Client Reluctance During Chairwork: A Qualitative Analysis of Schema Therapists' Experiences and Perceptions.

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Thesis declaration form

I confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Signature: 

Name: Natalie Halls

Date: 22nd June 2023

Overview

Many clients and therapists described chairwork as an emotionally intense but effective technique for psychological change. This three-part thesis examines client reluctance to chairwork in the context of schema therapy.

Part one of this thesis is a conceptual introduction introducing schema therapy, chairwork and client reluctance, and the theoretical models relevant to the study. It then reviews the schema therapy and chairwork effectiveness studies and qualitative research. The conceptual introduction highlights gaps in the literature and methodological issues. It also provides a rationale for the study, the research aims, and the methodological approach.

Part two is a qualitative study exploring how schema therapists understand, experience, and respond to client reluctance to chairwork. Individual semi-structured interviews were conducted to gather data from 16 accredited schema therapists across nine countries. A reflexive thematic analysis was used to analyse the interview data. The themes generated were seeing reluctance as normal and something to be understood, the impact of reluctance on the therapist, the relationship overcoming reluctance and warming the client up to chairwork. The themes are discussed in relation to existing theory and research, and the implications and suggestions for future research are outlined.

Part three critically appraises the key points of reflection and methodological considerations I encountered during the research process. Topics include research interest, the context, self-reflexivity, becoming a research interviewer, interviewing therapists, challenges generating themes, and further elaborating on the clinical implications for training providers.

Impact statement

Schema therapy is an increasingly popular form of psychotherapy, that has been developed for treating complex difficulties. Chairwork is a core part of schema therapy to address early maladaptive schemas, associated modes, and the behaviour patterns that perpetuate them. Chairwork is also used across various modalities, such as cognitive behavioural therapy, compassion-focused therapy, and emotion-focused therapy. This thesis has expanded on the knowledge of the application of chairwork in schema therapy. These findings may be relevant to other modalities also.

This thesis has adopted a qualitative approach to provide a rich understanding of complex processes in ST, namely, client reluctance. It has also offered insight into many areas for future research when considering client reluctance in chairwork. This is the first research to explore how schema therapists understand, experience, and respond to client-related reluctance in chairwork. Accordingly, it has the scope to support the development of schema therapy and chairwork in psychotherapy more generally. I plan to submit the research for publication in a relevant journal following the completion of the thesis.

The thesis offered insight into how therapists can understand and navigate reluctance to chairwork and improve their practice. A better understanding of how reluctance to chairwork is experienced, understood and responded to can contribute to therapist training. It has highlighted schema therapists' unique experiences and how more support is needed to navigate client reluctance to chairwork within therapy. The study can be disseminated to schema therapy and chairwork training providers and services. These findings highlight ways training providers and supervisors can support schema therapists and other therapists who use chairwork, such as experiential exercises to build confidence and gain feedback. An acknowledgement from the outset in supervision and training that reluctance can feel personally challenging and can trigger therapists' schemas may help prevent a negative impact on therapists as they embark on ST practice. This is likely to improve engagement in chairwork and, therefore, therapy outcomes if therapists are more able to understand and

respond helpfully to concerns and hesitations to participate in chairwork. I have already presented my research findings on placement in a staff CPD session on chairwork and gained feedback that it was helpful for encouraging their own use of chairwork in clinical work.

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Part 1: Conceptual Introduction

Schema therapy, chairwork, and client reluctance: Theoretical background and evidence base

Abstract

Schema therapy has evolved over the last 20 years, using experiential methods as a core component of treatment to support clients in healing early maladaptive schemas, meeting unmet childhood needs, and strengthening the healthy adult mode (Edwards & Arntz, 2012). Chairwork is a key component of schema therapy and has been widely reported as a highly emotive but effective technique for promoting psychological change, especially on an emotional level (Bell et al., 2020). The unique and intense nature of chairwork can result in struggles for clients to engage in the technique (Muntigl et al., 2020). This conceptual introduction provides a detailed introduction to the research topic by defining key concepts and theories in schema therapy, chairwork, and client reluctance. This is followed by an exploration of the literature surrounding chairwork, schema therapy, and client reluctance. Through an investigation of the literature available and the key concepts and theories, this conceptual introduction provides a rationale for the development of the empirical study. Key gaps and limitations in the literature are highlighted, especially a limited understanding of the effectiveness and process issues of specific components of the ST, such as emotionally demanding experiential methods like chairwork. In light of this, the empirical study was designed in order to understand further through qualitative methods how therapists understand, manage and respond to challenges within chairwork in schema therapy.

Introduction

Chairwork is an experiential technique used across a wide range of modalities (Pugh & Salter, 2021). Chairwork uses chairs, their position, movement, and dialogues to facilitate interactions between parts of the self and internalised representations of others to bring about change (Pugh, 2017). Chairwork focuses on speaking to issues directly rather than speaking about issues, providing a unique, powerful, and emotional experience (Pugh, 2019a).

Schema therapy (ST) uses cognitive, behavioural, relational, and experiential techniques to help individuals understand their unmet core emotional needs, meet those adaptively, and 'heal' their early maladaptive schemas (Arntz & Jacob, 2017). It was initially designed for treating personality disorders. However, there is growing evidence its use in other mental health difficulties (Taylor et al., 2017). However, there is a lack of good-quality research and multiple gaps that need to be filled (Peeters et al., 2022).

ST uses experiential interventions such as chairwork as a core part of the therapy. Experiential interventions aim to trigger and heal emotions connected with early maladaptive schemas and are argued to be the most effective way to produce changes to schemas (Young et al., 2003). Chairwork is a powerful intervention, frequently described as intense and emotive (Bell et al., 2020). Therapists and clients have often described anxiety and concern about managing the emotional impact of the intervention (Pugh et al., 2021).

Chairwork has been highlighted as emotionally demanding for both clients and therapists. Therefore, it is important to understand further what supports and interferes with the implementation of chairwork so clients can have the most beneficial outcomes in therapy. There has been no research to date on how schema therapists experience, understand and respond to client-related concerns and reluctance to engage in chairwork. The empirical paper sets to understand this further by interviewing accredited schema therapists to explore this issue. This will allow for a deeper understanding of the processes of facilitating chairwork and the development of ST.

This conceptual introduction will first define chairwork, ST, and client reluctance. It will also explore the theoretical underpinnings of ST and chairwork and why this can result in a reluctance to participate in chairwork. This will be followed by exploring the literature in both these areas and identifying the gaps in the research and how the empirical paper will seek to address those gaps.

Key Concepts

Schema Therapy

Defining Schema Therapy

ST is an integrative psychotherapy that combines elements of CBT, attachment theory, interpersonal, experiential, gestalt, and psychoanalytic schools (Young et al., 2003). The therapy aims to heal early maladaptive schemas (EMS) and associated memories, emotions, bodily sensations, and cognitions; it also aims for behavioural change from maladaptive to adaptive behaviour patterns (Young et al., 2003). As a result of healing EMS, ST aims to reduce the frequency and intensity of schema activation. Interventions target cognitive, emotional, and interpersonal functioning (Arntz & Jacob, 2017).

A core element of ST is the mode model, which are the sets of modes and coping styles that are active for an individual (later described). ST proposes techniques for each maladaptive or adaptive mode (Bamelis et al.,2014). The schema therapist works with the client's modes with the goal being to build and strengthen the 'healthy adult mode', heal the 'vulnerable child modes', and reduce the impact of 'maladaptive coping modes' such as the overcontroller and protector modes (van Genderen et al., 2012).

In ST, the therapeutic relationship is seen as a key ingredient for these changes, with the therapist providing 'limited reparenting', which involves the therapist identifying and meeting unmet needs within the bounds of the professional relationship (Young et al., 2003; Masley et al., 2011). Focusing on the therapeutic relationship to fulfil unmet needs supports the client to internalise the therapist as part of strengthening the healthy adult mode.

Therefore, the therapy emphasises interpersonal processes and the client-therapist relationship more than allied approaches such as CBT (Leahy, 2008).

History of Schema Therapy

Jeffrey Young and colleagues developed ST in the 1980s to improve therapies for patients with personality disorders and complex presentations (Young et al., 2003; Masley et al., 2011).

Not all patients benefit from cognitive behavioural therapy (CBT), and there are high relapse rates, especially for patients with chronic difficulties (Chand et al., 2018). While CBT aims to treat symptoms, for example, panic attacks or low motivation, ST aims to treat longstanding and complex problems that may result in relapse, such as dependence schemas (Young et al., 2003). Longstanding and complex psychological issues can interfere with traditional CBT due to the impact on the patient's sense of self. This can prevent goal setting, forming a therapeutic relationship quickly, difficulties accessing cognitions, and relapse once treatment has terminated (Young et al., 2003).

ST was initially developed for individuals with BPD and has recently expanded across various disorders. (Taylor et al., 2017). The development of ST has supported therapists working with individuals with chronic difficulties, childhood trauma, and interpersonal challenges to develop comprehensive case conceptualisations, particularly benefitting therapists working in a secondary or tertiary care setting (James, 2001). ST is now used transdiagnostically across a wide range of disorders, especially for patients with limited response to CBT, through targeting early maladaptive schemas maintaining chronic difficulties (Peeters et al., 2022).

Theoretical Model

There are four key theoretical concepts in ST: early maladaptive schemas, basic emotional needs, coping styles and modes. These key concepts will be described below.

Schema and Early Maladaptive Schemas

The term ‘schema’ has been widely used in psychological theories. In cognitive theory, Beck (1996) defines schemas as complex cognitive structures of internal stored representations of ideas or experiences. Once the schema is activated, meaning is made from these beliefs, which interact with other cognitive, emotional, physical, and behavioural systems (Beck & Haigh, 2014). Across psychological theories, schemas are the principles that underpin how individuals interpret and make sense of experiences in their life. Schemas are often formed in early life and remain throughout adulthood; for example, an individual raised in an abusive care system may develop beliefs that others are dangerous and may continue to have this belief when danger is no longer present in adulthood (Young et al., 2003).

Schemas can be positive (adaptive) or negative (maladaptive). Early maladaptive schemas (EMS) are defined as “pervasive patterns or themes of memories, emotions, cognitive and bodily sensations, regarding oneself and one’s relationship with others, developed in childhood or adolescent and elaborated throughout one’s lifetime and dysfunctional to a significant degree” (Young et al., 2003, p7). EMS can maintain unhelpful patterns of thoughts, behaviours, emotions, and relationship difficulties throughout one’s life.

Eighteen schemas were categorised into five domains based on unmet childhood needs, such as the need for safety, autonomy, emotional expression, and limits (Young et al., 2003). This was later re-organised into four schema domains, see appendix A (Bach et al., 2018). Theory suggests that when schemas are activated, an individual will experience negative emotions such as shame, anger, or grief (Young et al., 2003). EMS can be assessed and identified through the Young Schema Questionnaire (Young, 1998), the Young Parenting Inventory (Young, 1999), observations, historical review, and exploratory experiential methods such as imagery work (Kellog & Young, 2006).

Unmet Childhood Needs

ST emphasises that EMS and psychological difficulties result from unmet needs in childhood (Arntz & Jacob, 2017). Fassbiner et al. (2019) described the basic emotional needs of a child, which shape how they make sense of the world, as secure attachment, protection, love, attention, play, praise, experiences, and feedback.

ST uses attachment theory to suggest that the interaction between temperament and environments that do not meet the child's basic needs can result in frustration causing psychopathology and personality difficulties in adult life (Bowlby, 1977; Bach et al., 2018). If the child does not have their basic needs met (or if their needs are met inconsistently), in combination with cultural, societal, and biological factors, they may develop EMS (Derby et al., 2016). Individuals develop coping patterns, such as avoidant or compensatory behaviours, to manage the emotional difficulty of schema activation, which results in maladaptive schema maintenance. Figure 1 is an example of a visual representation of schema formation and maintenance cycle. ST is focused on helping individuals identify unmet emotional needs and EMS to respond to their needs, emotionally process them, and take steps for cognitive and behavioural change (Arntz & Jacob, 2017).

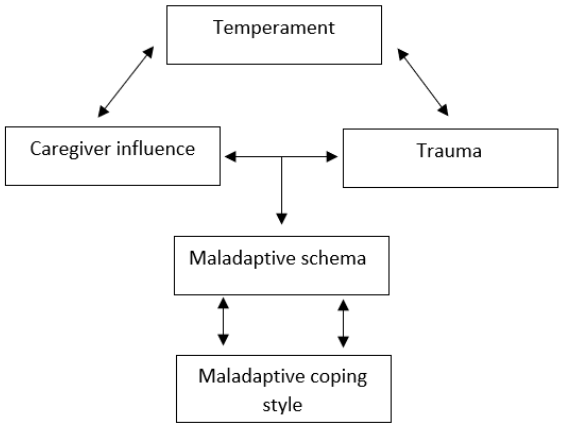

Figure 1. Origins of maladaptive schema. *Note*. Adapted from "Theoretical Model: Schemas, Coping Styles, and Modes", by van Genderen, H., & Arntz, A. van Vreeswijk, M., Broersen, J.,

& Nardort, M. *The Wiley-Blackwell Handbook of Schema Therapy: Theory, Research, and Practice* (p.28) 2015, West Sussex, UK. Copyright 2015 by Wiley-Blackwell.

Coping Styles

There are variations in how one schema may present in different people due to different schema coping styles. In ST theory, coping styles are individuals' characteristic behavioural responses to help the individual cope with a schema (Martin & Young, 2010). Young and colleagues (2003) defined three main coping styles: surrender, avoidance, and over-compensation. Arntz and colleagues (2021) revised these terms to fit cross-culturally more appropriately by coping styles defined by their underlying intrapsychic function; they revised surrender to resignation and overcompensation to inversion. The three main coping styles are the following (Arntz & Jacob, 2017; Young et al., 2003):

1. *Surrender or 'resignation'*: The individual acts as if the EMS is true and therefore 'surrenders' to behaviour patterns, for example, choosing an emotionally depriving partner after growing up with emotionally neglectful caregivers. The individual behaves and relates to others in a way that confirms and maintains the EMS.
2. *Avoidance*: The individual will avoid the EMS by avoiding social situations and emotions which may trigger and activate the schema, for example, by withdrawing, substance misuse, keeping busy, or overeating. This will be an attempt to avoid thinking about the schema.
3. *Over-compensation or 'inversion':* The individual will fight the EMS by acting as if the opposite of schema is true. For example, if they were subjugated as a child, they are dominating and controlling to gain control in their life. They may display behaviours such as devaluing others, correcting others for minor mistakes, or talking excessively about achievements.

Schema Modes

Modes can be described as short-term, momentary emotional states, whereas a schema is a long-term trait that can be activated at any point (Young et al., 2003). A mode is a state triggered by a combination of schemas and coping styles activated (Martin & Young, 2010). For example, vulnerable child mode can reflect many schemas, such as defectiveness, shame, and emotional deprivation. There are four main mode groups described below (Young et al., 2003; Arntz & Jacob, 2017; Rafaeli et al., 2014):

1. *Child modes* contain most of the core EMS causing an individual to experience intense and overwhelming feelings, for example, sadness, abandonment, fear, and rage. The vulnerable child mode is considered a core mode to work with, as it is a clear result of unmet needs. It represents the individual inability to soothe themselves (Rafaeli et al., 2011).
2. *Maladaptive parent modes* are internalised parental responses acquired through interactions with caregivers, observation, and modelling. For example, parental criticism may lead to a 'punitive mode', manifesting as intense self-criticism.
3. *Dysfunctional coping modes* are feelings and behaviours related to avoidant, surrendering or overcompensation coping styles. They are considered automatic adaptions to cope and survive in emotionally challenging environments, which continue into later life due to failure to learn other responses. For example, individuals may 'flip' into a 'detached protector mode' to disconnect from distressing emotions.
4. *The healthy adult mode* is the mode the therapist aims to strengthen. In this mode, the individual can engage in adult responsibilities and view life and themselves realistically whilst pursuing joy, pleasure, and play. The client's healthy adult mode can heal and moderate maladaptive modes.

Young and colleagues (2003) originally defined ten schema modes. Appendix B shows a complete list with mode descriptions (Martin & Young, 2010). Since the original mode model was developed, researchers have proposed more modes. Recent versions of the mode model have presented 14-18 modes, which raises the question of whether there is much difference

between the 16 EMS and modes (van Genderen et al., 2012; Lobbestael et al., 2007; Arntz & Jacob, 2017).

Key Interventions

ST interventions focus on helping clients meet their needs in healthy, adaptive ways (Young et al., 2003). Therapists either adopt a mode-focused or schema-focused approach to therapy, depending on the client's needs (Pugh, 2015). In the schema-focused approach, the aim is to 'heal' EMS and limit schema perpetuation. In the mode-focused approach, the aim is to strengthen the healthy adult mode, 'heal' child modes, and limit dysfunctional modes. Emotional needs underpin all ST interventions; for example, the therapist will focus on the needs in a traumatic situation in imagery rescripting. In chairwork, the client will be encouraged to defend their needs (Arntz & Jacob, 2017). Below is a summary of the key interventions in ST:

Education: is focused on the therapist and client working together to identify schemas causing difficulties, explore the origins of EMS, and communicate the ST concepts (Arntz & Jacob, 2017). This will be through assessment interviews, self-monitoring tasks and schema questionnaires (Young et al., 2003).

Cognitive interventions: are focused on the client building a case against the schema or mode by assessing the validity of the schema or mode (Arntz & Jacob, 2017). Techniques may include schema diaries, historical reviews, validity testing and schema flash cards (Young et al., 2003).

Experiential interventions: are emotion-focused interventions to trigger EMS and modes, and therefore expressions of difficult emotions, such as sadness and anger (Arntz & Jacob, 2017). Experiential interventions offer opportunities to strengthen cognitive interventions through healing a schema on an emotional level. Experiential interventions include imagery rescripting and chairwork dialogues.

Behavioural interventions: are used to help the client to start breaking patterns of behaviour that perpetuate the maladaptive schemas and modes (Young et al., 2003). Behavioural techniques include exposure, skills training, between-session homework, and relaxation (Arntz & Jacob, 2017)

Relational interventions: focus on the therapeutic relationship as the relationship is viewed as an intervention. The relationship allows the client to internalise the therapist as a healthy adult who fights against maladaptive schemas and supports them to live an emotionally fulfilled life (Young et al., 2003). Techniques include empathic confrontation, which is showing empathy whilst confronting problematic modes, and limited reparenting (Gülüm & Soygüt, 2022).

Chairwork

Defining Chairwork

Chairwork is a collection of experiential interventions which uses the positioning and movement of chairs as part of therapeutic interventions (Pugh, 2019a). Internal dialogues are chairwork interventions focused on dialogues with parts of the self or different points of view (Greenberg & Webster, 1982). External dialogues are chairwork interventions focused on imaginal dialogues with other individuals (e.g., a dialogue with someone who has died, and the client has unresolved emotional business with such as an abusive caregiver) (Kellog, 2012).

Chairwork History and Development

Chairwork originated in psychodrama, where the concept of using group drama and performance to change and resolve conflicts originated (Moreno & Moreno, 1969). Chairwork was further developed in gestalt therapy, shifting from group psychodrama to one individual moving between seats to perform all roles (Perls, 1973). In the 1970s, Leslie Greenberg began researching chairwork to allow for systemic guidance, training, and understanding of the mechanisms involved in chairwork; this informed the development of emotion-focused therapy

(EFT) (Pugh, 2019a; Pos & Greenberg, 2012). Currently, chairwork is used across multiple psychotherapy modalities, including CBT (Pugh, 2019a), compassion-focused therapy (CFT) (Gilbert, 2010) and ST (Young et al., 2003).

Chairwork Theory

Chairwork theory is grounded in principles and processes (Pugh et al., 2021a). Understanding chairwork principles, processes, and procedures allows therapists to be guided to use chairwork in a way that is creative and flexible across different modalities (Pugh & Bell, 2020).

(1) Principles

The key principles of chairwork are the following:

1. *Self-multiplicity:* refers to the idea that individuals are formed of multiple parts, modes, and voices, for example, the inner child and inner critic (Pugh & Bell, 2020). I-positions refer to these parts of the self, for example, the punitive parent part (Pugh, 2021).
2. *Information exchange:* refers to the idea that parts are capable of meaningful interactions that can be enacted through chairwork.
3. *Transformation*: refers to the idea that facilitating interactions with or between parts can bring about change. Depending on the therapeutic orientation, there will be different goals for transformation. In CBT, the aim for transformation may be for the self-critical client to have a more balanced perspective (Pugh & Bell, 2020).

(2) Processes

The key processes of chairwork are the following:

1. *Separation*: Chairwork begins by locating parts in different chairs. This essential therapeutic task allows for the externalisation of parts so that interactions between them can occur.

2. *Animation*: involves bringing the identified parts to life, allowing information exchanges to happen in the present moment. Animation may involve the client embodying a part and speaking in the first person with the tone and expressions of that I-position, or personification, which involves visualising the I-position in the empty chair (Pugh, 2021).
3. *Dialogues*: refers to verbal information exchanges between I-positions to facilitate changes in feeling, cognition, and behaviour (Pugh, 2021).

(3) Procedures

Chairwork is a process-based technique that can be used creatively depending on the therapist's modality and therapeutic style (Pugh & Bell, 2020; Pugh et al., 2021a). Internal chairwork techniques focus on dialogues between parts of the self (Kellog, 2014). Internal chairwork may be used for emotional expression, challenging EMS, supporting the development of alternative perspectives, and strengthening the healthy adult mode (Kellog, 2012). External chairwork techniques focus on dialogues with a person or object outside themselves, such as an abuser or bully (Kellog, 2014).

Kellog and Torres (2021) defined four dialogues in chairwork which they described as the foundation and core components of all chair dialogues (1) Giving voice; the therapist might interview the client in the role of a mode to better understand it, (2) Telling the story; the client might recount a distressing experience linked to the development of their schemas, (3) Internal dialogues; the client might converse with and challenge a part of themselves, such as a distressing mode or schema, (4) Relationships and encounters; the client might confront an external other in an empty chair who is linked to the development of their schema (such as a neglectful parent).

Chairwork across modalities

As chairwork is a process-based technique it can be used differently across a range of therapeutic modalities (Pugh & Bell, 2020). In CBT, chairwork can be used to target unhelpful

thoughts, behaviours and emotions (Pugh, 2017). An example of CBT chairwork can be cognitively modifying thoughts by using the chairs to explore different positions and perspectives to allow the client to make a decision, come to a balanced perspective (Pugh, 2019). Meanwhile, in CFT chairwork can be used to facilitate the development of a compassionate self that can soothe self-criticism and shame (Bell et al., 2021).

In psychoanalytic therapy, chairwork can be viewed as a means for understanding unconscious processes (Holmes, 2015). Chairwork dialogues can facilitate understanding unconscious emotions, thoughts, and conflicts towards significant others in a client's life. This also provides a route to exploring challenging relationships, identity, interpersonal trauma, and grief. In object relations theory the inner world of the individual is based on their experiences of the outer world (Greenberg, 1983). In chairwork, the inner world can be externalised within the therapeutic space (Holmes, 2015). Being able to externalise internal conflicts onto different chairs can allow the client to experientially explore internal conflicts.

Chairwork sits within a therapeutic relationship, and experiential methods such as chairwork can bring transference and countertransference dynamics surrounding the therapeutic relationship into awareness at the moment (Holmes, 2015). Chairwork can also produce enactments of unresolved conflicts within the context of the therapeutic relationship which provides an opportunity to engage with them to understand conflicting difficulties such as fears, life choices or desires (Meier, 2019). This can provide an opportunity to allow resolution of challenging relationship dynamics.

Whilst chairwork can be used as a valuable technique in therapy given the emotional intensity chairwork can produce it is important to consider the possible risks to ensure chairwork is being done responsibly (Pugh 2019b). Chairwork can be used to externalise internal conflicts, traumas, and unresolved issues. This can be emotionally intense for clients and therapists and possibly cause the risk of re-traumatisation, destabilisation, and dissociation (Kellog & Torres, 2021). Therefore, across all modalities, chairwork requires in-depth assessment, trust, safety, and containment. As chairwork can elicit distressing emotions

risk factors such as suicidality and self-harm should be considered when assessing for suitability for chairwork. Across modalities, when chairwork is done appropriately, effectively, and safely it can provide deep psychological change such as insight of oneself and emotional processing (Pos & Greenberg, 2012).

Chairwork in Schema Therapy

It is a common experience following cognitive techniques for a cognitive shift in a problematic belief without an emotional shift, often referred to as the 'head-heart lag' (Stott, 2007). The long-term effectiveness of therapy can be enhanced by going further than the cognitive level by involving emotional processing to reorganise emotional meaning to be stored on an implicational (felt sense) level rather than a declarative level (Samoilov & Goldfried, 2000; Barnard & Teasdale, 1991). Therefore, experiential techniques in ST, such as chairwork, target emotion-related meaning structures.

In ST, modes and EMS activation are welcomed in therapy sessions, as in-session activation can help bring about change (Rafeli et al., 2014). Emotions related to EMS are actively triggered in experiential techniques such as chairwork (Young et al., 2003). The therapist can then use techniques such as reparenting to heal emotions and meet unmet childhood needs.

The aims of chairwork vary according to whether a schema- or mode-focused approach is used, the client's formulation, the EMS or mode being addressed, and the client's associated unmet needs. Chairwork might be used in several ways, such as to create distance from a distressing EMS/mode (e.g., by placing it on an empty chair and moving it away); to modify an EMS (e.g., the client presents evidence supporting their EMS in one chair while the therapist presents counter-evidence in another chair (Pugh & Rae, 2019); to strengthen the healthy adult mode (e.g., the therapist models healthy responses to a parent mode held in another chair) (Pugh & Bell, 2020); or to encourage healthy emotional expression (e.g., the client confronts an abusive parent, held in an empty chair) (Kellog & Torres, 2021). Young and

colleagues (2003) proposed that emotion-focused techniques, such as chairwork, are one of the most effective ways to modify schemas.

Client Reluctance

A challenge for therapists is supporting clients who may not want to engage in the intervention proposed. It is common for practitioners to report client reluctance to engage in interventions which can cause distress (Clark, 2013). In this paper, client reluctance refers to the broad spectrum of levels of hesitation to engage in a therapeutic technique. Similar terms to reluctance have been referred to in the literature, such as 'client resistance' (Chamberlain et al., 1984). Client resistance has been defined similarly as the failure to collaborate or cooperate with the therapist and treatment (Newman, 1994). The term reluctance was used because it incorporates a wide range of types of hesitation to engage in an intervention (Muntigl et al., 2020).

Examples of client reluctance to therapy interventions include refusal of an intervention, subtle hesitation, ambivalence, or avoidance. Reluctance may present as clear and active, such as an overt objection or questioning the authenticity of the task, or subtle and passive, such as a long pause, deferring a response, shift in gaze or a worried facial expression (Muntigl et al., 2020). Other examples of reluctance may be criticism of the technique, homework non-compliance and withdrawal (Mamedova et al., 2020).

There are multiple causes of client reluctance to therapy techniques. Taking part in therapeutic techniques can cause high levels of anxiety and as a result, clients may be reluctant due to fears of the intervention being unpleasant and intolerable (Olatunji et al., 2009; Meyer et al., 2014). For example, in exposure therapy, the client takes part in feared situations, whilst in imagery rescripting, the client recalls traumatic events in detail (Abramowitz et al., 2019; Arntz, 2013). Some clients may be reluctant to engage in interventions despite believing the intervention is credible and effective. Clients may be reluctant to use experiential techniques due to fears of expressing emotions, losing control, or perceiving the task as

artificial and irrelevant to their difficulties (Watson & Greenberg, 2000). Muller and Schultz (2021) described it as the therapist's responsibility to 'sell' exposure therapy to clients with anxiety disorders to take part despite reluctance. Other reasons may be struggles in developing effective collaboration due to the therapeutic relationship, especially in therapies which are directive and change and action-orientated (Mamedova et al., 2019).

It is essential to address and navigate client reluctance in therapy due to its negative implications on therapy outcomes (Mamedova et al., 2019). A wide variety of research identifies the importance of clients engaging and actively collaborating in therapy tasks for successful outcomes (Rees et al., 2005; Tryon & Winograd, 2001). Reluctance has been associated with non-engagement of interventions, ruptures within the therapeutic relationship, homework non-engagement, attendance issues and treatment dropout, yet there is a lack of systematic steps to manage reluctance within therapy (Matos & Dimaggio, 2023; Newman, 1994).

The therapeutic modality used will influence how therapists understand and navigate reluctance. Experiential techniques in ST are designed to activate coping modes and EMS; therefore, avoidance and reluctance of these can be understood in terms of the client's EMS and coping modes (Leahy, 2012). In ST, empathic confrontation and limit setting have been referred to as a method for managing reluctance when avoidant coping modes are activated (Staarup et al., 2021). In the context of CFT, therapists have described the importance of understanding the wisdom in the client's fears, blocks and resistances (FBR), validating and de-shaming FBR, and using experiential interventions to address the FBR (Steindl et al., 2022). Motivational interviewing has been applied in CBT when working with resistance and ambivalence to change-based techniques (Westra, 2004). However, overall, there is little known about how therapists successfully navigate and respond to reluctance (Muntigl et al., 2020).

Across all modalities, the therapeutic relationship supports many therapeutic processes, such as negotiation of therapy tasks, encouragement to persist through therapy

challenges, trust to disclose, and try new therapy activities (Horvath & Luborsky, 1993). Matos et al. (2022) described the important interaction between the technique, the emotions elicited and the therapeutic relationship. Experiential techniques can elicit intense feelings of shame and embarrassment and understandably can result in negative feelings towards the therapy and therapist. Therefore, it is crucial that the therapist can manage the therapeutic processes and possible rupture within the relationship whilst promoting a sense of safety within the therapeutic relationship to support repair, collaboration and commitment to the techniques. Overall, reluctance can provide important information that can aid the therapist's formulation, and navigating the reluctance can be viewed as an essential intervention within itself (Newman, 1994).

Synthesis General Literature

Following the introduction to ST, chairwork, and client reluctance, the following section will consider the literature on these topics. This section will briefly highlight the evidence base on ST and chairwork. This will be followed by an exploration of patient and therapist experiences of ST and chairwork, highlighting both benefits and challenges of the therapy and technique. This section will highlight and discuss key gaps and limitations of the literature.

Schema Therapy: Effectiveness Studies

Since the first major research trials on ST for BPD, further studies have found ST to be an effective treatment for other psychological disorders (Giesen-Bloo et al., 2006; Jacob & Arntz., 2013). Meta-analyses report high levels of efficacy for ST in the treatment of depressive disorders (Körük & Özabacı, 2018) along with beneficial effects for symptoms of anxiety, obsessive-compulsive disorder (OCD), and post-traumatic stress disorder (PTSD) (Peeters et al.,2022). There is also research suggesting positive outcomes for eating disorders (Pugh, 2015), marital difficulties (Keybollahi et al., 2022), social anxiety, and procrastination (Parsafer et al., 2021).

Despite growing research and clinical interest in ST, existing outcome research for ST has major limitations. Multiple meta-analyses have reported issues with there being a limited number of high-quality studies (Körük & Özabacı, 2018; Peeters et al., 2022). Peeters et al. (2022) highlighted substantial methodological limitations in most studies in the meta-analysis on ST for anxiety, OCD, and PTSD. Effect sizes were reported to be at risk of being inflated due to methodological limitations. The authors called for future research to be improved to produce a solid evidence base for ST. Recommendations include ensuring schema therapists in studies are accredited and using a comparison group of another evidence-based treatment. A systematic review of twelve ST effectiveness studies treating various mental health difficulties found large effect sizes, especially for personality disorders (Masley et al., 2012). Given the positive results and limited evidence base for other therapies for personality disorders; there is a strong rationale for further research in ST, with a future focus on improving research design such as quality assessments of the therapy delivered (Bateman et al., 2015).

Finally, there is limited task-focused research in ST which makes it unclear which components produce the most effective change. An exception to this is task analysis research which has explored limited reparenting processes in ST, further clarifying the essential steps behind this critical relational process in ST (Gülüm & Soygüt, 2022). There has been a paucity of research on the effectiveness of chairwork in ST (van Maarschalkerweerd et al., 2021).

These difficulties in investigating ST can be reflected in the broader challenge of researching long-term psychotherapies in populations with complex difficulties (Bakos et al., 2015). Given the sparse evidence base, except for BPD, some researchers propose that ST should be used for other mental health difficulties based on client preference, clinical expertise, and using theoretical underpinnings of ST to justify its use (Taylor et al., 2017).

Schema Therapy: Patient and Therapist Experiences

Whilst there is a growing evidence base for ST, a proportion of patients do not respond or drop out (Gülüm, 2018). The reasons for this are unclear. However, qualitative studies have

provided some insights into the experiences of schema therapists and their patients, which may elucidate which aspects of ST are more or less helpful (Tan et al., 2018).

De Klerk et al. (2016) conducted qualitative interviews with patients who received ST for personality disorders and their therapists. Patient and therapist feedback on the positive aspects of ST included valuing the high-quality therapeutic relationship, the transparent theoretical model used, and specific ST techniques, particularly imagery. Participants described these techniques as particularly constructive for producing emotional shifts. Challenging aspects of ST reported included therapists finding the intensity of the therapy demanding and not finding the 50 sessions allocated enough. In addition, patients reported challenges with the emotional intensity of the process. Tan et al. (2018) interviewed patients with BPD who had completed 12 or more months of ST. Participants reported that the positive aspects of therapy were improved insight, ability to cope, and management of emotions. Participants reported experiential techniques as emotionally demanding but necessary for positive change. Qualitative research on patients in the early phases of imagery within ST reported that patients emphasised that more attention needed to be focused on the emotional impact of the intervention (Napel-Schutz et al., 2011). Patients reported finding imagery tiring, confrontational, emotional and stressful but a technique they perceived as having high value.

Overall, all the qualitative studies above highlight themes of the emotional impact of ST, in particular, the experiential interventions. Experiential techniques can be helpful but clearly demanding; therefore, understanding what supports and interferes with their implementation is essential. All of the studies were in populations of clients with a personality disorder diagnosis; further studies would be needed to explore the perspectives of other patient groups experiencing ST. The qualitative studies have complemented outcome research by providing a better understanding of ST and creating further improvement and opportunities for the development of ST (Napel-Schutz et al., 2011).

Chairwork: Effectiveness Studies

There is growing evidence and research on the use of chairwork for a variety of mental health difficulties, including anxiety and depression (Robinson et al., 2014), bereavement (Neimeyer, 2012), eating disorders (Pugh & Rae, 2019), self-compassion (Bell et al., 2021), resolving unfinished business (Greenberg & Malcolm, 2002) and supervision (Pugh & Margetts, 2020).

Most research exploring the effectiveness of chairwork has been in EFT and CBT-based studies. Adding chairwork into EFT for trauma resulted in more reliable improvement than those who did not (Paivio et al., 2010). Similarly, adding chairwork to the client-centred interventions improved outcomes for major depressive disorder and anxiety post-intervention and 18-month follow-up (Goldman et al., 2006; Stiegler et al., 2017).

There are limited but encouraging results for CBT chairwork with trial-based role plays being found to be equally effective in reducing negative core beliefs and self-criticism as conventional cognitive techniques (de Oliveira et al., 2012). Research comparing CBT with CBT integrating emotion-focused techniques, including chairwork, found both therapies equally effective for treating depression, anger and generalised anxiety disorder (Grosse Holtforth et al., 2019; Newman et al., 2011; Watson et al., 2003). Whilst results were comparable for both groups on most measures, those who took part in process-experiential therapy in terms of disorder symptoms some studies have found decreased self-reports of interpersonal problems (Watson et al., 2003; Butollo et al., 2016). Both studies suggest promising results regarding the efficacy of chairwork. However, it is not clear the impact of chairwork specifically due to there being other emotion-focused techniques added.

Stand-alone chairwork interventions significantly reduced self-criticism and improved self-compassion and self-soothing ability (Shahar et al., 2012). Emotional arousal research on unresolved anger found empty-chair interventions lead to increased fear and anxiety, which authors hypothesised were due to fears of being vulnerable due to expressing emotions towards the significant other (Diamond et al., 2010). Later research compared emotional expression to a significant another present in family therapy to imagining speaking to a

significant other in chairwork and found that chairwork produced more emotional processing than family therapy (Diamond et al., 2016).

There has been less exploration of the effectiveness of chairwork, specifically in schema therapy. The only study exploring the effectiveness of chairwork in ST compared chairwork to a cognitive 'thought-challenging' technique; results found that both techniques reduced the credibility of the punitive-parent mode, with cognitive methods reducing the credibility slightly more (van Maarschalkerweerd et al., 2021). However, feedback revealed that patients preferred the chairwork technique and perceived it as more effective.

Evaluating chairwork effectiveness is challenging due to the wide range of chairwork procedures and the previously described challenges of studies focusing on full treatment effectiveness (Pugh, 2017). A further challenge in determining chairwork efficacy is that many intervention-based studies add emotion-focused interventions, which include chairwork. It is, therefore challenging to draw clear conclusions on how much improvement is attributable to it. Through dismantling designs, future research can identify how specific components, such as chairwork, result in change (Papa & Follette, 2014). Despite these challenges, chairwork seems to be effective in different therapies for various disorders. Whilst these studies suggest chairwork is an effective technique, it has not undergone rigorous evaluation, unlike other interventions such as imagery (Pugh, 2017). There is also very little known about chairwork effectiveness in the context of schema therapy despite it being a core intervention in ST.

Chairwork: Patient and Therapist Experience

Qualitative research is a valuable method for identifying the acceptability of chairwork by exploring patients' and therapists' lived experiences of delivering and receiving chairwork across a range of therapeutic modalities. It can also clarify why engaging in chairwork is helpful or unhelpful and what supports its implementation.

In a study comparing a cognitive 'thought-challenging' technique with chairwork, patients preferred the empty chair technique to manage their punitive mode, with reports that

it helped elicit emotions in the session (van Maarschalkerweerd et al., 2021). Similarly, Chua et al. (2021) explored a single chairwork session in which participants were interviewed in the role of their eating disorder voice. The majority described the intervention as acceptable and helpful. Furthermore, participants reported finding the voice dialogue a valuable intervention for understanding and separating from the eating disorder voice and feeling more hopeful about recovery. Similarly, when receiving EFT for anxiety and depression, participants reported chairwork as the most powerful in-session experience, with participants also describing the technique as highly emotive and challenging (Robinson et al., 2014).

A commonality shared by studies investigating patients' and therapists' views on chairwork is concern regarding the emotional intensity of the intervention. Some studies have reported mixed feedback, with some patients describing it as challenging but productive and others describing chairwork as unhelpful and difficult to engage with (Marren et al., 2021). Similarly, research exploring CFT chairwork for self-criticism found patient reports of distress and avoidance during chairwork (Bell et al., 2020). Some patients in the study associated vulnerable emotions with therapeutic benefits such as tolerance, mastery, and understanding of emotions. On the other hand, others found this experience of intense emotions aversive.

High levels of intense emotions during chairwork for unfinished business with a significant other were positively correlated with shifts in perspectives towards the other (Greenberg & Malcolm, 2002). Therefore, it may be that intense, negative, or aversive initial emotional reactions to chairwork is not necessarily indicative of chairwork not being effective, perhaps the opposite. This is supported by patient reports of experiencing chairwork as embarrassing or awkward prior to engagement and intense, demanding, but meaningful once engaged with the chairwork (Stiegler et al., 2018). On the other hand, some participants reported chairwork as too intense to engage with, indicating that further research is needed to understand these emotional processes. Stiegler et al. (2018) suggested that given the intensity and unusual aspects of chairwork, therapists should focus on the therapeutic relationship before inviting clients to engage in chairwork. On the contrary, chairwork has also been

proposed as a route to supporting the development and strengthening of the therapeutic alliance rather than the therapeutic alliance being a prerequisite (Pugh et al., 2022).

Facilitating and initiating chairwork can be demanding for clinicians, requiring multiple complex interactions between the therapist and client (Pugh et al., 2021a; Muntigl et al., 2017). Qualitative research has also revealed that therapists have shared concerns about the emotional intensity of chairwork. While CBT therapists found benefit in using chairwork for eliciting emotional expression, they also described factors that prevent their use of chairwork, such as anxiety and concerns (Pugh et al., 2021b). Concerns included possible emotional dysregulation due to the emotional intensity of the technique. Other factors included limited training in chairwork and a lack of confidence and perceived competence in chairwork. These results highlight several factors impacting therapists to feel cautious about introducing chairwork.

Schema therapists have reported difficulties engaging patients in techniques with clients exhibiting rigidity and motivational difficulties (Bamelis et al., 2014). A conversation analysis of EFT therapists' attempts to engage clients in chairwork was the first study to explore what supported the successful negotiation of chairwork (Muntigl et al., 2020). The authors highlighted that in most observations, acceptance of chairwork was not immediate, and there was some form of hesitation or refusal in most cases. When exploring the process of therapists negotiating hesitations, successful negotiations included tentative encouraging statements such as 'At least try?' and 'Would you be willing'. As well as therapists taking a non-authoritative position, which shows the client that chairwork must be collaborative. Finally, successful negotiations involved therapists being sensitive to non-verbal and verbal indications of hesitation. There are likely other resources and actions not captured within this conversation analysis supporting successful negotiation. A single case study which used transcripts from EFT sessions with a client with depression and social anxiety highlighted roadblocks to chairwork, for example, performance anxiety, should be viewed as an opportunity for therapeutic work, especially to deepen the therapeutic relationship and

emotional change (Goldman & Goldstein., 2022). Further understanding of how hesitation is managed and assessing change factors to engagement in chairwork is essential to improve therapy training and the development of chairwork.

Upon reviewing the qualitative literature on chairwork from therapist and client perspectives, there are common themes around chairwork being viewed as an emotionally challenging and demanding but valuable technique within therapy. Overall, the studies suggest that the most helpful aspect of chairwork reported is emotional expression resulting in powerful shifts in therapy, greater understanding of emotions and tolerance of emotions, and improvements in interpersonal functioning. The most common blocks are initial embarrassment, anxiety and finding chairwork too emotionally intense. Qualitative research has been beneficial in highlighting clear concerns about the emotional intensity of chairwork. Marren et al. (2012) suggested that given the mixed client feedback, more consideration is needed on the adaptions of experiential interventions which cause intense emotions. Except for van Maarschalkerweerd and colleagues (2021), all of the research explored in this section were qualitative studies on the use of chairwork from other therapeutic modalities, as there has been limited research to date on patient and therapist experience of chairwork in the context of ST.

Methodological Issues: Summary and Development of the Current Research

Overall, upon exploring the literature on ST and chairwork, there are clear methodological issues and gaps. This section will summarise the strengths and limitations of current research and the rationale for the methodology used in the empirical paper.

The literature above has highlighted that apart from BPD, the research on the effectiveness of ST is limited (Taylor et al., 2017). While the initial evidence for other mental health difficulties is promising, it is unclear due to methodological issues. Recommendations for future research include having an active control group, RCT designs, power and sample

size calculations, ensuring the quality and validity of interventions through accredited schema therapists, and supervision and compliance checklists (Peeters et al., 2022).

Chairwork appears effective in EFT and CBT, particularly in improving interpersonal difficulties, emotional tolerance, self-criticism, anxiety and depression. It was challenging to draw conclusions on the effectiveness of chairwork in ST due to existing outcome research being focused on the effectiveness of the entire therapy package rather than specific techniques within ST. In contrast, imagery techniques have undergone RCT research testing imagery rescripting only versus imagery rescripting and ST, which allows for evaluation of the specific intervention (van den End et al. 2021). Without specific research on the individual interventions within ST, such as dismantling research designs, it is unclear which components of ST are particularly effective.

A challenge with quantitative research using outcome measures to establish effectiveness is that important processes or difficulties can be missed or not considered. The qualitative research in chairwork and ST highlighted the challenge of the emotional demand and intensity of chairwork from both therapist and client perspectives. The research has also indicated that it is common for there to be blocks, reluctance, resistance, or objection to chairwork (Muntigle et al., 2020; Pugh, 2018). Schema therapists have reported difficulties engaging patients in techniques where there are psychological inflexibility and motivational difficulties; therefore, research would benefit in assessing which factors improve engagement (Bamelis et al., 2014). Schema therapists agree that chairwork is an emotionally intense but crucial intervention in ST; therefore, understanding further client reluctance and challenges to engage in it is crucial for therapists to best support clients with challenging techniques (Kellog, 2012).

More research is needed on how therapists can best facilitate experiential interventions, including clients expressing concerns or reservations (Stiegler et al., 2018). Conversational analysis research and a case study have been the first and only research to explore client hesitations and therapists' responses specifically to chairwork (Muntigl et al.,

2020; Goldman & Goldstein, 2022). Through conversation analysis, therapists' verbal responses to chairwork hesitations were identified. However, how therapists understood and experienced these challenges and why they chose specific responses remains unclear. The studies also used EFT therapists, which makes the findings difficult to generalise to schema therapy and schema-focused chairwork.

There is growing but limited research on therapist challenges related to chairwork. Most of the qualitative research in both chairwork and ST focused on client perspectives. Initial therapist-based research findings suggest that some therapists are concerned about the emotional intensity of the intervention along with therapist anxiety and avoidance (Pugh et al., 2021b). As a result, key therapy interventions may be getting missed.

Qualitative methods of analysis provide opportunities for exploration of therapists' lived experiences of client-related reluctance to chairwork including, their emotional experience, how they understand reluctance, and how they choose to respond. The research in this thesis aims to gain detailed information on the psychological and emotional factors influencing therapists therefore, it is well suited to qualitative methods. It also gives voice to the clinicians delivering chairwork, so it is a ground-up approach. Qualitative methods would be useful, considering this is a new area of investigation. Therefore, the analysis can help generate hypotheses for future studies (Kazdin, 2008). A thematic analysis provides a method to analyse and report themes in rich and descriptive data (Braun & Clarke, 2019). Such research would identify shared themes and experiences amongst experienced therapists and inform ST training, clinical practice, and best practice guidelines. A reflexive thematic analysis involves the researcher explicitly acknowledging and reflecting upon their prior theoretical assumptions and how they inform the analysis. (Braun & Clarke, 2021). It is important for the researcher to own their perspective and interpretative role as research, theory, and personal background influence how the researcher analyses and interprets the data.

A distinguishing feature of ST is the emphasis on experiential techniques. Therefore, chairwork is central to ST training and practice (Kellog, 2004; Young et al., 2003). Based on

the current gaps in the literature and methodological considerations, we propose that interviewing schema therapists through qualitative methods is a suitable method for gathering rich descriptive data to capture the complexities of how schema therapists experience and manage client-related reluctance to chairwork across a wide range of psychological difficulties.

Aims of the Empirical Paper

The present study explores how schema therapists understand, experience, and respond to client reluctance to chairwork. This includes practical responses and internal emotional experience. A semi-structured one-to-one interview will be analysed through a reflexive thematic analysis to gather rich data and explore the complexity of therapists' experiences.

The study aims to fill gaps in the literature by:

1. Gaining feedback from therapists on their experience of client reluctance, specifically in chairwork
2. Understanding this experience specific to schema therapists who use chairwork frequently and for a wide range of complex difficulties
3. Understanding the internal experience of therapists in this situation, along with how they make sense of it and respond

The following research aims to explore the following questions:

1. How do schema therapists experience reluctance to chairwork?
2. How do schema therapists understand reluctance to chairwork?
3. How do schema therapists respond to reluctance to chairwork?

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Part 2: Empirical paper

Client Reluctance During Chairwork: A Qualitative Analysis of Schema Therapists' Experiences and Perceptions.

Abstract

Aims: Chairwork is an emotionally intense but effective technique for promoting psychological change and is a core intervention in schema therapy. Clients can be reluctant to use experiential techniques such as chairwork, yet little is known about how schema therapists navigate this. This study aimed to understand how schema therapists understand, experience, and respond to client-related reluctance to chairwork. **Method:** Recruitment was done via social media and the International Society of Schema Therapy email directory. Remote individual semi-structured interviews were conducted with 16 accredited schema therapists across nine countries**.** The data was analysed using the reflexive thematic analysis of Braun and Clarke (2022a). **Results:** The analysis generated four superordinate themes: 'Seeing reluctance as normal and something to be understood', 'Impact on the therapist', 'The relationship overcoming reluctance', and 'Warming the client up to chairwork'. **Conclusions:** Working with reluctance to chairwork is important in ST. There was an emphasis on being curious about reluctance, aware of the impact of reluctance on the therapist and moving towards more creative and spontaneous chairwork practice. This research has increased our knowledge of how schema therapists understand, experience, and navigate client reluctance to chairwork. The implications of these findings are discussed alongside the study's limitations and areas for future research.

Introduction

Schema therapy

Schema therapy (ST) is an integrative therapy that combines theory and techniques from cognitive, behavioural, psychodynamic, and gestalt therapy (Young et al., 2003). ST is an empirically supported treatment for several personality disorders (Jacob & Arntz, 2013; Bamelis et al., 2014; Giesen-Bloo et al., 2006). Preliminary research indicates that ST may also be effective for other mental health difficulties such as anxiety, depression, eating disorders, post-traumatic stress disorder and obsessive-compulsive disorder (Hawke & Provencher, 2011; Peeters et al., 2022; Pugh, 2015).

ST proposes that in childhood, everyone develops schemas which are patterns of information processing of thoughts, feelings, memories, and behaviours; when emotional needs are met, the individual develops healthy schemas which support the individual to adapt to situations with helpful behaviours (van Maarschalkerweerd et al., 2021). Early Maladaptive Schemas (EMS) are the pervasive life patterns of self-defeating, maladaptive thoughts, emotions, behaviours, and interpersonal interactions that develop in childhood due to a combination of unmet basic emotional needs, temperament, and interaction with the environment (Arntz & Jacob, 2017). EMS are maintained through coping styles which are how an individual copes with the emotional pain of schema activation. The three main coping styles are schema surrender or 'resignation' (giving into the schema and accepting the schema as true), schema avoidance (avoiding situations that trigger the schema), and schema over-compensation or 'inversion' (acting as if the opposite of the schema is true therefore behaving the opposite to what the schema makes one feel) (Arntz et al., 2021; Young et al., 2003).

In ST theory, modes are the momentary states, which are a combination of schemas and coping styles (Rafaeli et al., 2014). One common schema mode is the 'punitive parent mode' which is conceptualised as an internalisation of an abusive caregiver. Within ST, self-

criticism is understood as the activation of this mode. Schema healing is the fundamental goal of ST (Arntz & Jacob, 2017). Through healing EMS, the individual can change maladaptive behaviours, cognitions, and emotions that perpetuate schema activation (Young et al., 2003). Such healing occurs by strengthening the healthy adult mode, which is the mode that can validate and soothe the child modes, allowing for emotional needs to be met (Rafaeli et al., 2014).

ST combines cognitive, behavioural, experiential, and relational techniques to achieve this aim (Young et al., 2003). In ST, experiential techniques are emotion-focused techniques that support expressing and changing difficult emotions. Experiential techniques allow the client to experience unmet needs being met, have emotional distress soothed and learn ways to confront cognitive biases (Jing, 2018). The core experiential techniques in ST are imagery and chairwork. Research is growing into imagery techniques within ST with dismantling research designs (van den End et al., 2021). Research suggests that chairwork techniques in other therapies are effective (Paivio et al., 2010). There is currently limited evidence for schema-focused chairwork due to ST research being predominately focused on outcomes of the complete therapy rather than specific interventions within ST (van Maarschalkerweerd et al., 2021; Khasho et al., 2019; Masley et al., 2012; Körük & Özabacı, 2018). This paper will focus on chairwork as few studies have explored chairwork in the context of ST.

Chairwork

Chairwork refers to the collection of experiential interventions which use the positioning and movement of chairs as part of therapeutic interventions (Pugh, 2019a). Chairwork originates in psychodrama and had later developments in gestalt therapy (Monero, 1948; Perls, 1973). It has now been used in several therapeutic modalities, including ST (Young et al., 2003), cognitive-behavioural therapy (CBT) (Pugh, 2019a), and compassion-focused therapy (CFT) (Gilbert, 2010). In ST, chairwork is used to modify EMS, engage in mode dialogues, process painful memories, and strengthen the healthy adult mode (Pugh & Rae, 2019; Kellog, 2012). The main forms of chairwork in ST are role-play (e.g., historical role-play),

mode or schema dialogues, and empty chair dialogues with significant others (e.g., a childhood abuser) (Pugh & Rae, 2019). Emotionally evocative techniques such as chairwork are used in ST because schema change is believed to be more pronounced in the presence of high affect (Young et al., 2003; Teasdale, 1997). Process skills are used by the therapist to support the method, include the articulation of needs, using imagery to personify parts of the self, and repetition of key statements (Pugh, 2019b).

Reluctance in chairwork

Qualitative research in chairwork has highlighted important process-related issues that are less apparent when reviewing quantitative research. Qualitative research across a range of modalities investigating patient and therapist perspectives on chairwork highlighted challenges with the emotional intensity of chairwork which can result in therapists and clients' concerns engaging in the intervention (Bell et al., 2020; Robinson et al., 2014; Marren et al., 2021). For example, clients have reported feeling awkward and embarrassed when initially engaging in chairwork (Stiegler et al., 2018). Despite these difficulties, participants have also described chairwork as one of the most powerful, meaningful, and productive techniques. Research exploring therapist perspectives has also found that CBT therapists' anxiety about using chairwork and concerns about overwhelming clients prevented more use of chairwork in their practice (Pugh et al., 2021). Reluctance to engage in chairwork may be problematic for several reasons: for example, the client may not experience the full benefit of ST, resulting in reduced therapeutic gains and possible strains on the therapeutic alliance.

The therapeutic alliance is key for client engagement in experiential methods (Steindl et al., 2023). In ST relational techniques are emphasised (Young et al., 2003). The two key relational techniques in ST are limited reparenting and empathic confrontation. Limited reparenting refers to methods used to meet a client's emotional needs within the limits of therapy, for example, the therapist in the healthy adult mode and defending the client against unhelpful coping modes in chairwork (Gülüm & Soygüt, 2022). Empathic confrontation is used to help clients recognise the costs of unhelpful modes to stop unhelpful coping mode reactions

and support healthy emotional reactions (Fassbinder et al., 2016; Rafaeli et al., 2014). Some studies have highlighted the importance of the therapeutic relationship for facilitating the use of experiential techniques (Matos & Dimaggio, 2023). Conversely, experiential techniques can facilitate and improve the therapeutic relationship (Pugh et al., 2022). Therapists may feel hesitant to introduce chairwork to clients, especially if they have concerns about reluctance and the impact on the therapeutic alliance (Goldman & Goldstein, 2022).

Muntigl and colleagues (2017) described four key phases therapists are required in engaging clients in chairwork: 1) Formulating difficulties, 2) Recruiting participation in chairwork, 3) readjusting the participation frame, and 4) making contact. Conversation analysis research in emotion-focused therapy (EFT) has highlighted that typically when inviting clients to engage in chairwork initially, there is hesitation, reluctance, delayed engagement, or objection (Muntigl et al., 2017). This initial reluctance required the therapist to interact sensitively yet effectively to recruit collaboration, but in some cases, chairwork was abandoned following client reluctance (Muntigl et al., 2020). The conversational analysis research does not inform how therapists understand and experience reluctance. There is also limited generalisability to other models of therapy for example, ST uses types of chairwork aside from the 2-chair dialogues used in EFT.

As far as we know, no study has been published investigating ST therapists' perspectives on their experience and subjective responses to client-related reluctance to chairwork. There has been limited research on therapists' perspectives in the context of ST, and this is the first study exploring schema therapists' perspectives on chairwork (Klerk et al., 2017). A deeper understanding of schema therapists' experience of client reluctance to chairwork would improve further developments into chairwork training and schema therapy as an approach. It would also allow for the generation of hypotheses for future studies, which is useful as a new area of investigation.

Research aims

In summary, there is a need to understand the complex processes of chairwork in schema therapy, particularly ST perspectives on the challenges related to engaging clients in chairwork. This study aimed to contribute to the gap in the literature by qualitatively exploring how schema therapists experience, understand and respond to client-related reluctance to chairwork interventions. Qualitative methods were suitable for gathering rich, detailed data to explore therapists' lived experiences (Braun & Clark, 2006). This can provide important insights into the processes of facilitating chairwork and subsequently improve chairwork training and the development of chairwork. In this paper, reluctance will include the broad range of hesitation to engage in chairwork, such as delaying a response, challenging the validity of chairwork and refusal (Muntigl et al., 2020). Data were collected through semi-structured interviews and analysed via reflexive thematic analysis (RTA). The following research questions were considered:

1. How do schema therapists experience reluctance to chairwork?
2. How do schema therapists understand reluctance to chairwork?
3. How do schema therapists respond to reluctance to chairwork?

Methods

Ethical consideration

The study received UCL ethical approval (Appendix C). A non-substantial amendment was approved to confirm the interviews would be international and additional demographic questions regarding the country of residence.

Recruitment

The unique experiences of therapists were valued over the ability to generalise results; therefore, a convenience sampling strategy was used as opposed to sampling methods designed to reduce bias. Participants self-identified themselves by responding to an advert for the interview through email. The advert was posted on special interest groups on social media

and The International Society of Schema Therapy email list. All eligible therapists who responded to the advert were included.

Saturation is the most widely used justification of sample size in qualitative research (Vasieleiou et al., 2018). However, saturation does not match the assumptions and values of RTA, as saturation suggests that there is no new information to be identified (Braun & Clarke, 2019). The researcher instead reflected throughout the process of interviews on the richness of data collected and considered if it had met the study's aims. A partly pragmatic approach was taken to recruitment numbers due to financial constraints of funding and researcher time; it was estimated that 12-18 participants would be a suitable range to generate complex data within the pragmatic constraints. Upon the 16th interview being completed recruitment ended as no further participants came forward, and the researcher felt that the data gathered displayed rich and complex data patterns.

Inclusion and exclusion criteria

Inclusion criteria required that participants: (a) were accredited with The International Society of Schema Therapy (ISST) as a standard or advanced schema therapist or advanced supervisor schema therapist supervisor trainer; (b) were aged 18 or older; (c) were sufficiently fluent in English to take part in the interview; (d) had access to resources required to take part in the remote interview such as video device and internet connection. Participants who use chairwork and schema therapy in their practice without accreditation or were in the process of gaining accreditation were excluded to ensure they had adequate experience in schema therapy and chairwork to provide meaningful and relevant responses.

Participants

Twenty-two schema therapists contacted the researcher to express an interest in the study. Six participants did not participate for various reasons, including not responding and not having full accreditation. Sixteen participants completed the interview; Table 1 shows a full list of participant demographic information. The therapists' mean age was 49.4 years (SD

= 12.0, range = 34-72); please note that two participants reported their age as ‘60+’, therefore they were unable to be included in this age reporting where the exact figure is unknown. The mean reported years since accreditation was 7.2 years (SD = 4.3, range = 1-16). All participants were White and located in nine countries. Most participants were female, aged 40-49, located in Europe or Australia, accredited as an advanced schema therapist, and working as a clinical psychologist.

Table 1

Participants' demographics (N=16)

Demographic	n (%)
Gender	
Female	12 (75%)
Male	4 (25%)
Age	
30-39 years	3 (19%)
40-49 years	6 (38%)
50-59 years	2 (13%)
60+ years	5 (31%)
Country of residence	
Australia	5 (31%)
England	3 (19%)
Germany	2 (13%)
Hungary	1 (6%)
Israel	1 (6%)
Sweden	1 (6%)
Ireland	1 (6%)
US	1 (6%)
Poland	1 (6%)
Accreditation status	
Standard schema therapist	2 (13%)
Advanced schema therapist	11 (69%)
Advanced supervisor schema therapist	3 (19%)
Years since accreditation	
1-5 years	4 (25%)
6-10 years	9 (56%)
11-16 years	3 (19%)
Profession	
Clinical Psychologist	10 (63%)
Psychotherapist	5 (31%)
Psychiatrist and psychotherapist	1 (6%)

Procedure

Participants were emailed the consent form (Appendix D) and participant information sheet (PIS) (Appendix E). Upon completing the consent form and confirming interest, the researcher scheduled an individual remote video interview. The interview consisted of a semi-structured interview which varied between approximately 30-60 minutes. At the beginning of the interview, participants were given an opportunity to ask questions. Demographic data was collected before moving to the main interview. Participants were then asked to confirm they consented to the video call being recorded, and the interview was audio recorded and later transcribed for analysis. Upon interview completion, the study incentive of a small charitable donation was made.

Interviews

A pilot interview was conducted with one of the research supervisors to gain feedback on interview skills and questions. The interview was then revised using the feedback from the pilot interview and discussion with research supervisors. An interview approach was used for an in-depth exploration of participants' experiences, understanding and responses to client reluctance in chairwork. Interviews were semi-structured to allow the researcher to explore the key research aims, whilst allowing opportunities for unexpected topics that arose in the session to be explored (Appendix F).

Data analysis

RTA was identified as a suitable method for analysis in line with the research aims of identifying patterns of meaning across schema therapists to support understanding of the commonalities and complexities of their experience (Braun & Clarke, 2022a). Underpinning RTA is the assumption that coding and theme generation is an inherently subjective process where the researcher will interpret the data based on their assumptions (Braun & Clarke, 2022a). RTA was used to allow the researcher to acknowledge and reflect on how their views, background, and clinical and research experience may shape the data analysis (Terry &

Hayfield, 2020). RTA differs from other thematic analysis approaches, such as coding reliability thematic analysis, which uses methods like multiple coders to increase accuracy and reliability in the data analysis (Byrne, 2022).

RTA was preferred over other qualitative methods as it provided a way to capture the patterns of shared meaning across therapists' by engaging with therapists' accounts reflexively and thoughtfully to generate themes (Braun & Clarke, 2019). As the research questions were focused on therapists' subjective understanding, experiences and how this influenced their responses, it was considered more appropriate than conversation analysis which can provide observable communicative sequences but not the internal processes that inform such sequences (Muntigl et al., 2020). RTA was chosen over interpretative phenomenological analysis (IPA) to gain a broader overview across a larger sample size than IPA typically allows (Smith et al., 1999).

As RTA is a theoretically flexible approach, there are many approaches to thematic analysis which are informed by different ontological and epistemological assumptions (Fryer, 2022). Critical realism is an epistemological position that proposes reality exists independent of the researcher's ideas, however, it proposes that experiences and understanding of reality are mediated by language, cultural context and membership (Braun & Clarke, 2022a). A critical-realist approach was considered an appropriate position for the researcher to adopt to highlight therapists' lived experiences and responses whilst also situating cultural and social resources that underpin their responses, for example, schema therapy training and therapist identity.

The researcher used a hybrid approach for coding, both inductive and deductive reasoning. A combination was used to allow for what might emerge in the raw data (inductive approach), and using theory and past research relevant to the research aims to interpret data (deductive approach) (Dusi, 2022). The following steps were used to analyse the data in line with the original Braun and Clarke (2006) paper and further guidance to adhere to the RTA approach (Braun & Clarke, 2019):

1. Familiarisation: The first few interviews were transcribed verbatim using Scrintal transcription software. Due to the inaccuracy of the data transcribed, the rest were transcribed manually. During the transcribing process, participant information was anonymised. To familiarise themself with the data, the researcher re-listened to the audio recordings and re-read transcriptions. The researcher made notes on initial ideas of themes to engage with the data actively.
2. Generating initial codes: The researcher used N-Vivo software to generate inductive and deductive codes across the dataset systematically. Codes were developed on both semantic and latent meaning. Codes relevant to the research questions were tagged and named throughout the data set (Appendix G).
3. Generating initial themes: All codes generated in the previous step were collated to develop broader patterns of shared meaning and the initial themes. The researcher examined the data to develop clustering of codes to develop the initial candidate themes and subthemes. Multiple written and paper thematic maps were used to support the early phases of organising themes into overarching themes and sub-themes more visually (Appendix H).
4. Reviewing themes: This phase involved checking and reviewing the themes until they reflected the data. The candidate themes were refined in two phases. The first involved reading all the collated extracts for each theme to review patterns of coherence. The second phase involved checking the validity of individual themes in relation to the data set by re-reading transcriptions to check if themes reflect the data and add any codes not previously identified. The reviewed themes were placed into a thematic map for visual representation.
5. Defining and naming themes: Each theme was refined, named, and clearly defined. The researcher ensured that each theme description was clear, related to the research aims and did not overlap with other themes (Dusi, 2022). This phase supported the researcher in considering further how themes related to each other. Throughout phases 3-5, the researcher regularly had meetings with research supervisors to

support the development of themes for example, to ensure themes were conceptually coherent.

6. Producing the report: The final stage involved producing the present report. The researcher considered the order of presenting themes in a clear, logical and meaningful manner. The researcher used quote examples of each theme to illustrate and provide evidence for each theme.

Researcher's reflexivity

The study results will be mediated by the various aspects of what the researcher brings to the research process, such as identity, experience, and skills (Braun & Clarke, 2021b). In RTA, the researcher's subjectivity is viewed as a resource rather than a risk to validity to be controlled for (Braun & Clarke, 2022a). The researcher was a white British, heterosexual female in her late twenties. The researcher was also a Trainee Clinical Psychologist completing the research as part of the Doctorate in Clinical Psychology. The researcher had no professional training in ST or chairwork and predominately practised CBT and CFT. As the interviews proceeded, the researcher learnt more about ST and chairwork through the interviews and completing the conceptual introduction. Since beginning the research, the researcher sought opportunities to practise chairwork on placements. The researcher had minimal experience in qualitative methods. However, she had received some training as part of her course. The researcher acknowledged inexperience in qualitative methods, and the topic areas may have resulted in missing some important exploration routes in interviews. The researcher may have missed opportunities to explore important experiences relevant to the participant's nationality, ethnicity, and age. In line with RTA methodology, the researcher reflected on her emotions, assumptions and predictions and linked these to possible influences on the analysis (Braun & Clarke, 2022b). The researcher observed an assumption that reluctance to chairwork would be a challenging experience. A reflexive journal and discussions with research supervisors supported the researcher in managing and monitoring the influence assumptions may have that could prevent contradictions from being observed.

Quality

Several strategies were used to ensure RTA quality. Braun and Clarke's (2022a) fifteen-point checklist for quality RTA was used to ensure quality at all stages of the research process, such as checking transcriptions for accuracy and explicitly stating specific approaches to thematic analysis. A reflexive journal was used to consider prior assumptions and knowledge and continually reflect on the research process. Allowing sufficient time was also crucial to ensuring the quality of the analysis. Where possible, the researcher ensured regular breaks and suitable pacing of the analysis.

Results

The analysis generated four superordinate themes, each containing three subthemes (see Table 2).

Table 2 Overview of themes and subthemes

Superordinate theme	Subtheme
1. Seeing reluctance as normal and something to be understood "It's not personal"	a. Coping modes and avoidance b. Schema-driven reluctance c. Reluctance is to be expected at first
2. Impact on the therapist "I'm still a human!"	a. Therapists' schemas and modes b. The journey to confidence c. Reducing personal impact
3. The relationship overcoming reluctance "Safety in the room"	a. Trust b. Interpersonal process skills
4. Warming the client up to chairwork "It's just about acclimatising people"	a. Psychoeducation and modelling b. A gradual approach c. Spontaneity and Creativity

Theme 1: Seeing reluctance as normal and something to be understood "It's not personal"

Subtheme 1a: Coping modes and avoidance

All participants felt that reluctance was often an important communication that informed their formulation, with the reasons for reluctance taking the conversation down a “path that will be helpful” (P1). Thus, curiosity about reluctance was essential. Participants also emphasised that reluctance provided “meaningful” insights into what might be happening for the client outside of therapy:

> *If someone is saying no to chairwork … don't really take it to mean anything personal about you. We have just got to be curious about what are they communicating? Because it will always be something important. (Participant 1)*

Underpinning participants’ curiosity was the belief that reluctance reflected schema activation, notably avoidance coping modes. Participants used ST theory and clinical experience to stress that chairwork exposes intense emotions that often activated clients’ coping modes. For example, participants noted that many clients wanted to avoid intense feelings associated with child modes: “The most difficult thing for most clients is the chair of the vulnerable child” (P6). Participants emphasised that clients who have strong over-controlling modes often feel overwhelmed by child modes and so struggled with chairwork.

> *People who have very strong over-controlling modes… the more difficult it is to work them into wanting to do chair work… because it brings up that insecurity. It brings up fear... This is something where I could get out of control because I don't really know what it is and I don't want to be out of control. (Participant 7)*

A few participants also spoke about “appreciating” the client expressing and “asserting” their reluctance in comparison to other clients who might agree to chairwork despite reluctance in an attempt to please the therapist. Some participants preferred to avoid referring to coping modes as “bad” or something to “bypass”, and instead adopted an accepting stance towards coping modes. However, they recognised this does “not always sit with the schema therapy model” (P12).

I've always been confused by schema [therapy] because really no other therapeutic model has this idea that there is a bad bit that must be scalped out…How do you cut out a part that is mental? From a more meta-psychology point of view, it doesn't make any sense (Participant 8)

Subtheme 1b: Schema-driven reluctance

All participants shared their experiences of linked how reluctance often stemmed from clients' EMS:

Perfectionists often want to know what it is and how to do it in advance... There's the unrelenting standard schema, you know, the fear of looking foolish, the fear of doing it wrong, making mistakes. (Participant 7)

Most participants reflected that when working with clients with entitlement and grandiosity schemas, reluctance might be the client becoming critical towards the therapist and their approach to gain control of the session due to fears of losing power and control. Participants noticed reluctance often being linked with defectiveness, shame, and failure schemas with "the fear of not fulfilling what the therapist expects and to make a mistake" (P15) so clients may view chairwork as a performance to get right. Similarly, those with emotional inhibition schemas struggle with the emotional expression inherent in chairwork.

It's hard to with the people who are emotionally inhibited and [therefore] avoidant… it's hard to get them to speak in the first person and not… keep stepping out of role all the time. (Participant 4)

Subtheme 1c: Reluctance is to be expected at first

Many participants said, in the beginning, they often "expect a little bit of resistance" (P2). They stressed that initial reluctance is understandable as experiential strategies are something clients are likely to have never experienced before in previous therapies. Participants shared

reflections on the wider context of therapies and how often doing experiential interventions rather than just being and talking is unexpected for the client coming into ST for the first time.

> *If they were in a previous therapy, they've just got used to… chatting, chatting, chatting. (Participant 2)*

Several participants spoke about clients' initial beliefs about chairwork being a "superficial" technique which is not a useful therapeutic intervention that can help them. Many participants shared the perspective that clients need to experience chairwork first to change these beliefs and reduce reluctance.

> *Once people experience it… the wall starts to fall, you know, it starts to crumble sometimes [clients] have such a deep experience from it even on the first try. (Participant 7)*

Theme 2: Impact on the therapist "I'm still a human!"

Subtheme 2a: Therapists' schemas and modes

All participants described the impact client reluctance had on their own mode activation. Participants described being "fluid", "playful", and "fun" when the client is freely engaged in chairwork, which often seemed like the happy child mode. In contrast, when the client was hostile and critical towards chairwork, other modes were activated. Participants spoke about flipping into their vulnerable child mode with anxiety resulting in avoidant coping. Many participants had examples of clients to whom they did not introduce chairwork again or found it hard to keep going. Several participants referred to the importance of recognising therapist avoidance is important due to the belief if therapists are not doing chairwork then they are not doing ST.

> *Sometimes I also feel rejected or insecure…my own critic kicks in and tells me something like, "He doesn't think that you're competent" … then, of course, I feel stressed. (Participant 9)*

Many participants also spoke about how the therapist's own EMS may influence them to be reluctant towards chairwork and focusing on client reluctance is "letting therapists off the hook" (P13). EMS such as unrelenting standards and emotional inhibition may result in therapists' fear of doing chairwork wrong or activating intense emotions. A few participants spoke about the impact of subjugation in blocking chairwork due to beliefs around the client being "unhappy or scolding" (P14) if they suggest chairwork. Participants believed it is important to have self-awareness and engage in self-reflection to manage one's schemas in the context of chairwork.

> *A typical therapist schema is defectiveness, "I'm not a good therapist", and unrelenting standards, and if it's that, then "I have to read one more book" … I think it's necessary to know what are your own limitations to go into chairwork and then you can work on the specific block. (Participant 15)*

Subtheme 2b: The Journey to Confidence

Most participants placed an emphasis on the challenge of clients being more likely to be reluctant to do chairwork if the therapist is not confident in the method. Therapists spoke about needing to "sell it to a degree" (P13) which is much easier if the therapist appears confident.

> *If you kind of look confident, you look like it's worthwhile… I'm selling it to the client. (Participant 5)*

Many participants acknowledged that in the earlier phases of their ST practice, they did not feel confident and suggested: "fake it till you make it". Participants spoke about the importance of practising doing chairwork with clients once knowing the basic principles, as this will produce confidence through practice and learning. Participants explained their interpretations of why reluctance occurs changed as they gained experience and confidence.

> *It's like, I don't know, this must be me… [I'm] not executing it correctly. But then over time, when you've met lots of people, you're like, oh yeah... Humans are just complicated. (Participant 1)*

Most participants had trained in other models prior to ST (e.g., CBT) and were unfamiliar with managing intense emotions and moving around the room when first using chairwork. During this time, many participants preferred the control, structure, and lower levels of affect of cognitive methods. Some participants said that they found imagery easier initially due to there being less involvement required from the client.

> *The majority of us are trained either cognitive behaviourally or psychodynamically. It's all insight oriented, it's cognitive…it's not really about opening things up and coming into contact with these deeply emotional experiences… I think a lot of people [therapists] aren't comfortable with that. (Participant 13)*

Subtheme 2C: Reducing personal impact

Participants spoke about the ways they try to reduce the personal impact of reluctance. Participants discussed the need for self-reflection and to be self-aware of the impact of reluctance and their responses, several participants referred to finding their personal ST useful. Participants believed it was important to be accepting that chairwork may not go to plan and to bring their own healthy adult mode to cope.

> *When I introduced chairwork…she totally criticised it… I never introduced it again… sometimes I will put it aside and won't try to introduce experiential techniques at all. I take it as like a self-practice to, you know, to work on. How to bring back the sense of safety and courage that I somehow lost with this client? (Participant 12)*

Most participants valued learning from others such as having discussions with peers, on ST social media groups, and training. This helped to understand reluctance and have opportunities to practise and learn ideas. Several participants spoke about valuing giving and receiving supervision to manage reluctance:

> *I think the supervision is helpful in terms of "Okay, this is not about me doing a bad job". Let's pull this apart and recognise what it's about, and what direction we need to*

go… supervision is a key thing to give us the confidence and brainstorm different ideas. (Participant 4)

Therapists also spoke about contextual factors which hinder their ability to respond to reluctance. These include workload and tiredness resulting in the therapist feeling less motivated. One participant spoke about the impact of a high caseload:

On a day like today if I really need to persuade the client to try chairwork…maybe I won't [do chairwork] today … you haven't slept well…you need to be fully present and engaged and working in a public health system you're constantly busy and don't have the time…that's just a reality. (Participant 14)

Theme 3: The relationship overcoming reluctance "safety in the room"

Subtheme 3a: Trust

All participants privileged the importance of trust in the therapeutic relationship overcoming reluctance to chairwork.

A lot of it is dependent on the alliance that's made and the level of trust... Some people [respond] "Yeah I'll try it"…But then there's some people who need to establish trust and it really depends on how challenging their schemas are. (Participant 7)

Underpinning this was the belief that trust allows for "safety" and "connection" which produces the environment for which a client feels safe enough to take risks and try chairwork without fear of judgement from the therapist. Trust also was thought about in terms of how much the client has faith in the therapist's judgement. This meant that even if the client feels reluctant to do chairwork they trust and have confidence in the therapist's judgment of what will be helpful in therapy.

I put a lot of effort in a therapeutic relationship. If this is good… you can introduce the method easier they trust in you. They like you. They know you. There is a good

therapeutic relationship, and they see, you know, it works, so it doesn't matter what method. (Participant 2)

Some participants made links to limited reparenting when discussing the importance of trust in the therapeutic relationship for helping clients to feel able to do chairwork. Limited reparenting was referred to as helping the client to feel understood, connected, not judged and comfortable. These relational factors help the client to be able to take risks and step outside of their comfort zone with the trust in the therapist that they can support them, is present with them, and can help if chairwork is difficult.

I do think it's [chairwork] more an interpersonal thing as in doing it with you I think there's something about having to work on that limited reparenting that therapeutic bond… is more important I think than any other giving information not giving information about it before. (Participant 14)

Subtheme 3b: Interpersonal process skills

All participants shared beliefs that the therapist's interpersonal process skills are key to overcoming reluctance. Participants highlighted the therapist's role in giving the client the motivation to be able to try chairwork even when feeling reluctant to doing so. Most participants emphasised that the therapist needs to be encouraging and reassuring:

Encourage, encourage, encourage every little step they are doing. (P2).

Many participants valued openly normalising with clients the discomfort of chairwork including normalising parts and the uniqueness of chairwork.

Tell them "there's nothing you can [do] wrong it's just to understand better what's going on within you. We all have these different parts, your parents have, I have, you have, your boss has" so normalising this and putting away the shame or the fear of failure. (Participant 15)

Participants spoke about telling clients experiences with other clients have found it useful despite initially feeling reluctant also “everybody thinks it’s strange the first time” (P7). Some participants spoke about the challenging balance of using interpersonal skills to encourage chairwork and for people to go outside their comfort zone without tipping into a “power struggle” and possibly causing damage to the therapeutic relationship.

> *You don't want to get into a power struggle with people, that could be like the issue of their life… they've had over-controlling parents and there has always been a power struggle. So… it's sort of sneakily getting them to do the work [laughs]. (Participant 7)*

Some participants expressed further discomfort when discussing examples of clients who have been so reluctant that they did not participate in chairwork even after years of ST. Some participants spoke about when there is an ongoing reluctance to experiential techniques questioning if ST is the right approach and making sure clients are aware that they are missing a key ingredient of ST and using empathic confrontation to validate the reasons for the reluctance along with setting some “limits or boundaries”, therefore valuing being firm on limiting avoidance modes which may prevent work with vulnerable child modes.

> *If a client really does not want to do it I am not gonna damage the reparenting relationship by forcing them, but I would say well you know we can come back to it ... I do think this is important or…you're not getting the full experience of ST if we don't do it. (Participant 14)*

Theme 4: Warming the client up to chairwork “It’s just about acclimatising people”

Subtheme 4a: Psychoeducation and modelling

Participants believed that sometimes they have experienced reluctance when ST concepts of modes and parts are not clear to clients and then there needs to be more guidance, especially in the initial stages. Some participants spoke about the dilemma of wishing to use chairwork

to understand these concepts but finding this challenging without psychoeducation when there is reluctance “They’re not going to do it unless I start to break down what this mode is” (P7)

> *So there's sort of a chicken and egg process of educating people about modes and different parts of themselves …but at the same time, chairwork can be a really good way of helping people to understand the different modes. (Participant 4)*

Many participants shared examples of how they often join and model mode dialogues to support understanding chairwork and ST concepts. Some examples included the therapist expressing how they would feel in that scenario or using their knowledge about the client to play their mode or demonstrating how the healthy adult mode would respond. Participants seemed to enjoy being alongside the client and a part of the client’s experience in mode dialogues with one participant describing modelling modes as “powerful for them and even for myself” (P3).

> *I said “Can I be you? I'll just be your part.” I've listened to their tone of voice, and when they're giving me answers people can be surprisingly animated when they don't realise they are…sometimes I enhance it a little bit… And it's quite interesting for me because I really feel the character when I do that [laughs]. (Participant 11)*

Participants spoke about the benefits of the client being about to visually see the therapist being a mode such as reducing embarrassment and normalising parts and talking to people who are not present.

Subtheme 4b: Gradual approach

When thinking about preventing and responding to reluctance many participants adopted a flexible approach to gradually introducing chairwork with ideas around “starting small” and using “little steps”. Underpinning this perspective is the assumption of “some people aren’t ready to jump in” (P4) so focusing on “scaffolding” and working within the individual clients’

window of tolerance is helpful initially. Many participants felt that their gradual approach was key to preventing and responding to reluctance:

> *You can help somebody engage with it without having to sit in a chair and be a mode… finding ways to gently introduce people to chairwork…either the therapist being the modes, just putting out the chairs and demonstrating how the different modes might function together, getting people to talk, say what that mode would say….and then keeping going…thinking about "Okay, how can we build on it this week?" (Participant 4)*

Often, participants described approaching chairwork in a format similar to an exposure hierarchy. Participants used chairwork theory to think about gradually introducing the key process skills into chairwork:

> *I don't need embodiment right now, maybe personification, or maybe objectification. (Participant 12)*

Participants described initially introducing key concepts through parts language. This included therapists talking about parts using phrases like "There's a part of you that's very critical" (P8) so the client can become familiar with ST language and separation. Participants then take separation a step further to personify the part and imagining it in the chair. By removing the step of embodiment participants viewed this as a safer, less emotionally intense option for those more comfortable on a "cognitive level". Finally, once the client has engaged in separation and personification, they can move to the chair to embody the part.

> *I use a three-step approach because you know as soon as I start hearing a critical voice, I say "Well there's a part of you that's very critical isn't it" and I won't do anything more than that… "Oh I've heard it again"… so I'm looking to build some evidence for that part …. "we've been putting little sticky notes on that part for a while"… if we were to put that part over there on the chair what would it look like? (Participant, 8)*

On the contrary, a few participants preferred to go straight into "full" chairwork: "I do chairwork in the first 15 minutes I meet them" (P10). Participants who preferred to start chairwork early in therapy described the benefits of their approach as being able to showcase to clients what ST and chairwork is and to use chairwork as an assessment tool.

> *Try and roll it in sooner rather than later…it's gonna come across to the clients this is part of what we do… so from the outset setting up the expectation… I'm a schema therapist and this is the way I work. (Participant 14)*

Whereas those who preferred to start chairwork later had concerns about exposing clients to vulnerable emotions too soon and preferred to focus on building the therapeutic relationship first. Overall, all participants appeared to approach their decision-making flexibly depending on their beliefs regarding the individual client's readiness to do chairwork.

Subtheme 4C: Spontaneity and Creativity

Participants stressed the importance of chairwork being something that should be integrated into the therapy and naturally flow into the session rather than something overly planned with the client. Participants stressed that over-explaining chairwork can be unhelpful. Participants reflected on times they had given a lot of explanation and it resulted in reluctance as it caused the client to overthink and then have concerns about chairwork.

> *It is really natural for me... Rather than "blah blah blah chairwork helps us hear from the different parts" and you know like over-explain … just the easiest way is to "Can we hear from that part? Do you mind moving to that chair and speaking from that part?" Like…boom! [laughs]. (Participant 1)*

Participants believed that therapists need to be able to adapt to the client creatively in session in response to reluctance. This involves a process of understanding what the client is and is not willing to do and adapting accordingly. Participants shared ways they have creatively adapted chairwork to following chairwork principles, I.e., parts work but excluding the use of

chairs: for example, drawing, photographs of the client as a child, holding objects, puppets, and imagining parts. Most participants viewed creative alternatives as an effective alternative when there is a reluctance to switch seats "You can get the same job done it's just not a chair" (P13).

Most participants shared beliefs that schema therapists should trust their creativity and not feel constrained in chairwork by being too procedural in how chairwork is done. Many highlighted that chairwork is based on principles rather than a step-by-step manualised intervention, which many therapists are used to. Participants shared opinions that creativity will take you outside of familiar ways of working and the therapist's comfort zone, but this can be helpful.

The resistance is not the problem…the patient is not the problem. The problem is your toolbox... So be more creative…help the patients see in another way, because you reach the same result, that the chairwork is meant to do ….they [supervisees] think, "I should do this. And I cannot go outside." I say, "Hey, you can do as you want. You have trained in one way. But then when you are comfortable with that, try to go outside the box. Because if the patient needs it, you have to. (Participant 10)

Discussion

This study sought to understand schema therapists' perspectives on how they experience, understand, and respond to clients who are reluctant to do chairwork. An RTA identified four superordinate themes and nine subthemes. The superordinate themes were (1) seeing reluctance as normal and something to be understood, (2) impact on the therapist, (3) the relationship overcoming reluctance, and (4) warming the client up to chairwork. These findings emphasised how challenging chairwork can be for both therapists and clients, especially those therapists earlier in their ST career and clients new to therapy, highlighting the challenges for all involved. These themes are now discussed in relation to the existing literature.

Seeing reluctance as normal and something to be understood

The first superordinate theme, seeing reluctance as normal and something to be understood, referred to the importance of therapists understanding and formulating the reasons behind reluctance. Participants took an accepting stance regarding reluctance, describing initial reluctance as something they often expect when introducing chairwork. This is supported by EFT research, showing that clients often do not immediately accept chairwork proposals (Muntigl et al., 2020; Stiegler et al., 2018). This also appears to be expected in ST, as many participants described being unsurprised by reluctance. Consistent with previous research participants described common reasons for reluctance being fears of intense emotions, embarrassing oneself and getting it wrong (Stiegler et al., 2018; Marren et al., 2021).

Formulating reluctance to chairwork in terms of client modes and schemas enabled participants to take an impersonal and non-blaming stance. Participants viewed reluctance as meaningful as it provided valuable information for developing formulations and guiding treatment. When the clients were critical of the therapist's proposal or the chairwork task itself, it was often formulated as a coping mode, such as an over-compensator mode rooted in EMS, that is trying to protect the client from emotional pain; for example, past humiliation the client is trying to avoid in the present. The therapist can use empathic confrontation to collaboratively share this observation with the client in a caring, non-blaming way; therefore, coming to a shared formulation of the reluctance can be a meaningful interaction and intervention (Gülüm & Soygüt, 2022). Formulating was viewed as helpful for the participants to maintain a healthy adult stance and not slip into their own coping or parent modes, for example, responding to clients from their punitive or overcontrolling modes. This process of understanding reluctance is linked to limited reparenting, with the therapist providing a 'healthy adult' response which is responsive and containing in the face of distress (Gülüm & Soygüt, 2022).

Chairwork triggers intense emotions associated with EMS and modes to produce productive and helpful emotional change (Arntz & Jacob, 2017; Marren et al., 2022). Reactions to chairwork proposals, such as distress and reluctance, can reflect relevant problematic

responses and emotional reactions in the client's life, aiding understanding for formulation (Muntigl et al., 2023). Other therapies have also stressed the importance of using formulation to make sense of client fears, blocks, and resistances to therapeutic tasks, processes, and concepts such as self-compassion (Steindl et al., 2022).

Impact on the therapist

The second superordinate theme, focused on the emotional impact of reluctance on therapists and the therapist's role in reluctance. Understanding therapists' emotional experiences is essential, as this can negatively impact therapy (Muran & Eubanks, 2020). Therapist anxiety about chairwork can lead to avoidance of using chairwork in session (Pugh et al., 2021). Participants believed they were not immune to being triggered in sessions and shared experiences of reluctance activating their own EMS and modes. Participants identified feeling shamed, rejected, and self-critical. These feelings influenced some participants not to bring up chairwork again with some clients, especially when they felt criticised for introducing it. This may be an example of therapists slipping into avoidance coping modes because of reluctance, for example, compliant surrender mode. Schema therapists have previously identified the negative impacts of their own schema activation on clinical work, such as failing to set limits, becoming avoidant in session, or responding aggressively; and thus, being unable to respond to the client from their healthy adult mode (Pilkington et al., 2022).

Commonly identified therapist schemas, such as unrelenting standards, can lead therapists to feel they have failed when there are challenges or reluctance to interventions (Haaroff, 2006). Participants recognised this was more common earlier in their ST practice; however, with experience and time, they began to recognise that reluctance is common and not a personal failure as a therapist. Therapists need to self-regulate their reactions and vulnerabilities to reluctance, such as feeling like a failure as a therapist, which can lead to unhelpful responses to reluctance, such as putting too much pressure on themselves or the client and potentially repeating unhelpful patterns in the client's life (Centonzone et al., 2023). Participants shared their experience of a helpful change of perspective by stepping away from

ideas of ‘right’ or ‘wrong’ ways of facilitating chairwork. This made them feel less stressed and able to respond more freely and effectively when chairwork does not go to plan, which is especially important when using action-based methods (Giacomucci, 2021).

In line with past research, participants identified ways to reduce the impact of being triggered, such as supervision, personal therapy, self-practice and self-reflection (Pilkington et al., 2022; Farrell & Shaw, 2017). Participants described the importance of supervision to support them in understanding challenging interactions and returning to their healthy adult mode. Supervision can assist supervisees to problem solve difficulties whilst understanding the impact of therapists’ own schemas and mode activation on therapy processes (Greenwald & Young, 1998). Previous research as well as the current study showed that therapists see personal therapy as beneficial for gaining awareness and management of triggers (Moe & Thimm, 2021; Pilkington et al., 2022). Participants highlighted the usefulness of using chairwork within supervision to understand themselves and chairwork better through roleplaying challenging examples of sessions where there was reluctance. Using chairwork within supervision provides opportunities for self-practice of chairwork which can aid self-development, awareness, deeper learning, and treatment fidelity in the face of obstacles (Pugh & Margetts, 2020).

The relationship overcoming reluctance

The third superordinate theme focused on the therapeutic relationship as the key to preventing and overcoming reluctance. Participants stressed the need for clients to trust the therapist to feel safe enough to be vulnerable in chairwork. The therapeutic relationship and the technique will interact and influence one another; for example, a strong therapeutic alliance can enable clients to take part in chairwork, but also a positive experience of chairwork can strengthen the alliance for further chairwork engagement (Flanagan et al., 2020; Pugh et al., 2022). Participants believed therapists need to focus on interpersonal processes, particularly the limited reparenting relationship, to provide a corrective emotional experience that the client can internalise (Gülüm & Soygüt, 2022). Collaboration on the tasks of therapy is closely linked

to the relationship between the client and therapist (Wampold & Flückiger, 2023). Whilst the therapeutic relationship is essential for facilitating chairwork, chairwork can be an effective way to develop and strengthen the therapeutic relationship (Matos & Dimaggio, 2023; Pugh et al., 2022). Participants highlighted this dilemma, with some preferring to start chairwork early on in therapy and others preferring to wait until a working alliance is established.

Participants spoke about how certain types of reluctance feel more personally challenging than others, mainly when working with clients with grandiose and entitlement schemas who may be more critical towards the therapist when they propose chairwork. Consistent with previous literature, participants revealed that clients with narcissistic personality disorder (NPD) tend to blame and criticise the therapist and activate intimidation and self-doubt in the therapist (Behary & Dieckmann, 2011). Therapists can face challenges and ruptures in the therapeutic relationship when using chairwork with clients with NPD, however, working through and resolving ruptures and challenges can increase engagement, address emotional regulation difficulties, and increase trust (Centonze et al., 2023).

Participants highlighted the need to be supportive, encouraging and reassuring in the face of reluctance without getting into 'power struggles' or forcing the client to do chairwork. Underpinning these concerns were worries about potentially rupturing the relationship or repeating an earlier maladaptive relationship. Some participants gave examples of where they shared concerns with their clients that they are not doing ST if they do not engage in experiential exercises. Kellog (2012) described the challenge of therapists needing to push to make chairwork happen without going 'too far'. Empathic confrontation allows the therapist to combine empathy and reassurance with therapeutic direction to manage avoidant modes without being critical towards the client (Flanagan et al., 2020).

Warming the client up to chairwork

The final superordinate theme highlighted how participants respond to reluctance by gradually approaching chairwork. Chairwork originates from psychodrama, where 'warming

up' is vital to building a sense of playfulness, trust and rapport, which can gradually arouse the individual's interest, curiosity, collaboration and spontaneity (Blatner, 2005). Participants shared that some clients need more warming up time to engage in chairwork than others. Warming up is the process of preparing oneself for action, participants felt this was relevant for chairwork (Giacomucci, 2021). Past research has highlighted psychoeducation and making the rationale clearer as useful for preparing reluctant clients for chairwork (Muntigl et al., 2020). Many participants agreed with this and shared other ideas such as modelling chairwork dialogues. Doubling is a facilitative intervention that involves the therapist speaking for the client to bring up emotive cognitions that the client may be avoiding or unable to express (Pugh, 2019b). Doubling allows the client to have intense emotions and thoughts seen and heard by the therapist who is not overwhelmed by them, thus promoting trust and confidence in the therapeutic relationship and themselves (Blatner, 2000).

Therapists can adjust the pace and emotional intensity of chairwork to keep within the client's window of tolerance (Ociskova et al., 2022). Many participants shared their gradual approach to chairwork. They begin by talking about parts with clients and then ask the client to imagine the part in the chair before eventually moving over into the chair. Participants appeared to believe that this is key to not only managing reluctance but preventing resistance, as it meant chairwork was a natural next step that made sense in the flow of the session. Some participants preferred introducing chairwork spontaneously in session rather than a lengthy explanation of what chairwork is, the rationale and what to expect. Participants felt the latter was more common for inexperienced therapists who tend to over-explain chairwork due to their uncertainties and anxieties. Creativity and spontaneity are the most useful skills in experiential interventions, yet this is challenging for therapists who prefer structure and certainty (Pugh et al., 2021; Monreno, 1987). Participants felt there was a broader issue of therapists needing to be more comfortable working more creatively in therapy and therapists feeling stuck in traditions of manualised ways of working associated with therapies such as CBT. Therefore, participants highlighted the importance of schema therapists building their

confidence to gain the courage to express creativity and spontaneity in their chairwork practice.

Clinical Implications

The findings suggest that reluctance to chairwork is best conceptualised as a meaningful communication that can aid understanding and inform case conceptualisation. Moreover, working through reluctance can be viewed as a valuable part of the treatment rather than a hindrance that often results in therapist self-blame or frustration. Clearly, there is no one size fits all response to reluctance: responses should be tailored according to hypotheses about the causes of reluctance (e.g., relevant modes and EMS), clients' formulation, stage of therapy, and the quality of the therapeutic relationship. Therapists should focus on developing a therapeutic alliance to help the client feel understood and trusting, thereby maximising the likelihood of client engagement in chairwork. Chairwork itself can strengthen the therapeutic alliance. However, it is recognised that the pressure and emotional impact of reluctance can impact the therapist's ability to conceptualise and make effective clinical judgments and responses; therefore, supervision, self-monitoring, and professional training are vital to ensure therapists access to their healthy adult mode is not compromised (Muran & Eubanks, 2020). ST training providers and supervision should support therapists to understand reluctance to chairwork and normalise the experience of reluctance. Therapists may also consider improving their self-awareness to their own modes and schemas activation, such as personal therapy, using chairwork in supervision, self-reflection and self-practice.

Finally, training could benefit from highlighting the roles of creativity and spontaneity in chairwork and how to adapt chairwork to the client. Many participants revealed they had come from therapy backgrounds where manualised or static interventions are emphasised (e.g., CBT). Therefore, creative ways of working required for chairwork can be a challenging shift for therapists. Training and supervision are crucial to support therapists in this transition. Behavioural rehearsal training active training strategy where therapists role-play stimulated therapy situations (Beidas et al., 2014). Incorporating reluctance-focused behavioural

rehearsal into ST training may be helpful so therapists are better prepared to manage reluctance to chairwork.

Research implications

The study helped identify several areas that would benefit from further research. The study focused solely on therapists' subjective experiences and perceptions of client reluctance in their ST practice. Additional research is needed to understand better clients' perspectives of reluctance to chairwork in the context of ST. Other areas for future research to understand are what process-outcome factors are required for managing reluctance to chairwork effectively. Whilst the research benefited from in-depth interviews from therapists' perspectives, alternatives to self-report data may be helpful. Task analytic studies can help identify factors that contribute to more productive experiences of introducing and facilitating schema-focused chairwork, and managing reluctance (Bennett et al., 2006). This could allow a better understanding of the mechanisms behind helpful responses, such as offering reassurance (Goldman & Goldstein, 2022; Muntigl et al., 2020). There were mixed opinions regarding when to introduce chairwork amongst the participants; therefore, future research could compare outcomes between starting chairwork early compared to later in therapy, as well as determining the optimal way to introduce chairwork. Finally, researching training methods, such as behavioural rehearsal would be beneficial to understand which methods help therapists navigate reluctance to chairwork most effectively (Pugh et al., 2021).

Strengths and limitations

The study is a novel area of research understanding therapists' perspectives on chairwork in ST, including therapists' emotional experiences. Overall, a strength of the study was the use of an international sample from nine countries and fully accredited therapists. Whilst RTA methodology does not aim to make claims for generalisability, it would be reasonable to assume that some of these findings are relevant to other modalities that use chairwork, such as CBT and CFT (Braun & Clarke, 2022c). On the other hand, the limitation of a broad

sample is that it is unknown what aspects of the therapist's identity, for example, country of residence or level of accreditation, are associated with which responses. The study used accredited schema therapists on the basis that this would ensure experience and competence in chairwork. However, this may have resulted in limitations around the diversity of therapists and responses for example, therapists who practice schema-based chairwork without accreditation which may be more common in the public sector or less experienced therapists.

The open questions used to explore client reluctance in ST practice means results may have lacked specificity regarding whether reluctance worked in the same or differing ways depending on if clients express strong rejection or slight hesitation. Future research could compare how schema therapists respond to minor hesitation versus a solid objection to identify specific approaches for each type of reluctance to chairwork.

All participants were fluent in English and were primarily based in Western societies. ST has begun to be used worldwide; however, it is unclear if these results would generalise to ST therapists and clients from diverse cultural backgrounds. Despite using an international sample there were limited findings regarding client-related factors in reluctance to engage in chairwork, for example, cultural background. Therapists need to be aware of important cultural factors when responding to reluctance to chairwork. Future research could benefit from understanding perceptions of chairwork with clients from minoritised backgrounds to understand further adapting chairwork for culturally sensitive practice (Cheung & Nguyen, 2012). Nearly all participants made references to working in private practice which may have influenced how reluctance is viewed and managed. Only one participant referred to working in the public health sector and identified this impacting their ability to manage reluctance to chairwork, when feeling tired and stretched with a high caseload. Therefore, future research could explore chairwork in the context of public health settings.

Conclusion

Chairwork is a challenging, emotionally demanding, but valuable technique that can be used creatively to provide shifts in therapy. This was the first study to explore schema therapists' perspectives on client reluctance to chairwork. This filled a gap in the literature by clarifying how schema therapists understand, experience and respond to client reluctance to engage in chairwork. Chairwork can be challenging for both therapists and clients, especially in the early stages of treatment. The research showed that therapists view reluctance as a meaningful communication which can be a helpful part of formulation and treatment rather than a hindrance to therapy. It also identified that despite this at times reluctance can be challenging, especially when therapist schemas and modes are activated and further support is required to help manage those challenges to help bring therapists back into healthy adult mode. Finally, the therapeutic relationship and flexibility using chairwork is key in navigating chairwork. Further research is needed to understand clients' perspectives on reluctance to chairwork in ST and process-outcome factors associated with the successful engagement of chairwork in ST.

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Part 3: Critical appraisal

Introduction

I will begin this critical appraisal by sharing personal reflections on the research process from my reflexive journal. This will include my interest in the research topics, the broader context and the role of self-reflexivity in reflexive thematic analysis (RTA). In the second section, I will discuss some methodological considerations I had in becoming a research interviewer, interviewing schema therapists, and generating themes. I will present some of the challenges I faced and how I attempted to overcome these and develop my research skills. Finally, in the third section, I will discuss some of the implications of the empirical paper for schema therapy (ST) and chairwork training providers. In particular, the importance of discussing the topic of reluctance within ST and chairwork training.

Personal reflections from the reflexive journal

Research Interest and learning

I was drawn to this topic for several reasons. I was interested in ST because it is a promising cost-effective treatment for those with personality disorders (Van Asselt et al., 2008; Giesen-Bloo et al., 2006). As a trainee clinical psychologist primarily experienced in cognitive behavioural therapy (CBT) and third-wave approaches, I often felt that on placements, my methods were sometimes lacking for clients with more enduring mental health difficulties, so I was curious to learn more about ST. I was also very interested in experiential techniques such as chairwork because I noticed this as something I lack confidence in my clinical practice, a common experience for many therapists from CBT traditions (Pugh et al., 2021a). Like many other therapists, I felt more comfortable talking than doing in my practice (Pugh et al., 2021a). I reflected that this is likely due to my anxieties about getting experiential interventions 'right' and assumptions that clients would not want to participate in such interventions; therefore, it often feels safer to stick with talking and exploring. This meant that I had my assumptions coming into this research that client reluctance would be experienced as a problematic experience. As I wrote in my reflexive journal about this, I realised that I needed to be aware

of this assumption to allow myself to notice findings are not consistent with this viewpoint. This was later the case as I learnt that many therapists, whilst sometimes found reluctance personally challenging, largely viewed reluctance as meaningful, to be expected and a productive part of therapy.

As someone in a trainee position, it was an exciting prospect to be able to interview accredited schema therapists about their views and experiences of chairwork. I also felt drawn to hear about their perspectives on client reluctance to chairwork in their practice as I was aware chairwork was something schema therapists use as a core intervention. As part of writing the conceptual introduction and empirical paper, I also looked forward to being able to read and immerse myself in the chairwork and schema therapy literature.

Research context

Despite being an evidence-based treatment for personality disorders, ST teaching is not routinely offered in UK clinical psychology training courses and services (NICE, 2009). Across trainee clinical psychologists, there is evidence of a desire to use ST but barriers to using training on placement, such as a lack of knowledge of ST across clinical supervisors (Kingston et al., 2014). In my experience of reaching my final placement, I have yet to hear about ST being used in services. The ST literature referenced the challenge of contributing to the evidence base due to the inherent research challenges of studying longer-term treatments for complex mental health difficulties (Bakos et al., 2015). Many systematic reviews on ST highlighted quality issues within the ST evidence base (Taylor et al., 2017; Peeters et al., 2022). Similarly to ST, chairwork is not routinely offered as part of clinical psychology or CBT training programmes, despite experiential methods being possibly more effective for cognitive and emotional shifts than traditional cognitive methods alone (Pugh et al., 2021a). Chairwork can be used across modalities, in supervision and for supporting various symptoms and difficulties (Pugh & Margetts, 2020; Pugh & Salter, 2018). It does not have to be a longer-term treatment, with growing evidence for single-session chairwork (Pugh, 2021b). Despite this, CBT therapists have highlighted a lack of opportunities to receive supervision for chairwork

and access to training (Pugh et al., 2021a). It, therefore, felt necessary to contribute to the ST and chairwork evidence base to improve services provision and training opportunities for therapists.

Self-reflexivity

There are multiple approaches to thematic analysis (Braun et al., 2016). In RTA the researcher's subjectivity is highlighted (Braun & Clarke, 2021). Researchers are socially located and will bring their subjectivity to each stage of the research to construct meaning (Giampapa, 2011). With this perspective, my subjectivity was viewed not as a source of threat and bias to be removed but as a resource (Braun & Clarke, 2023a). I coded and developed themes using an inductive and deductive orientation to the data. The critical-realist stance to RTA highlighted that data collected will be co-constructed and interpreted realities situated by language, historical, political, and cultural contexts (Braun & Clarke, 2022). I aimed to develop data-driven codes and themes so I could stay close to the participant's subjective experience and meaning of reluctance to chairwork and what influences their responses. I was entering all the RTA stages, having learnt about ST and chairwork theory. Therefore, it would be inevitable that I would be interpreting the data with a theoretical lens as well, which is a deductive approach (Braun & Clark, 2022). Therefore, RTA felt an appropriate method to explicitly position my subjectivity in the research and acknowledge a continuum of inductive-deductive reasoning to coding and theme generation (Braun & Clarke, 2023c).

An assumption that I came into the research with was that client reluctance would be viewed negatively, perhaps as something to minimise as much as possible. I realised this in my research journal and therefore tried to remain aware of other ideas that may be different to my own. Something that struck me was therapists' own changes in perspectives about reluctance, for example, taking a more relaxed, creative approach and recognising it takes time to develop a relationship. There were also positive perspectives of reluctance being meaningful and helpful for client formulations.

Interpretation is also situated within the wider context which will influence how the researcher makes sense of the data (Braun & Clarke, 2022). As I went through the interview process, I reflected on the importance of context. In my context, as someone positioned in a public national health service (NHS) role in England, time is often pressured, with a focus on delivering short-term evidence-based interventions. I have not had the experience of working with a client for longer than 6 months. I learnt that almost all participants worked privately in different countries, therefore worked in a very different organisational context to myself. Many of the participants shared that they worked with the same clients for years in private practice. Therefore, participants did not necessarily share my initial assumption that there would be pressure to overcome reluctance to chairwork as quickly as possible to progress in therapy. I only spoke with one participant who shared her experiences of working in a public health setting and why that can add challenges for example, when managing a caseload and tiredness from the demands of the work context. It made me wonder about the sample I had recruited and how there may be limitations; for example, private practitioners have fewer restrictions on practice (Singh et al., 2023). Future research could benefit from exploring client reluctance to chairwork in the public sector to address whether the experience of reluctance is the same or different in the public sector.

Methodological considerations

Becoming a research interviewer

Something that I reflected on doing the research process was the different roles of leading a clinical interview versus a research interview. Prior to beginning interviews, I completed a pilot interview with a research supervisor who was not involved in the design of the initial research questions to gain some feedback. This was invaluable for preparing for research interviews. Pilot interviews allow the researcher to test the clarity of questions, and build on important interview skills such as active listening (McGrath et al., 2019).

I had some concerns about interviewing schema therapists as I had assumed that as a researcher I should be more knowledgeable of the topics being questioned. I felt uncomfortable that I was coming into the interviews without much knowledge and experience of ST and chairwork as this was prior to completing the required reading for the conceptual introduction. Considering these power dimensions with my supervisor following the pilot interview was helpful in considering these dynamics ahead of the interviews (McGrath et al., 2019). I was relieved to learn that as a researcher taking a curious approach, not an expert approach, is helpful in encouraging the participant to expand on their ideas and perspectives. This meant I would need to talk less than I normally would in a clinical interview, write fewer notes and focus on active listening (McGrath et al., 2019). A curious approach fits with non-positivist qualitative research such as RTA, in that it is fundamental that researchers do not assume one version of knowledge and reality (Clarke & Braun, 2013).

I also learnt to steer clear of too much 'summarising' and adding ideas to what the interviewee is saying, as I may do in my clinical practice. This is because of the importance of helping the participant to share and expand on their ideas. My supervisor gave me plenty of tips on how to dig deeper in interviews and help someone expand on what they have just said, such as simple follow-up questions like "I'm interested to hear more about what you meant by x?". I reflected that in the pilot interview, there were times that I had assumed what my supervisor meant by certain words or ideas, so it was helpful to improve my research interview skills to gather more information about an individual's unique meaning. Following the pilot interview, I was able to refine some of the questions and consult with my primary supervisor based on my experiences of delivering the interview and feedback. An example is, including an "anything else you would like to add?" question, this later in the interviews led to lots of interesting points from participants and often extended the interviews. Overall, the pilot interview was a key factor in refining the quality of the interview.

Therapist interviewing therapists

Throughout the process, I was aware of the multiple insider positions I shared with participants and outsider positions I did not share (Gallais, 2008). As previously discussed, I was aware of the possible power dynamics of interviewing participants who I felt were more experienced and knowledgeable in the topics discussed. I was also aware that I might be viewed as a peer which could result in participants not wanting to share particular topics due to fears of being judged for clinical decisions (Chew-Graham et al., 2002). During interviews, participants sometimes asked me if I had experienced similar things or participants understandably assumed, I was a schema therapist and experienced in chairwork. I found that reminding them I was curious and interested in their perspectives and experience helped me respond to questions such as these. Many participants shared their experiences from personal therapy and times when reluctance strongly impacted them emotionally. This was perhaps a positive sign that I had developed a good rapport with participants for them to be open about personal experiences. I also felt that whilst it was a research interview, my clinical skills helped me guide and respond to emotional content.

I noticed benefits and challenges with my professional position being similar in some senses (a therapist) and different in others (not qualified or practising ST/chairwork). My similar professional position meant participants at times believed I would resonate with certain topics and perhaps this made the participant feel safe to share experiences, for example, when discussing times they didn't feel confident as a therapist managing reluctance. On the other hand, I quickly noticed after the first few interviews that resonating with topics might result in more assumptions regarding aspects of participants' experience, which can limit my ability to explore areas further. Researchers who are not professionals in the topic area have the benefit of being able to approach the interview from an unknowing position which can result in asking more questions and getting further detail from participants (Coar & Sim, 2006). I noticed that I was asking more follow-up questions about something which was novel to me. Reflecting on this, I ensured that in future interviews I remained curious about aspects of the participant's experiences that I also could relate to.

Generating topics, not themes

When reviewing my candidate themes with research supervisors, they identified that I had fallen into a common RTA pitfall of confusing themes and topic summaries (Braun & Clarke, 2021). This was problematic because topic summaries do not fit with the conceptual underpinnings of RTA, which is to tell interpretative stories (Braun & Clarke, 2022). Upon discussion, reading and reflection there were signs that I had gathered topics instead of themes in this initial attempt at theme generation. Signs included having a long list of themes, superordinate themes strongly linked to interview questions and single-word theme names (Braun & Clarke, 2023b). I believe I had fallen into this problem for several reasons. As this was my first time doing a RTA, understandably, my inexperience in qualitative methods may impact the quality of my data analysis. Upon coding the data, I was overwhelmed by the number of interesting ideas participants shared and wanted to capture it all which lead to too many subthemes, another sign of generating topics and not themes (Braun & Clarke, 2022). Partly, I may have been rushing the data analysis due to tight deadlines, which meant I prematurely closed the analysis meaning I only produced superficial results (Connely & Peltzer, 2016). This realisation was frustrating and disappointing as it meant I would need more time. However, it allowed me to rethink my analysis and think more deeply about what a theme is and how I can generate them. Topic summaries tend to cluster observations and are often mapped closely to the interview questions (Braun & Clarke, 2023a). On the other hand, themes are uniting central meaning (Braun & Clarke, 2022). I reconsidered about thinking what the meaning and importance of the topic described. Using the expertise of my supervisors and further reading, I was able to learn from this error and more carefully and thoughtfully generate my themes following this. Following this process, I observed that the themes generated were more related to united meaning and interpretive stories. There were also fewer subthemes which are associated with quality and depth in comparison to many subthemes (Braun & Clarke, 2023b). In future, I would spend more time prior to analysis reading about how to ensure quality analysis for the specific analysis of choice. I also

acknowledge that identifying mistakes such as these also led to some interesting discussions with the supervisory team and deeper learning of RTA. Having to take steps back to refine themes is a normal part of the RTA journey; by reviewing and redirecting the analysis, the researcher can go down a more helpful path for quality analysis (Braun & Clarke, 2022).

Upon reflection, it also may have been helpful to use the opinions of research supervisors to compare insights on the coding process. The use of multiple coders to gain inter-rater reliability was not used as it is more in line with positivist assumptions consistent with coding reliability thematic analysis where research subjectivity is viewed as a risk to quality that needs to be minimised (Boyatzis, 1988). This is not compatible with RTA assumptions of coding being an interpretative practice (Braun & Clarke, 2023a). On the other hand, multiple researchers can be used in line with RTA assumptions to build insight and enhance understanding in the coding process rather than to agree on codes (Braun & Clarke, 2023b).

Implications for training providers

Overall, the present study and past research highlighted reluctance to chairwork as an important topic in chairwork practice, ST therapy and other modalities that use chairwork (Muntigl et al., 2020; Stiegler et al; 2018). There was a range of factors influencing participants understanding, experiences and responses. A better understanding of how reluctance is experienced and navigated can contribute to therapist training (Muntigl et al., 2020).

Clearly, there are many ways to understand and respond to reluctance to chairwork. Holding this in mind, training providers could consider implementing reluctance into the training syllabus to allow opportunities for trainees to understand client reluctance to chairwork and allow a space for open discussions about reluctance. Having reluctance named at training may offer to normalise this experience and increase confidence in responding when it occurs, perhaps resulting in the therapist's ability to remain in healthy adult mode. In line with chairwork's psychodrama roots, training could highlight the role of the therapist's creativity and spontaneity, which means there is a range of possible responses to adapting in navigating

reluctance to chairwork (Giacomucci, 2021). Participants highlighted how important peers and supervisors were for generating ideas. Therefore, group discussion on reluctance to chairwork may be a helpful way to gain emotional support from peers and build confidence (Napel-Schutz et al., 2017).

Offering opportunities to practice responding to reluctance, such as behavioural response training and case discussions, could allow trainee therapists to test out navigating reluctance and feel more equipped to manage challenging client scenarios (Beidas et al., 2014; Pugh et al., 2021b). Experiential learning, such as role plays of reluctance scenarios, can help build skills, gain feedback, and understand one's own reluctance to techniques (Napel-Shutz et al., 2017; Qui et al., 2020). Training can offer therapists the scaffolding to help therapists learn about client reluctance to chairwork. Finally, therapists valued knowing signs of their own schema and mode activation. Whilst in line with previous research, personal therapy may be helpful for an in-depth awareness of one's own early maladaptive schemas and mode activation; supervision was highlighted as a useful place to unpick instances of mode activation and to help therapists to come back to their healthy adult mode (Pilkington et al., 2022). Training providers could also offer trainees support on how to engage in self-practice and self-reflection to build awareness of mode activation (Farrel & Shaw, 2017). Using chairwork in supervision to role-play challenging client reluctance scenarios was also described as productive and helpful for gaining confidence in chairwork (Pugh & Margetts, 2020). Overall, the research highlighted the importance of putting reluctance to chairwork on the training agenda for chairwork, ST courses and supervisor courses.

Conclusion

During the research process, I considered the impact of researcher subjectivity on the development of the project and all stages of the RTA. Using a reflexive journal, I was able to state my assumptions and personal experiences and how these interacted with the research. I developed my research interview skills to adapt from being a clinical interviewer to a research interviewer and consider the impact of my professional identity on the interview process.

Finally, the study had important implications for training providers of schema therapy and chairwork to help support schema therapists understand and manage client reluctance to chairwork, thus improving the quality of treatment offered to clients.

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Appendices

Appendix A: Early Maladaptive Schemas and Schema domains

Domain 1: Disconnection and rejection

Related needs: safety, connection, acceptance, care

Emotional deprivation: Individuals often struggle to get close to others and access support.

Social isolation/alienation: Individuals will feel they do not belong and are different from others.

Emotional inhibition: Individuals will find it unpleasant to express emotions and may label them unimportant or unrequired.

Defectiveness/shame: Individuals will feel they do not deserve respect, care and love from others. They will typically experience feelings of inferiority and being unwanted.

Mistrust/abuse: Individuals will fear being embarrassed, humiliated, or abused by others.

Domain 2: Impaired autonomy and performance

Related needs: autonomy, competence, identity and performance

Dependence/incompetence: Individuals will feel helpless and require others' help in their daily tasks and responsibilities.

Failure: People will feel they are less intelligent and able than others. It is commonly associated with perfectionism.

Subjugation: Individuals will focus their attention and adapt their behaviours to meet the needs, opinions and ideas of others needs rather than their own.

Abandonment/instability: An individual will constantly worry about loss and abandonment by others and believe relationships do not last.

Enmeshment/undeveloped self: Individuals will experience a weak sense of identity, struggle to form opinions, and need reassurance to make decisions.

Vulnerability to harm and illness: Individuals will display exaggerated fears and worries around illness, natural disasters and tragic events.

Domain 3: Impaired limits

Related needs: Realistic limits, self-control

Entitlement/grandiosity: Individuals will have difficulties with accepting limits and feel as though they are superior to others. They tend to self-aggrandise, feel entitled, and seek power and control.

Approval-seeking/recognition-seeking: individuals will focus on others' opinions of them and will want others to have a good impression. They will focus behaviours on receiving approval and appreciation from others and will struggle to identify their own needs.

Insufficient self-control/self-discipline: Individuals will struggle with delayed gratification, patience and perseverance.

Domain 4: Excessive responsibility & standards

Related need: Balanced standards and responsibilities

Self-sacrifice: individuals will focus on identifying the needs of others and attending to those and will experience feelings of guilt when focusing on their own needs.

Unrelating standards/hyper-criticalness: individuals tend to set ambitious goals, feel under constant pressure to achieve them, and set high standards for everything they do.

Punitiveness: Individuals will feel others, and themselves should be punished when mistakes are made.

Negativity and pessimism: Individuals will focus on the negatives, expect problems in all situations, and often feel anxious.

Appendix B: Mode list with descriptions

Child modes
Vulnerable child: the abused, rejected, abandoned, and deprived child. Feeling lonely, misunderstood, sad, isolated, uncared for and powerless. For example, believing others are dangerous. Angry child: feelings associated with being enraged, frustrated, humiliated or betrayed by the vulnerable child's unmet needs. For example, expressing anger in outbursts. Impulsive/undisciplined child: acting on desires and focusing on short-term gratification. Feelings of anger when unable to engage with impulses and desires. Happy/content child: when emotional needs are being met. Feelings of being loved, protected, accepted, understood and validated and being able to be adventurous and respond spontaneously.
Maladaptive coping modes
Compliant surrender: behaving in a passive and submissive way. Approval-seeking behaviours due to fears of rejection or conflict and not expressing healthy needs or desires. Detached protector: inability to connect emotionally with others and cutting off from needs and emotions, viewing them as dangerous and overwhelming. Feelings of disconnection, withdrawal, boredom, disinterest, and emptiness. Over-compensator: behaviours that are aggressive, dominant, competitive, and controlling. Behaving in extreme ways to avoid others hurting or controlling them. May show concerns around status.
Maladaptive parent modes
Punitive parent: strong beliefs of others and themselves needing to be punished or blamed. An internalised parent who punished child modes as bad. Behaviours towards self and others tend to be blaming, shaming, critical, punishing and abusive. Demanding or critical parent: concern, pushing and pressure to achieve high standards or perfection. Putting others' needs before their own and negative beliefs around expressing feelings or acting playfully and spontaneously.
Healthy adult mode
Healthy adult: can validate the vulnerable child and set reasonable limits for angry and impulsive child mode. Ability to perform the required tasks of adulthood, whilst pursuing pleasurable activities. Behaviours are aimed at maintaining positive wellbeing and relationships.

Note. Adapted from “Schema therapy”, by Martin, R., & Young, J. Dobson, K. *Handbook of Cognitive Behavioural Therapies* (p.332) 2010, West Sussex, UK. Copyright 2010 by The Guildford Press.

UCL RESEARCH ETHICS COMMITTEE
OFFICE FOR THE VICE PROVOST RESEARCH

12th July 2022

Dr Matthew Pugh
Faculty of Brain Sciences
UCL

Cc: Natalie Halls

Dear Dr Pugh

Notification of Ethics Approval with Provisos
Project ID: 22119.001
Title: How do schema therapists experience and navigate client-related challenges during chairwork?

I am pleased to confirm that your study has been ethically approved by the UCL Research Ethics Committee until **12th July 2023.**

Ethical approval is subject to the following conditions:

Provisos

- Please ensure permission is granted by The Internal Society of Schema Therapy Group for circulating research recruitment information to group members, if required.
- Please add the ethics ID number to the consent form and Participant Information Sheet.
- Please include in the Participant Information Sheet that you plan to use anonymised/pseudonymised quotes from the interview in the future reports and publication. Direct quotes are often difficult to anonymise fully and participants can often identify themselves, rendering such quotes pseudonymous, and publishers can require consent to publish direct quotes.

Notification of Amendments to the Research
You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form' - https://www.ucl.ac.uk/research-ethics/responsibilities-after-approval

Adverse Event Reporting – Serious and Non-Serious

It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol.

The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Final Report

At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

In addition, please:

- ensure that you follow all relevant guidance as laid out in UCL's Code of Conduct for Research
- note that you are required to adhere to all research data/records management and storage procedures agreed as part of your application. This will be expected even after completion of the study.

With best wishes for the research.

Yours sincerely

Professor Michael Heinrich
Joint Chair, UCL Research Ethics Committee

Appendix D Consent form

CONSENT FORM FOR THERAPISTS IN RESEARCH STUDIES

Please complete this form after you have read the Information Sheet.

Title of Study: How do schema therapists experience and navigate client-related challenges during chairwork?
Department: Department of Clinical Psychology
Name and Contact Details of the Researcher: Natalie Halls [redacted]
Name and Contact Details of the Principal Researcher: Dr Matthew Pugh [redacted] Prof Lucy Serpell [redacted]
Name and Contact Details of the UCL Data Protection Officer: Alexandra Potts [redacted]

This study has been approved by the UCL Research Ethics Committee: Project ID number: 22119.001

Thank you for considering taking part in this research. The person organising the research must explain the project to you before you agree to take part. If you have any questions arising from the Information Sheet or explanation already given to you, please ask the researcher before you decide whether to join in. You will be given a copy of this Consent Form to keep and refer to at any time.

I confirm that I understand that by ticking/initialling each box below I am consenting to this element of the study. I understand that it will be assumed that unticked/initialled boxes means that I DO NOT consent to that part of the study. I understand that by not giving consent for any one element that I may be deemed ineligible for the study.

		Tick Box
1.	I confirm that I have read and understood the information sheet for the study.	
2.	I am aware that I can email and discuss any questions or concerns with Natalie Halls on [redacted]	
3.	I understand that the information I provide about myself and my clinical practice will be used for research purposes	

4.	I understand that personal information will be collected and will remain confidential and that all efforts will be made to ensure I cannot be identified, including in any publication. I understand that direct quotes from interviews will be used in the future reports and publication.	
5.	I understand that my data will be stored securely and that my contact details will not be shared with any third parties or be used for any purposes except for those I explicitly agree	
6.	I consent to my interview being audio recorded and understand that the recording will be deleted immediately following transcription and analysis	
7.	I understand that my participation is voluntary and that I am free to withdraw at any stage without giving reason (I do not have to finish the interview)	
8.	I understand that whilst the study is open for recruitment, I will be able to withdraw my data without giving a reason by emailing my request to [redacted]	
9.	I confirm that I am an ISST accredited provider of schema therapy, either at Standard or Advanced level	
10.	I understand that I will not benefit financially from this study, however a £20 contribution will be made to DEC Ukraine Humanitarian Appeal as a result of my participation	
11.	I consent to voluntarily take part in this study	

If you would like to be informed of the results of the study, please provide your contact details below

	Yes, I would like the results sent to me	
	No, I would not like the results sent to me	

If yes, preferred contact address for the results of the study (email or postal address)

_____

_____ _____ _____

Name of participant Signature Date

_____ _____ _____

Name of researcher Signature Date

Appendix E Participant Information Sheet

Participant Information Sheet For Schema Therapists

UCL Research Ethics Committee Approval ID Number: 22119.001

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: How do schema therapists experience and navigate client-related challenges during chairwork?

Department: Clinical Psychology

Name and Contact Details of the Researcher: Natalie Halls [redacted]

Name and Contact Details of the Principal Researcher: Dr Matthew Pugh [redacted]

1. **Invitation Paragraph**

   You are being invited to take part in a research project. Before you decide it is important for you to understand why the research is being done and what participation will involve. Please take the time to read the following information carefully. Take your time to read the following information carefully. If there is anything that is not clear or you would like further information, do contact Natalie Halls on [redacted]

2. **What is the project's purpose?**

   Chairwork is a powerful method of intervention, and represents a key technique in schema therapy. However, relatively little is known about how therapists understand and respond to client concerns, resistances, and objections to chairwork during schema therapy.

   This research aims to explore how schema therapists understand client-related concerns and objections to chairwork, how they navigate these challenges during schema therapy, and how they make sense of the impact of these experiences, both professionally and personally.

   It is hoped that this study will provide therapists, supervisors and trainers in chairwork with valuable insights and understandings, identify training needs, and contribute to more effective practice.

3. **Why have I been chosen?**

   You have been invited to take part because you are an accredited provider of schema therapy (either at standard or advanced level) and use chairwork in your schema therapy practice.

4. **Do I have to take part?**

   It is up to you to decide whether or not to take part in this study. If you decide to take part, you will be asked to sign a consent form which acknowledges that you have read this sheet and

agree to participate. You can withdraw from this study at any time without giving a reason. If you decide to withdraw, you will be asked what you wish to happen to the data you have provided up to that point.

5. What will happen to me if I take part?

You will be invited to a one-to-one video interview with the researcher over a secure tele-conferencing platform (Microsoft Teams). This interview is estimated to take around 30 minutes, although it may take up to 60 minutes. You will be asked questions around your experiences of delivering chairwork in the context of schema therapy, in particular your experience of client objections and related challenges when using these methods.

6. Will I be recorded and how will the recorded media be used?

Yes, the interview will be recorded and transcribed. Any information you provide will only be used for the sole purpose of this study. Any information which might identify you as an individual will be removed from the transcription of your interview. Pseudonymised direct quotes from interviews will be used in future reports and publication. No other use will be made of your interview data without your written permission, and no one outside the project will be allowed access to the original recordings or transcriptions. All data collected for the purposes of the study will be destroyed once the analysis has been completed.

7. What are the possible disadvantages and risks of taking part?

There may a risk that discussing and reflecting on challenging clinical experiences may feel uncomfortable. There may also be the burden of taking the time to participate in the study. Any unexpected discomforts, disadvantages and risks to participants, which arises during the research, should be brought immediately to the researchers attention.

8. What are the possible benefits of taking part?

Being given the opportunity to discuss and reflect on clinical practice and explore important clinical interactions of detail may be a benefit for the participant. Other benefits include:

- Provide useful information to the literature of chairwork which will guide future training providers of training needs
- Provide therapists in the field and their supervisors the chance to explore this common experience of objections and seek guidance
- Implications on the development of schema therapy and chairwork as an approach and intervention
- For every interview we conduct we will be giving a £20 donation to DEC Ukraine Humanitarian Appeal, so each interview will provide a unique and additional contribution to the charity

9. What if something goes wrong?

If you have any concerns about the research or would like to make a complaint, the first person to contact would be the principle researcher or their supervisor. However, if it is felt this has not been handled to your satisfaction, the Chair of the UCL Research Ethics Committee can be contacted on [redacted]

10. Will my taking part in this project be kept confidential?

All interviews will be voice recorded and recordings will be stored on a passworded protected encrypted recording device and on a password protected laptop. Any recordings will be destroyed once transcription and analysis are complete. Interview transcriptions will have any identifiable information removed and all personal data collected will be kept separate to interview transcriptions. All the information that we collect about you during the research will be kept strictly confidential. You will not be able to be identified in any ensuing reports or publications.

11. Limits to confidentiality

Please note that your confidentiality will be strictly adhered to unless there are concerns about potential harm to yourself or another person as a result of something you have disclosed. In such cases, the University may be obliged to contact a relevant third party. Your confidentiality will be respected within the constraints of legal and professional guidelines.

12. What will happen to the results of the research project?

The results will be disseminated and presented in the researcher's doctoral thesis, which forms part of her Doctorate in Clinical Psychology. This will be likely completed in June 2023. It is hoped that the study will be publish within a relevant, peer-reviewed journal. Please note that your personal information will not be reported in any report or publication.

13. Local Data Protection Privacy Notice

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at [redacted]

This 'local' privacy notice sets out the information that applies to this particular study. Further information on how UCL uses participant information can be found in our 'general' privacy notice:

For participants in research studies, click here

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this, and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at [redacted]

14. Who is organising and funding the research?

The research will be funded by University College London.

15. Contact for further information

Any further questions can be directed to Natalie Halls on [redacted] Dr Matthew Pugh [redacted] or Prof Lucy Serpell [redacted]

Thank you for reading this information sheet and for considering taking part in this research study.

Appendix F Interview questions

Introduction

- Introduce self

- Check available for up to one hour

- Check if any questions

Demographic data collection

- Country of residence/practice

- Job role

- Accreditation/qualification in schema therapy (standard/advanced/supervisor)

- Length of practice as a schema therapist

- Age

- Gender

- Ethnicity

Sample interview questions

- What client concerns tend to arise when you use or introduce chairwork?

- How do you understand or make sense of client reluctance to chairwork?

- What does it mean for you when the client says no?

- What are the most common/typical client reluctance to chairwork? Examples

- Have there been any types of reluctance that have surprised you?

- Are some objections/reluctance/blocks more difficult than others?

- Do you have an example of a client reluctant to engage in chairwork which was particularly difficult?

- Do you find any schemas or modes influence the type of objections you get/how you understand them?

- What is it like for you when clients express concerns or object to chairwork?

- How do you respond to client objections?

Ending questions

- Is there anything else you would like to say about the challenges that can arise during chairwork, or anything you feel is in important?

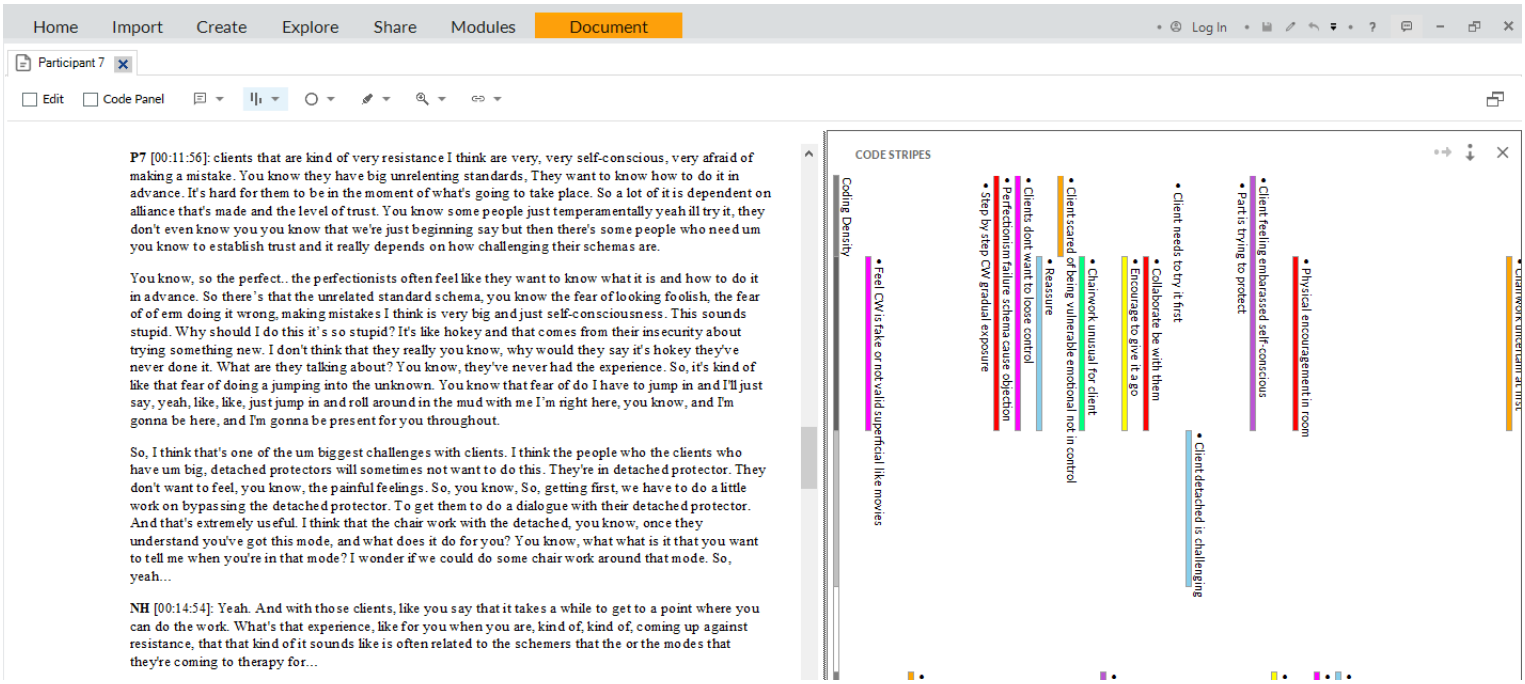
- What would be your recommendations based on your experience to other therapists who may experience client-related concerns or objections to chairwork?

Finishing interview

- Thank participant and remind them money will be donated to charity for participation

- Check any questions/concerns

Appendix G Example of coding interview transcript on NVivo



Appendix H: Organising codes to generate initial themes