer support to you:

- People who take part in the interview are welcome to approach me about any distress they experience. I would not be able to give advice or offer counselling, but I would be available to think about how you are feeling in relation to the interview. We might think together about who might be able to help and who you might like to share the information with.
- If I notice that you appear to be upset, I might check this out with you after the interview.

- After the interview, I would provide information about support you could access if you feel you need it.
- You could also contact a member of your healthcare team at ███████ ████████████████████████ for support if you needed to.

I have a responsibility to consider the safety of the people who take part in the study. If I am concerned about the safety or well-being of yourself or others, I am legally required to inform someone who may need to know or help. I will discuss this with you first, where possible.

There are two main situations where this might happen:
1) If you tell me about any illegal activity you have taken part in.
2) If I am worried about your safety and well-being or the safety and well-being of other people linked to you.

What if I decide to take part, but then change my mind?
You can change your mind at any point. You do not have to give a reason why and you will not be at a disadvantage for changing your mind. During the interview, if you do not feel comfortable answering a particular question, you do not have to answer it. If you would like us to stop the interview, we can do this at any point.

I have some questions about the study; can I contact you?
Yes, I am happy to answer your questions. You can contact me by email or telephone; my contact details are at the top of this letter.

I would like to take part. What do I do now?
You might have already agreed for a member of your healthcare team to pass me your contact details; in this case you will hear from me soon. If you did not agree for your contact details to be given to me, but would like to talk to me about possibly taking part, you can contact me by email or telephone (contact details at the top of this letter). Or you can speak to a member of your healthcare team at ██; they will ask you for a contact phone number or email address so I can contact you. If, once we have spoken, you agree to participate I will notify your healthcare team of this, provided you agree to this. On the day of the interview, I will give you a consent form to read and sign before we start. You will have the chance to ask more questions if you need to before you decide whether to sign the form.

What if I'm not happy with how the study has been conducted?
If you have any questions or concerns about how the study has been conducted, please contact the study's academic supervisor Dr Dave Harper, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Tel: 0208 223 4021. Email: D.harper@uel.ac.uk)

OR

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ.
(Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Thank you for reading this letter.

Yours sincerely,

Hannah Whitehead
Trainee Clinical Psychologist
University of East London

Appendix F. Consent Form

IRAS ID: ███████

Centre Number:

Study Number:

Participant Identification Number for this trial:

<div style="text-align:center">

TRUST LOGO

</div>

CONSENT FORM

Title of Project: An exploration of schema modes in psychosis

Name of Researcher: Hannah Whitehead

Please initial box

1. I confirm that I have read the information sheet dated 26/09/2017 (version 5) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.

☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.

☐

3. I agree to my healthcare team being notified that I am taking part in this study.

☐

4. I understand that relevant sections of my medical notes may be looked at by individuals from my healthcare team at the ██████████ ██████████ where it is relevant to my taking part in this research. I give permission for these individuals to have access to my records.

☐

5. I understand that data collected during the study may be looked at by individuals from the University of East London and regulatory authorities,

☐

where it is relevant to my taking part in this research. I give permission
for these individuals to have access to this data.

6. I agree to take part in the above study. ☐

_____	_____	_____
Name of Participant	Date	Signature
_____	_____	_____
Name of Person taking consent	Date	Signature

(One copy to be kept by the participant, and one copy by the researcher)

Appendix G. Information Sheet for Healthcare Professionals

School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

<u>**UNIVERSITY OF EAST LONDON**</u>

The Principal Investigators
Hannah Whitehead, ██████████████████████

Information Sheet about Participation of a Service User in a Research Study

Re: ██████████████

This letter is informing you that the above named service user has given verbal consent to participate in a research study. The study is part of a Professional Doctorate in Clinical Psychology at the University of East London and is an exploration of schema modes in psychosis. I have arranged to meet with the service user on ██████ at ██████████ for an interview and completion of a questionnaire.

Informed consent will be sought on the day of the interview. If informed consent is given, he/she will be interviewed about his/her experiences related to psychosis.

It is possible the service user might get upset during or after the interview, if he/she is talking about difficult experiences. If I notice that he/she appears to be upset, I will check this out with him/her after the interview and will think together about who might be able to provide help and support. After the interview I will speak to the healthcare professional responsible and share information concerning any distress that may have been displayed by the service user. Whether the service user appeared distressed or not, I will ask the healthcare professional to check directly with the service user.

If you have any questions the study, please contact me on the above email address or phone number.

Yours sincerely,

Hannah Whitehead
Trainee Clinical Psychologist
University of East London

Appendix H. Interview Schedule

Introductions and engagement
Agree approximate length of interview, can take breaks, ice breaker questions e.g. how was your journey here? Ask if they would like a summary of the research.

Exploration of experiences of psychosis
'Psychosis can be experienced in different ways, and people can find it useful to describe these experiences in a way that makes sense to them; for example, hearing voices, believing things that others find strange, speaking in a way that others find hard to follow, or feeling as though others are out to get you.'

'Do any of these descriptions fit with your experiences? How would you describe your experiences? What do you call them?'

Questions specific to Young's modes
'I am going to tell you a little bit about the way that many people's difficulties are viewed in a therapy called Schema Therapy, and I'm going to ask you to tell me if you think it fits for you. In Schema Therapy it is believed that everyone experiences themselves differently at different moments. While we may feel very healthy and relaxed in one moment, we may feel vulnerable and sad in another. In another situation we may feel nothing. Schema Therapy describes these different experiences as modes. We can be in one mode for a while, but then change over into another mode, depending on the situation.'

'I have descriptions of a few modes written on these cards. I am going to give you a card to read, and I will also read it out to you. As I read it, think about whether you have ever experienced anything similar. I will then ask you some questions about it. Then I will give you the next card. Do you have any questions?'

PRESENT MODES ON CARDS

1) Demanding Parent
> You push yourself to do your best in everything. You feel under pressure to achieve.
> You try to never make a mistake, and if you do you're critical of yourself.
> You don't allow yourself to relax until all the work is done.

2) Punitive Parent
> You think you're bad and/or dislike yourself most of the time.
> You feel that you deserve to be punished. You might have the urge to punish yourself (e.g. by harming yourself), or not allow yourself to do pleasant things.

3) Vulnerable Child
> You often feel completely alone, weak and helpless, or that nobody loves you. You might feel frightened, sad, abandoned, or anxious without a particular reason.

4) Angry Child

You feel anger and rage. When you get angry you might not be able to control yourself. You might become furious and shout, or have violent thoughts and impulses. This may cause serious problems in your life.

5) Impulsive/Undisciplined Child

You believe that you can do what you want, no matter how other people feel or   think about it.

You find it hard to stop yourself from doing something you want to do, even if you know you should not do it.

You feel strong and powerful, and it can feel good to put others in their place, but afterwards you might feel bad in some way.

6) Surrender Coping

You think about other people's needs, not your own. You do things you don't want to do, because others want or demand it.

You allow others to treat you badly.

You try to please others to avoid conflict.

7) Detached Protector Coping

You avoid things you find difficult, such as conflicts with others, social contact, painful emotions, or thinking about yourself and problems.

You feel numb or empty.

Prompt: You might drink alcohol, take drugs, eat, or distract yourself to avoid certain emotions.

8) Overcompensating Coping

You act the opposite to how you actually feel. You might behave very self-confidently, assertively, or try to impress others. Underneath you might feel insecure or helpless.

You are very critical about what others do or don't do.

If you are criticised, you jump to your defence. You might blame others.

Questions (to ask about each of the modes)**:**

1) Do you ever feel like this or experience anything like this?

2) Can you tell me what this is like?
   Recent example?
   Prompt: what do you feel like/what do you do when that part of you predominates? – how strong/intense is this feeling/urge/behaviour – whatever they have described?
   Prompt: what kinds of thoughts tend to come up when you are in that mode? – is there anything that you do in response to these thoughts?

3) How often do you tend to experience this?

4) Does anything in particular seem to trigger this off / what seems to get it going?

Prompt: Internal triggers (e.g. thoughts, images, memories, feelings) or external triggers (e.g. arguments)

5) How long does this mode last/how long does this mode go on for?
Prompt: How does it stop / what kinds of things might make it stop?

6) Do you think there is any relationship between this mode and the voices/paranoia you experience?
Prompt: Do the voices/paranoia change when in this mode? Is this mode experienced differently when you hear voices/feel paranoid?

7) We have discussed several modes. Do you think there are any others you experience? What are these like?

Additional prompts
- What was that like for you?
- Can you tell me more about that?
- Can you give me an example?
- What are some of the ways you [don't feel good about yourself]?
- How did it make you feel when [she] used to [talk to you] that way?

Appendix I. Mode Cards

1 You push yourself to do your best in everything. You feel under pressure to achieve. You try to never make a mistake, and if you do you're critical of yourself. You don't allow yourself to relax until all the work is done.	**2** You think you're bad and/or dislike yourself most of the time. You feel that you deserve to be punished. You might have the urge to punish yourself (e.g. by harming yourself) or not allow yourself to do pleasant things.
3 You often feel completely alone, weak and helpless, or that nobody loves you. You might feel frightened, sad, abandoned, or anxious without a particular reason.	**4** You feel anger and rage. When you get angry you cannot control yourself. You become furious and shout, or have violent thoughts and impulses. This causes serious problems in your life.

5	6
You believe that you can do what you want, no matter how other people feel or think about it. You find it hard to stop yourself from doing something you want to do, even if you know you should not do it. You feel strong and powerful, and it can feel good to put others in their place, but afterwards you might feel bad in some way.	You think about other people's needs, not your own. You do things you don't want to do, because others want or demand it. You allow others to treat you badly. You try to please others to avoid conflict.
7	8
You avoid things you find difficult, such as conflicts with others, social contact, painful emotions, or thinking about yourself and problems. You feel numb or empty.	You act the opposite to how you actually feel. You might behave very self-confidently, assertively, or try to impress others. Underneath you might feel insecure or helpless. You are very critical about what others do or don't do. If you are criticised, you jump to your defence. You might blame others.

Appendix J. Transcription Notation System (adapted from Braun & Clarke, 2013)

Feature	Notation and explanation
Identity of speaker	Speaker's name, followed by colon (e.g. Nasir:) signals identity of speaker. Interviewer: is used for when interviewer is speaking. New line used every time a new speaker starts. First word of each new turn of talk in a capital letter.
Laughing	[laughter] signals laughing by person speaking.
Pausing	[.] signals a pause that is significant but brief (i.e. a few seconds). [number] indicates a longer pause, e.g. [7] for a 7 second pause
Spoken abbreviations	If someone speaks an abbreviation then it is transcribed, e.g. EIS for Early Intervention Service, but it is not abbreviated unless speaker did so.
Brief interjections	If person says a brief interjection when other person is speaking, present in < >, e.g. 'I will ask you about your experiences of this <ok> before'.
Inaudible speech	[inaudible] for speech and sounds that are completely inaudible. When some can be heard use single parentheses to indicate best guess, e.g. (ways of life)
Non-verbal utterances	Render phonetically and consistently common non-verbal sounds uttered by participants, e.g. 'um', 'er', mm', 'mmhm'.

Use of punctuation	Mindful use as can change meaning of spoken data.
Reported speech	When a person provides an apparent verbatim account of the speech or thoughts of another person (or their own past speech). Signal using inverted commas, e.g. and she said 'I don't know what to think'.
Identifying information	Provide unmarked, appropriate alternatives to potentially identifiable information.

Appendix K. Example of Annotated Transcript Excerpt

On the following two pages are an excerpt from Sheila's transcript. The notes below can aid interpretation of the process and acronyms used.

Left column: Researcher's comments and codes about the schema mode that the participant is currently being asked about. Codes are categorised according to matrix column headings (e.g. 'contributing factors', 'experience of mode'). Codes and comments in the left column correspond to interview data highlighted in yellow.

Right column: Researcher's comments and codes about other schema modes identified in the data (i.e. any modes not currently being asked about). Codes are categorised according to matrix column headings (e.g. 'contributing factors', 'experience of mode'). Codes and comments in the right column are in blue and correspond to interview data where text colour has been changed to blue.

VC=Vulnerable Child mode; PP=Punitive Parent mode; AC=Angry Child mode

468 Sheila: Cause I want to do it too, mindreading. I don't know how
469 they do it. Because I think it's doctors, and that friend that I think
470 reads my mind. At one point she went to, she went to study to
471 become a doctor, so maybe, but she's not anymore, so maybe from
472 her course there's doctors, friends, so like maybe they help, they set
473 up a business and stuff.

474 Interviewer: Ok so you've been trying to figure out how they can
475 mind read.

476 Sheila: Mmhm.

477 Interviewer: Yeah, ok. And so, how often do you feel alone?

478 Sheila: About the mind reading?

479 Interviewer: Yeah or, or even just generally, how often?

480 Sheila: Um, not really lonely. Oh, when I take my medication,
481 because it sedates me, it gives me this feeling, and I don't like, it's
482 not a nice feeling

483 Interviewer: What medication is it?

484 Sheila: Chlozopine. And so [.] I feel like, ill, and like [.] I can't explain
485 yeah, it makes me feel like I'm alone, kind of.

486 Interviewer: Oh right, that's not good, you know when medication is
487 supposed to help you, but actually it's not having a good effect,
488 sometimes.

489 Sheila: Mmhm.

490 Interviewer: Ok, that's difficult. Ok, great. [Reads mode card 4]

491 Sheila: Anger and rage, I do feel it with the voices. They wind me up.

492 Interviewer: Right, I'm not surprised.

493 Sheila: Um [.] sometimes they say to me that they're joking but
494 sometimes they say it at the last minute [.] it's like why?

495 Interviewer: At the last minute that they're joking?

496 Sheila: Yeah.

497 Interviewer: And what kinds of things do they say?

498 Sheila: That I'm stupid. And there's this thing that I did when I was
499 younger, and they call me a name.

500 Interviewer: Oh right, ok. And it's, how does that feel then when
501 they're calling you that name?

502 Sheila: It's horrible, yeah. Sometimes I can keep calm and just you
503 know, let them cuss me but other times I just lose it and then we
504 start fighting and I start swearing out loud, at them and stuff.

14

	505	Interviewer: And does that make a difference?
	506	Sheila: Up to a point. They let me swear at them up to a point but if I
	507	get carried away then they start shouting back at me.
Responses to mode (AC) – voices just go away; shouting at the voices can make them stop	508	Interviewer: Ok, ok, and how does that all stop?
	509	Sheila: It just goes away.
	510	Interviewer: Is it like what you said before, sometimes if you really
	511	shout at them <they stop> then they might stop?
	512	Sheila: Yeah.
	513	Interviewer: But other times you'll be fighting for a couple of days?
Contributing factors (AC) – psychosis/paranoia/v oices – anger only occurs in response to this?	514	Sheila: Yeah.
	515	Interviewer: Yeah, ok [.] and are there times when you feel anger
	516	and rage but it's not to do with the voices?
	517	Sheila: No. Oh no just about my friend that can read my mind.
Contributing factors (AC) – memory of something that happened with a friend	518	Interviewer: Oh you mentioned sometimes you'll get angry with a
	519	friend or angry at someone.
	520	Sheila: I think I did say that, yeah.
	521	Interviewer: And how often does that happen?
Experience of mode (AC) – always angry at friend	522	Sheila: Because something happened between me and one of my
	523	friends. So, it's al- [.]I'm always thinking that way about her.
	524	Interviewer: Oh right, ok, what that she can read your mind?
Responses to mode (AC) – cuss friend to voices	525	Sheila: And there's stuff that she's said to me and done. She hasn't
	526	done anything wrong but she has if you know what I mean. So I'm
	527	always angry at her. And, oh yeah when I say, when I cuss her to the
	528	voices, I say please don't punish me and then they say, then they
	529	don't I think.
	530	Interviewer: Oh ok, so you [.]
	531	Sheila: If I beg them really nicely they don't cuss me.
	532	Interviewer: Oh, so you have to beg?
	533	Sheila: Yeah.
Mode influences psychosis? (AC) – tell voices when angry at someone	534	Interviewer: Ok. And when you're angry at your friend do you tell
	535	your friend that you're angry with her, you tell the voices?
	536	Sheila: Yeah I tell the voices. Maybe they want me to tell the person
	537	but I'm not that kind of person, unless you really really hurt me,
	538	then maybe I might. No it depends who you are actually yeah.
	539	Interviewer: Ok, in what way?

Right margin annotations:

Contributing factors (PP) – psychosis/voices punishing her

Experience of mode (PP) – feel bad about self; punishing/self-attack?

Experience of mode (S) – don't tell person if angry; avoid conflict.

Contributing factors (S) – depends on relationship to person; if really hurt by person

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Appendix L. Cohen's Kappa Calculations

Application: This statistic is used to assess inter-rater reliability when observing or otherwise coding qualitative/ categorical variables. Kappa is considered to be an improvement over using % agreement to evaluate this type of reliability.

Interpreting Kappa: Kappa has a range from 0-1.00, with larger values indicating better reliability. Generally, a Kappa > .70 is considered satisfactory.

The data: The research required the identification of schema modes from transcripts. It can be difficult to distinguish between modes, due to their complexity and the supposed combinations of thoughts, feelings and behaviours that distinguish them from one another. Two raters identified which schema mode they felt that extracts of transcripts best related to. Kappa will be used to assess the inter-rater reliability of this identification process. The modes will be abbreviated to Punitive Parent = PP, Demanding Parent = DP, Vulnerable Child = VC, Angry Child = AC, Impulsive Child = IC, Compliant Surrender = CS, Detached Protector = DPr and Overcompensator = OC.

The ratings of each of the 16 quotes were entered into a contingency table. Agreements between the two raters were placed in diagonal cells. For example, both raters identified quote 9 as OC, therefore this was tallied into the lower-right diagonal cell. Disagreements between the raters were placed in one of the off-diagonal cells. For example, rater #1 thought quote 1 was IC but rater #2 thought it was OC, so this was tallied into the middle column of the last row. Below is the result of tallying the ratings of each quote by each rater.

		Rater 1								Row totals
		PP	DP	VC	AC	IC	CS	DPr	OC	
	PP	2	1							3
Rater 2	DP		1							1
	VC			2						2
	AC				2					2
	IC					1				1
	CS						3			3
	DPr							2		2
	OC					1			1	2
Column totals		2	2	2	2	2	3	2	1	Overall total = 16

The overall total was computed, ensuring that the row and column totals summed to the same value for the overall total and the overall total matched the number of cases in the original data set. The total number of agreement was then computed by summing the values in the diagonal cells of the table.

Σa = 2 + 1 + 2 + 2 + 1 + 3 + 2 + 1 = 14

Based on this, the % agreement would be 14/16 = 81.25%. The expected frequency for the number of agreements that would have been expected by chance were computed for each coding category. This was done using the same formula as for computing expected frequencies for Pearson's X^2, but now the formula was applied only to the diagonal cells. Computation of the expected frequency of agreements by chance for the punitive parent mode is shown. Below that is the contingency table with the expected frequencies in each of the diagonal cells shown in parentheses.

$$ef = \frac{\text{Row total * Column total}}{\text{Overall total}} = \frac{2 * 3}{16} = 0.37$$

Rater 1

		PP	DP	VC	AC	IC	CS	DPr	OC
	PP	0.37							
Rater 2	DP		0.12						
	VC			0.25					
	AC				0.25				
	IC					0.12			
	CS						0.56		
	DPr							0.25	
	OC								0.12

The sum of the expected frequencies of agreement by chance was then computed:

$\Sigma ef = 0.37 + 0.12 + 0.25 + 0.25 + 0.12 + 0.56 + 0.25 + 0.12 = 1.79$

Kappa was then computed:

$$K = \frac{\Sigma a - \Sigma ef}{N - \Sigma ef} = \frac{14 - 0.37}{16 - 0.37} = .87$$

The Kappa obtained was greater than .70 and therefore satisfactory.

Appendix M. Matrix Template

One template was created per mode and populated with quotes that appeared to fall under each respective mode.

Participant	Contributing factors (including triggers, psychosis, childhood experiences)	Experience of mode (associated thoughts, images, feelings etc, frequency, duration)	Responses to mode (coping, how does it stop)	Mode influences psychosis?
Nasir				
Tom				
Mukhtar				
Sheila				
Ali				
Jane				
Kadir				

Appendix N. Table of Quotes, Codes and Themes for Vulnerable Child Mode

Quotes	Codes	Theme
Nasir: "I do feel lonely" (490)	Feel lonely	Separate to Others
Nasir: "I do feel isolated" (496)	Feel isolated	
Nasir: "I have no sort of like adult humour I can communicate with and keep information private...It's any adults I've trusted and have betrayed my trust" (527-532)	Betrayal of trust	
Mukhtar: "I feel like I've been abandoned by a lot of my friends, that I was close with" (489-490)	Feel abandoned by friends	
Mukhtar: "I've always had a picture of being like um alone" (500-501)	Always felt alone	
Mukhtar: "I have my own way of thinking. So you can say like I'm into video games and a lot of people I know they don't like video games" (512-514)	Different to others	
Mukhtar: "It was racism, also bullying I used to go through at school. I mean I think the school I went to. I don't know, that's just life you know, you just have to live with it and cope" (552-554)	Felt alone due to bullying and racism	
Mukhtar: "there's a feeling of weirdness...So it's like at first you're alone, and then you're abandoned. So it's the same people I was talking about come back again, and they want to be your friend again and they want to be closer. And it's like, you can't forget the memories and stuff." (645-650)	Alone then abandoned Betrayal/mistrust	
Sheila: "alone [.] alone [.] well [.] no, I I do, but I don't want to go into it" (445-446)	Feel alone	
Ali: "finding me isolated and alone and they're all around and in [London Borough] and I'm the only	Isolated Nobody on 'my side'	

one from my side then I'm isolated" (267-269)		
Ali: "I'm waking up, I'm feeling completely alone, I'm feeling weak within myself physically, then I'm thinking what's been happening, why am I feeling physically weak" (456-458)	Feel completely alone Physically weak	
Ali: "So-called friends who's not really friends. And so-called family who's not really family. But only friend I have is me myself and my illness" (881-883)	'So-called' friends and family Illness is my only friend	
Kadir: "They never had anything wrong with them when they was younger. Even now they ain't got nothing like that wrong with them. You know, they're lucky" (117-119)	Comparison to others Feel defective/different to others	
Kadir: "And I think 'why have they got everything and I've got nothing'. I think, you know, I feel like I've been left out, do you know what I mean?" (127-129)	Comparison to others Feel left out	
Kadir: "like my family, you know, like, as I say I've always been sort of like, drifted away from them all the time, I've never been sort of like that really close bond" (332-334)	Never close to family	
Kadir: "I just get the feeling I'm not wanted in this life, you know, I keep thinking 'there's no room for me in society anywhere', you know" (400-402);	Unwanted by society	
Kadir: "I feel I've been [.] pushed on this roadside and left for dead while you know, they've all gone off you know, galavanting, off and the thing. I feel bad, I feel horrible" (882-884)	Left for dead Abandoned	
Kadir: "I think to myself 'my family just don't want nothing to do with me'" (855-856)	Unwanted by family	

Kadir: "Yeah we both sit there thinking like you know, 'we've just been dumped here by our family'. It's like we've got the plague or something, and they're going to catch a disease off us or something, do you know what I mean?" (908-911)	Abandoned Feel defective/like has a disease	
Nasir: "whenever I hear something, er something, either a family or relative says something that's related to the stories that are being spread about me basically...It does make me feel more alone, and [.] angry at the same time, sort of thing" (559-568)	Memories related to paranoia trigger anger and feeling of being alone	The Influence of Voices and Paranoia on Feeling Separate
Mukhtar: "because stigma, they think, like [.] um [.] so therefore um [.] I was possessed by a demon people" (459-460)	Friends thought possessed Feels stigmatised	
Mukhtar: "when I was trying to go to my friends and tell them about it they, they instead took me for an exorcism" (468-469)	Friends thought possessed Betrayal of trust	
Mukhtar: "so I was trying to tell them about it and basically I found out they knew everything and all that. And they weren't helping me, and it left, really, and that's why it really caused a like a, big like space between like, yeah, distance between them and me" (478-481)	Distance from friends	
Mukhtar: "I like the idea of powers and stuff, supernatural powers, yeah and they probably find it odd the way I think...that might be the reason why I'm alone" (516-523)	Feels different to others Alone because of beliefs	
Mukhtar: "There's a lot of feeling of betrayal. Interviewer: By who? Mukhtar: The friends and the people, um [.] the people who were, so there was a time when like people used to look up to me and used to called out to help, but, call	Betrayal of trust Loss of friends	

me out to help, but no longer you know, are like that anymore" (622-628)		
Sheila: "it feels like my friend can read my mind, and she knows what the voices are and she's done mind reading. And I feel like I'm alone because, my friends know what the voices are but I don't" (451-454)	Voices/paranoia increase sense of distance from friends	
Sheila: "Chlozopine. And so [.] I feel like, ill, and like [.] I can't explain yeah, it makes me feel like I'm alone, kind of" (484-485)	Medication affects sense of loneliness	
Jane: "I just feel like I'm on my own…I definitely feel helpless, because I'm speaking to people, I'm saying like 'they can hear what I'm thinking', everyone's like 'no they can't'" (380-410)	Feels like on her own Paranoia contributes to helplessness Alone in her beliefs/experiences	

Appendix O. Table of Norms for the Schema Mode Inventory

Mode	Abbr	Your Score	Very Low	Average	Moderate	High	Very High	Severe
Child Modes								
Vulnerable Child	VC		1	1.47	1.98	3.36	4.47	6
Angry Child	AC		1	1.81	2.29	3.09	4.03	6
Enraged Child	EC		1	1.20	1.49	2.05	2.97	6
Impulsuive Child	IC		1	2.15	2.68	3.05	4.12	6
Undisciplined Child	UC		1	2.27	2.87	3.47	3.89	6
Contented Child (Reversed)	CC		6	5.06	4.52	2.88	2.11	1
Avoidant Modes								
Compliant Surrenderer	CS		1	2.51	3.07	3.63	4.27	6
Detatched Protector	DP		1	1.59	2.11	2.95	3.89	6
Detatched Self-Soother	DS		1	1.93	2.58	3.32	4.30	6
Overcompensating Modes								
Self-Aggrandizer	SA		1	2.31	2.90	3.49	4.08	6
Bully & Attack	BA		1	1.72	2.23	2.74	3.25	6
Parent Modes								
Punitive Partent	PP		1	1.47	1.86	2.75	3.72	6
Demanding Parent	Dpa		1	3.06	3.66	4.26	4.86	6
Healthy Adult Modes								
Healthy Adult (Reversed)	HA		6	5.16	4.60	3.60	2.77	1