An exploration of compassion focused therapy chairwork for clients with depression, self-criticism, and shame

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Sensitivity: Internal

Contents

List of tables	Page 2.
List of appendices	Page 3.
Abbreviations	Page 4.
Statement of intellectual ownership	Page 5.
Abstract	Page 6.
Acknowledgements	Page 8.
Chapter 1. Introduction	Page 9.
Chapter 2. Literature review: Depression, shame, and self-criticism (The problems)	Page 18.
Chapter 3. Literature review: Compassion focused therapy and chairwork (The potential solutions)	Page 53.
Chapter 4: Methodology: Theoretical background	Page 84.
Chapter 5: Methods	Page 103.
Chapter 6: Self-critic study analysis 1.	Page 122.
Chapter 7: Self-critic study analysis 2.	Page 132.
Chapter 8: Multiple-selves study analysis	Page 143.
Chapter 9: Relationship factors analysis	Page 154.
Chapter 10: Discussion	Page 172.
References	Page 227.
Appendices	Separate document

List of tables

Table numbers: the first numeral refers to the chapter number where the table is located; the second numeral refers to the order of the table within the chapter.

Table 2.1 Summary of Major Depressive Disorder in DSM-5
Table 3.1. Principles and process of chairwork (adapted from Pugh and Bell, 2020)
Table 3.2. Forms of chairwork dialogue (adapted from Pugh & Broome, 2020; Pugh & Bell, 2020)
Table 3.3. Steps within the two-chair self-compassion task (adapted from Bell, 2022).
Table 5.1. Overview of studies
Table 5.2. Intervention outline for study 1: self-criticism chairwork
Table 5.3. Intervention outline for study 2: multiple-selves chairwork
Table 5.4. Interview schedule for study 1
Table 5.5. Interview schedule for study 2
Table 5.6: Participant characteristics from study 1: self-criticism
Table 5.7. Participant characteristics from study 2: multiple selves
Table 5.8. Measures: participant sample and norms
Table 5.9. IPA analytic stages (adapted from Smith et al., 2009)
Table 6.1. Summary of themes and occurrence for self-critic study analysis 1
Table 7.1. Summary of themes and occurrences for self-critics study analysis 2
Table 8.1. Summary of themes and occurrences for multiple selves analysis
Table 9.1. Summary of themes and occurrences for relationship factors analysis
Table 10.1. Project super-ordinate themes (across all studies)
Table 10.2 Clinical guidelines and practitioner points for CFT chairwork

List of appendices

Appendix 1. Paper 1: “A definite feel-it moment”: Embodiment, externalisation and emotion during chair-work in compassion-focused therapy

Appendix 2. Paper 2: “Suddenly You Are King Solomon”: Multiplicity, Transformation and Integration in Compassion Focused Therapy Chairwork

Appendix 3. Paper 3: Multiple emotions, multiple selves: Compassion focused therapy chairwork

Appendix 4. Ethics study 1 favourable opinion

Appendix 5. HPA approval study 1

Appendix 6. Ethics study 2 favourable opinion

Appendix 7. HPA approval study 2

Appendix 8. Example of initial hand-written notation

Appendix 9. Example of reflective diary when developing case themes for a single case

Appendix 10. Example of case themes developed for a single case

Appendix 11. Example of evidencing themes for a single case

Appendix 12. Example of a single sub-theme from a master-table of superordinate themes (with examples)

Appendix 13. Section of training outlining chairwork steps

Abbreviations

ACE-Adverse childhood experiences

APA- American Psychological Association

BDI- Beck Depression Inventory

CFT- Compassion Focused Therapy

CMT- Compassionate Mind Training

CBT- Cognitive Behavioural Therapy

DSM- Diagnostic and Statistical Manual of Mental Disorders

EFT- Emotion Focused Therapy

FSCRS- Forms of Self-Criticizing/Attacking and Self-Reassuring Scale

HADS- Hospital Anxiety and Depression Scale

HAMD- Hamilton Rating Scale for Depression

HPA- Hypothalamic-Pituitary-Adrenal Axis

IAPT- Improving Access to Psychological Therapies

ICD- International Statistical Classification of Diseases and Related Health Problems

NHS- National Health Service

NICE- National Institute for Health and Care Excellence

OAS- Other as Shamer Scale

PHQ- Patient Health Questionnaire Depression Scale

PHE- Public Health England

SCID- Structured Clinical Interview

SCS- Self-Compassion Scale

SSRIs- Selective Serotonin Reuptake Inhibitors

WHO- World Health Organization

Statement of intellectual ownership

I can confirm this PhD thesis is my own original work. During the completion of this thesis, I have presented my findings in the following publications:

-Bell, T., Montague, J., Elander, J, & Gilbert, P. (2020). ‘A definite feel-it moment’: Embodiment, externalization, and emotion during chair-work in compassion-focused therapy. *Counselling and Psychotherapy Research, 20*, 143-153.

-Bell, T., Montague, J., Elander, J, & Gilbert, P. (2021a). ‘Suddenly you are King Solomon’: Multiplicity, transformation, and integration in compassion-focused therapy chairwork. *Journal of Psychotherapy Integration, 31*, 3, 223–237.

-Bell, T., Montague, J., Elander, J, & Gilbert, P. (2021b). Multiple-emotions, multiple-selves: chairwork in compassion focused therapy. *The Cognitive Behavioural Therapist, 14*, E22.

Whilst supervised in the development of each publication, the writing has all been my own. To the best of my knowledge, the thesis does not contain material from other sources, except where duly referenced in the text.

Abstract

Depression is a leading global cause of disability, impacting on physical, social, and psychological wellbeing. Despite developments in psychological and pharmacological treatments, depression continues to be associated with high levels of chronicity and relapse. One way to understand depression is as a heterogenous syndrome that can take the form of various subtypes and constellations of symptoms. There is the potential to improve client outcomes by developing treatments that target specific processes or symptom clusters in depression. Shame and self-criticism are examples of such processes. They both predict and maintain depression and reduce the effectiveness of evidence-based treatments for depression.

Compassion-Focused Therapy (CFT) was designed specifically for clients with self-criticism and shame and is an integrative psychotherapy based on the scientific application of compassion. A core-component of CFT is 'chairwork', which refers to a collection of experiential psychotherapy methods that utilise chairs, their positioning, and movement between them. One CFT chairwork exercise encourages clients to enact their self-critical dialogue, between different chairs, before bringing compassion to both sides of the internal conflict. Another exercise, known as 'multiple selves', seeks to differentiate multiple threat emotions by using various chairs, allowing clients to explore emotional conflicts and regulate their emotions with compassion. Despite the central role of chairwork in CFT, there has been no previous research on the subject. There is also limited research on client's experience of chairwork as a psychotherapeutic intervention.

This thesis explores the two CFT chairwork interventions mentioned above, and their application for clients with depression, problematic shame, and self-criticism. The research is qualitative in nature and seeks to give voice to clients' experiences and meaning-making regarding the interventions. A total of 21 clients with depression were interviewed after undertaking the chairwork exercises. Their interviews were transcribed and analysed using Interpretative Phenomenological Analysis (IPA).

From the first analysis of data relating to the self-critic chairwork exercise, the following themes were identified: ‘embodiment and enactment’, ‘externalising the self in physical form’, ‘emotional intensity’ (chapter six). The second analysis generated themes of ‘differentiating selves’, ‘mental imagery of selves’, and ‘integrating and transforming selves with compassion’ (chapter seven). The analysis of the multiple selves exercise developed themes relating to ‘appreciating emotional complexity’, ‘the role of chairwork process’, and ‘compassionate integration’ (chapter eight). A final analysis took account of the data-set across both interventions to explore the role of relationship factors in CFT chairwork (chapter nine). The analysis generated themes of ‘being directed and coached’, ‘being seen (bringing the inside out and outside in)’, and ‘being in a caring relationship’.

The results provide insights into the core mechanisms and processes of CFT chairwork and, more broadly, of chairwork as a psychotherapeutic method. The implications for CFT practice and training are discussed and a ‘guidelines for best practice’ has been produced. The results are also discussed in the context of depression, shame, and self-criticism

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Chapter 1: Introduction

This chapter introduces the thesis content and structure. It begins by summarising the background and rationale of the research, focusing on the problems of depression, self-criticism, and shame and the approaches used to treat them, specifically compassion-focused therapy (CFT) and chairwork. This is followed by a reflection on the personal relevance of the study and a justification of the use of interpretative phenomenological analysis (IPA). The chapter then clarifies the research aims and questions before providing an overview of the research methods and implementation. The chapter concludes by outlining the thesis structure in a chapter-by-chapter summary.

The discussion of depression is restricted to 'Major Depressive Disorder' (hereafter 'depression').

Background, rationale, and professional relevance

My first professional exposure to the psychological treatment of depression was as a trainee in the newly formed Improving Access to Psychological Therapies (IAPT) services. IAPT was developed to provide evidence-based psychological treatment for anxiety and depression and is now the predominant provider of psychotherapy in England's National Health Service (NHS). CBT remains the principal therapy offered within IAPT and is typically delivered in a protocol-based, disorder-specific manner. Whilst the remit of IAPT has broadened, CBT treatment was initially provided for eight disorders. Anxiety was addressed in seven disorders, using tailored treatment protocols, whilst depression was not sub-categorised, and its treatment was accordingly uniform. Despite the benefits of IAPT, 60% of people with a depressive episode do not meet 'recovery' criteria following a course of CBT treatment in IAPT services (Gyani et al, 2013). The limited effectiveness of current psychotherapies for depression, and the high level of relapse despite treatment (Vittengl et al., 2007), warrants further research into how psychological treatments for the disorder can be developed or refined.

The notion of 'major depression' as a single homogenous disorder has been repeatedly challenged (Ingram & Siege, 2010; Goldberg, 2011). In diagnosing Major Depressive Disorder,

the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) (American Psychological Association, APA, 2013) requires the presence of five or more symptoms from a list of nine (see chapter 2), with at least one needing to be loss of pleasure or depressed mood. As Irons (2014) highlights, 227 different combinations of symptoms could still attract the same diagnosis, within which there could be a vast array of symptom severity, persistence, and frequency. Depression is also related to a variety of different biopsychosocial pathways, maintenance processes, and comorbidities (Lara & Klein, 1999). As I have seen in my own practice, the diagnosis of depression is equally given to a client reacting with 'agitation' to a recent bereavement as to a client with 'psychomotor retardation' and chronic low mood relating to childhood neglect.

One way of improving treatment outcomes in depression is to target specific symptom constellations and maintenance processes (Forgeard et al., 2011). High levels of shame and self-criticism are examples of such targets. They are both predictive of depression (Powers et al., 2004; Andrews et al., 2002), both act as key mediating factors between childhood adversity and depression (Dunkley et al., 2010; Andrews & Hunter, 2010; Matos et al., 2014), and both play important maintaining roles in the disorder (Yamaguci et al., 2014; Thompson & Berenbaum, 2006). Their presence can also reduce the impact of evidence-based psychological treatments and limit general help-seeking (Hook & Andrews, 2005; Marshall et al., 2008). Self-criticism has also been conceptualised as a specific personality style/dimension (which includes fears of disapproval and over-control) that confers vulnerability to depression, is linked to specific symptom composites, and is associated with depression severity (Blatt, 2004; Luyten et al., 2007). Both self-criticism and shame are, like depression, associated with experiences of insecure attachment and critical/hostile upbringing (Koestner et al., 1991; Passanisi et al., 2015).

CFT is a psychotherapeutic modality designed for the treatment of self-criticism and shame and was originally applied with clients from harsh and emotionally cold or critical backgrounds (Gilbert, 2014). As identified by Gilbert (2009), people with these experiences and backgrounds often have difficulties in generating self-directed warmth, kindness, and compassion. The therapy therefore seeks to develop clients' capacities to give and receive compassion and to experience associated feelings of safeness/soothing (Gilbert, 2010). Frequently this entails working therapeutically with the fears, blocks, and resistance to such experiences. In my own

clinical practice, I took an interest in CFT following the failure of cognitive methods to change my clients' feelings of shame and inherent 'badness', despite being able to dispute the logic of their negative cognitions. As I later discovered, Gilbert (2014) identifies his own encounters with 'rational-emotive dissociation' as the stimulus for creating CFT (see chapter 3). CFT is now a well-established psychotherapy for various mental health problems, demonstrating particular benefit in treating self-criticism and populations unresponsive to traditional approaches (Craig et al., 2020).

To create emotional and motivational change in clients, CFT utilises a variety of experiential methods. One such method is chairwork. Chairwork is a set of action-based practices that use multiple chairs to dialogue between parts of the self or with the representations of others (Pugh, 2020). The approach involves processes and procedures such as personification, embodiment, movement between chairs, and role-reversal (Pugh & Bell, 2021). In CFT, chairwork is fundamentally used to apply compassion to parts of the self experiencing distress (Gilbert, 2010). 'Set pieces' of CFT chairwork include bringing compassion to a self-critical dialogue enacted between two chairs. Another, known as 'multiple-selves', involves generating compassion for various threat emotions, separated onto multiple chairs. Chairwork is known for its emotive, enactive, and relational nature and is often used to address and integrate internal conflict (Kellogg, 2015), making it a medium that complements the core principles and aims CFT. Despite the key role chairwork plays in CFT clinical practice, there was no prior research in this area.

Years of delivering CFT chairwork in my psychotherapy practice has only reinforced my appraisal of its importance. Chairwork is frequently the main intervention that clients value and remember at the end of treatment. It is also the intervention that creates the most change and generates the most fear and resistance. Chairwork fundamentally requires clients to do the extraordinary: to speak to themselves in the form of an empty chair. It also requires clients to change roles, walk about the room, visualise people that aren't there, and embody parts of themselves, like the self-critic, that can be monstrous in character. It is undoubtedly a strange method but also a powerful one, shown to create more therapeutic change when compared to verbal methods (de Oliveira et al. 2012). Whilst research outside of CFT has pointed to

prospective mechanisms of change within chairwork- such as the use of multiple chairs to facilitate metacognitive decentering and broaden self-schema (Chadwick, 2003)- much is still unknown about how the approach works.

For CFT practice, it is of particular interest how clients find self-compassionate dialogues during chairwork and how they can be used to counter threat-based self-relating. From personal observation and client reports, self-compassion is facilitated when a part of the client is externalised, situated in an empty chair, and related to as if it were another person. Such chairwork processes offer a novel means to side-step traditional blocks to self-compassion yet are experienced as highly emotive. Similarly, revealing one's inner workings on the 'stage' of the therapy room can create therapeutic intimacy and shared insight, yet can also trigger the very shame the therapy seeks to address. In terms of depression, I have found that chairwork offers a means to move beneath a client's global inhibition and avoidance, exploring the emotional and relational complexity that underpins it, whilst providing a means to bring compassion directly into their internal world. This project therefore aims to explore the rich multiplicity of client experience during CFT chairwork and identify the salient mechanisms of action when applied to self-criticism, shame, and depression.

Personal relevance

The project has a personal relevance for me. During my adolescence I experienced repeated episodes of clinical depression that resulted in hospitalisations. I was treated with various pharmacological approaches and ultimately with electro-convulsive therapy. Whilst I was offered cognitive-behavioural therapy, I found the presence of self-criticism and shame impeded any benefit, echoing the findings mentioned above.

As my depression improved, and as I have treated depression in other people, I have come to appreciate how complex and multifaceted the problem can be. During later therapy, I was able to see my depression more as a consequence or endpoint of other processes, and as a form of protection to avoid or manage core threats or fears. Whilst medication improved the severity of my depressive symptoms, it didn't help resolve the experiences that prompted the wider systemic collapse. For me, such experiences have included shame and lack of social safeness, blocked

drives for connection and care, and inhibited assertiveness and anger. The work of a life-time! As mentioned above, my professional experience has highlighted a similar complexity of interacting processes and factors that underpin depression in others.

The project is also personally relevant in relation to my own practice of self-compassion. Whilst I have gained some benefit from methods that seek to challenge negative self-beliefs or remove unwanted symptoms, I have found this approach creates further self-antagonism as the difficulties remain or return. In my own life, I have benefitted most from developing a compassionate way of understanding and working with such difficulties, whereby they are tolerated and integrated via self-directed care. My personal hope for the project is that I can improve the way I train and deliver CFT, so that others can experience the same benefits of compassion.

Research approach

A qualitative approach was adopted given the focus on client experience and meaning. The project is concerned with what it is like to undertake the chairwork interventions and what occurs subjectively during its various stages and demands. This includes an interest in clients' experiences of embodiment (e.g., of the angry self), personification (e.g., of the self-critic), externalisation (e.g., of inner relationships), separation (e.g., leaving a 'part' of the self on chair and transitioning to another) and any relational factors that support these processes and procedures. The project is also concerned with how clients make sense of these experiences and what it means to them, what is important and what is learnt about the self, compassion, and the various problems of focus. The area is also under-researched which warrants an exploratory orientation to foster theory development rather than verifying established hypotheses (Willig, 2008).

The methodology chosen was Interpretative Phenomenological Analysis (IPA). The epistemology of IPA is drawn from phenomenological, hermeneutic, and idiographic traditions (Smith et al., 2009). A phenomenological emphasis on the nature and texture of subjective experience is well suited to an intervention that explores and blends a client's inner and outer world, that concretises the imaginal, and that charges movement and space with subjective

meaning. A phenomenological approach also complements the body-based nature of the intervention and its emphasis on multi-sensory and affective processes. Hermeneutic considerations are also apposite for research that seeks to understand and interpret the experiences of clients as they themselves are reflecting on its meaning and significance. IPA requires the acknowledgement of, and engagement with, this 'double-hermeneutic' so that phenomenological description is balanced with interpretative analysis and reflection. IPA's idiographic commitment is also well suited to the project's fore-grounding of individual experience and the aim of capturing nuance, complexity, and granularity beyond the global label of depression. Similarly, the focus on improving treatment by listening to service-users' experience is in line with IPA's emphasis on 'giving voice' to participants' concerns (Larkin et al., 2006).

The theory and practice of IPA, and rationale for choosing this approach, is further expounded in chapter four.

Research question and aims

The research question for the thesis was: 'how do clients with depression, shame, and self-criticism experience chairwork interventions in CFT?'

The study's primary aim was to produce an interpretative phenomenological account of clients' experiences of CFT chairwork to understand what they learnt and valued from the interventions. A secondary aim was to develop an appreciation of which elements of CFT chairwork were the most important for clients with depression, self-criticism, and shame, and how they have their impact. A final aim was to improve the delivery and training CFT chairwork, based on the experiences of the clients interviewed.

Research implementation

To achieve the research aims, two studies were undertaken with clients recruited from a primary care NHS IAPT setting. 12 clients were recruited for the CFT chairwork study for self-criticism. For the multiple-selves chairwork study the initial aim of recruiting 10 clients was reduced to 9 due to Covid-19 restrictions. The clients were interviewed by the researcher immediately

following the chairwork intervention as delivered by their therapist as part of routine treatment. The interviews were recorded and transcribed verbatim and the resultant data was analysed using IPA. As per standard IPA practice (Smith et al., 2009), the clients were analysed on a case-by-case basis, generating superordinate themes for each individual, before producing a group-level analysis that is presented in this thesis. The findings of each study were finally prepared for publication in relevant peer-reviewed journals.

Structure

Chapter two is a literature review of the main problems addressed in the thesis. It begins with a focus on depression, its diagnosis, prevalence, impact, and measurement. The chapter then explores various conceptions of depression, covering biological and genetic, social and relational, evolutionary, and psychological explanations and related research. The section on depression concludes with an overview of its treatment. The chapter continues in a similar format for both shame and self-criticism, covering their definition, various conceptualisations, measurement, impact, and treatment. The relationship between both shame and self-criticism and depression are also reviewed.

Chapter three provides a literature review for the potential solutions to these problems. It begins with CFT: its development, theoretical underpinning, interventions, areas of application, and evidence-base. The chapter then focuses on chairwork: its definition and development in psychotherapy; the principles, processes, and process-skills that support it; its various forms and procedures; and its evidence-base. The final section of the chapter brings the previous sections together in reviewing CFT chairwork and how the method complements the modality's theory and principles. This section provides details of key CFT chairwork interventions and their underpinning rationale. The chapter ends with a reflection on how CFT chairwork can be applied for depression, shame, and self-criticism.

Chapter four focuses on IPA and the epistemological foundations of the methodology used in the thesis. The chapter begins by expanding the rationale for using IPA, before reviewing the three theoretical foundations of IPA: phenomenology, hermeneutics, and idiography. This includes an

overview of key concepts and historical developments, how they relate to the contemporary practice of IPA and to the current study. The chapter concludes by addressing criticisms of IPA.

Chapter five describes the methods used to address the research questions posed above. The chapter first outlines the research design before providing a step-by-step guide to both interventions. This is followed by a description of recruitment and data collection and a report of the participant samples. The chapter then details the analytical process and includes a discussion of reflexivity and validity checks. It concludes with a report of how ethical considerations were addressed in the research.

The following four chapters contain the analysis of the thesis. The analysis presented in chapters six and seven relate to the self-critic exercise. The three superordinate themes presented in chapter six relate to chairwork process and their impact on participants. The themes are: embodiment and enactment; externalising the self in physical form; and emotional intensity (accessing and experiencing emotion, and overwhelming emotion and avoidance). Chapter seven covers themes relating to self-multiplicity and integration. The themes are: differentiating selves (from singular to multiple and developing new selves); mental imagery of selves (the benefit of 'seeing' selves and linking them to memories); and integrating and transforming selves with compassion (moving from conflict to integration, and transforming the critic).

Chapter eight presents the analysis from the multiple-selves intervention. The analysis generated three super-ordinate themes that complement and elaborate the themes of the prior chapters. The themes are: appreciating emotional complexity (multiplicity and differentiation, and the dominance, absence and integration of emotions); the role of chairwork process (embodiment and standing and moving); compassionate integration (the role of empathy and acceptance, and the integration of emotions).

Chapter nine is an analysis of relationship factors from the entire data set. The analysis found numerous factors that inhibited and facilitated the interventions. The themes identified are: being directed and coached (directed in tasks and coached psychologically and emotionally); being seen (concealment and shame, and the benefit of an external perspective); and being in a caring

relationship (the importance of establishing trust and safeness within the therapeutic relationship, the clients' experience of soothing and compassion from the therapist during the intervention). 'Safeness' within CFT is distinguished from 'safety', with the former related to experiences associated with the soothing/parasympathetic system and the latter associated with threat-related defences and protection (Gilbert, 2020). The distinction between the soothing/safeness system and threat/protection system of emotions is explored in chapter 3.

The final chapter, chapter ten, is a discussion of the analysis contained in the prior four chapters, linking participants' experiences to broader literature, research, and theory before clarifying implications and recommendations for research and clinical practice. The discussion addresses the research aims and question posed above, focusing on what can be learnt about the mechanisms of CFT chairwork, what can be learnt about depression, shame, and self-criticism, and what can be learnt about the treatment of those problems with CFT chairwork. Specific recommendations are made for the clinical application, training, and supervision of CFT chairwork based on the findings. The chapter ends with a reflection the research's limitations and suggestions for future research in this area.

Chapter 2: Depression, Shame and Self-Criticism (the Problems)

Introduction

This chapter is a review of literature relating to depression, shame, and self-criticism. It focuses on defining and conceptualising each of these areas, in addition to considering their aetiology, treatment, and interactions. The review is restricted to 'Major Depressive Disorder' (hereafter 'depression') and its occurrence in adults.

This chapter reviews 'the problems' that will be addressed within the overall project. The following chapter (chapter three) will review 'the potential solutions' to these problems, in the form of CFT and chairwork.

Depression

Diagnosis

To diagnose depression the DSM 5 (APA, 2013), requires the symptoms summarised in table 1.

Table 2.1 Summary of Major Depressive Disorder in DSM-5

The individual must be experiencing five or more symptoms during the same 2-week period and at least one of the symptoms should be either (1) depressed mood or (2) loss of interest or pleasure. 1. Depressed mood most of the day, nearly every day (via subjective report or observations of others). 2. Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day. 3. Significant weight loss or weight gain, or decrease or increase in appetite nearly every day. 4. Insomnia or hypersomnia nearly every day. 5. Psychomotor agitation or retardation nearly every day (as observable by others). 6. Fatigue or loss of energy nearly every day.

7. Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
8. Diminished ability to think or concentrate, or indecisiveness, nearly every day.
9. Recurrent thoughts of death (not just fear of dying), recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

These symptoms must cause the individual clinically significant distress or impairment in social, occupational, or other important areas of functioning. The symptoms must also not be a result of substance abuse or another medical condition.

The DSM coding for depression also relates to recurrence, severity, the presence of psychotic features, and whether remission is indicated. Specifiers include ‘peripartum onset’, ‘seasonal pattern’, ‘with anxious distress’, and ‘with mixed features’ (which relates to the presence of ‘manic’ symptoms). ‘Persistent Depressive Disorder (Dysthymia)’ is also included in the DSM-V (APA, 2013) and relates to chronic and recurrent depressive experiences (i.e., over two years). The International Statistical Classification of Diseases and Related Health Problems (ICD-10) (World Health Organization, WHO, 2016) similarly categorises depression via severity and the presence of psychotic symptoms, whilst drawing a distinction between recurrent and persistent forms.

The standard diagnostic categorisation of depression has been criticised for focusing on the number and severity of symptoms rather than on particular clusters or constellations that might represent distinct subtypes. As highlighted by Irons (2014), the same diagnosis of depression might be given to a vast number of symptom variations, which gives the impression that such symptoms are interchangeable and equally indicative of the same underlying condition. In a challenge to the conception of depression as a unified syndrome, Fried and Nesse (2015) identified hundreds of unique symptom profiles in clients with depression, whilst Keller and Nesse (2006) found that different life events led to different constellations of symptoms. The diagnosis of depression also contains inherently opposite features (e.g., both increased and depressed appetite) and can be triggered by an array of factors varying from substance use, bereavement, and physical illness (Rantala et al., 2018). There is also potential that by organising

depression into distinct subtypes and symptom clusters, treatment could be tailored and specialised to target specific profiles, causes, and processes in depression (see discussion of shame and self-criticism below) (Ingram & Siegel, 2010; Rantala et al., 2018).

Prevalence and impact

The WHO (2017) estimates 4.4% of the global population has depression, with the total number of people living with the disorder predicted to be 322 million. The total number of people living with depression globally has increased by 18.4% between 2005 and 2015 (WHO, 2017). Life-time prevalence of Major Depressive Disorder was found to be 16.9% in the US with a 12 month prevalence of 10% (Kessler & Bromet, 2013). There are significant differences reported across national surveys: for example, Weisman et al. (1996) found lifetime prevalence of depression varied from 1.5% (Taiwan) to 19% (Beirut). Lifetime prevalence of depression is higher in high-income countries (14.6%) when compared to countries with low- to middle-incomes (11.1%) (Bromet et al., 2011). It has been argued that cross-national differences might be influenced by varying thresholds used at diagnostic interview (Kessler & Bromet, 2013).

The average age of onset for depression is early to mid 20s, with a peak risk period between mid-late adolescence and early 40s (Kessler et al., 2007). The prevalence of depression generally decreases with age in Western countries (Weissman et al., 1996), but increases with age in low-middle income countries (Kessler et al., 2010). Women suffer from depression approximately twice as commonly as men (Van de Velde et al., 2010; Bromet et al., 2011). The prevalence of depression is also increased in individuals who are separated or divorced as opposed to married (Andrade et al, 2003) and in people who have never married (Kessler & Bromet, 2013). WHO surveys suggest that individuals with the lowest income in high income countries (e.g., France, Germany, and the US) have a two-fold increased risk of depression, whilst in low-middle income countries, income is not related to risk of depression (Kessler & Bromet, 2013).

The course of depression is 'markedly heterogenous' (Klein & Allmann, 2014, p.64), but an average duration for a depressive episode is 20-30 weeks in both clinical and non-clinical samples (Keller et al., 2013). However, the longer the episode of depression the lower the probability of recovery, and for 10-20% of people an episode becomes chronic (Keller et al.,

2013). Cross-sectional surveys suggest that between one-third and two-thirds of people with lifetime depression will have recurrent episodes in a given year (Hardeveld et al., 2010; Bromet et al. 2011). With each recurrence of depression, the risk of additional recurrences increases and the interval between episodes shortens (Eaton et al, 2008). On average, a person with depression is likely to have five to nine episodes over their lifetime (Burcusa & Iacono, 2007). Early onset depression (childhood or adolescence) is associated with increased likelihood of future episodes (Rao et al., 1999) whilst late onset depression is linked with faster relapse rates and poorer prognosis (Mitchel & Santiago, 2009).

People with depression also have a high likelihood of being diagnosed with a comorbid anxiety disorder. 58% of people with lifetime depression have a lifetime anxiety disorder, and 51% of people who had depression in the past 12 month period also had an anxiety disorder (Kessler et al., 1996). For children and adolescents, this rises to 75% (co-morbid depression and anxiety) (Kessler et al., 2001). Of note, depression is often secondary to other disorders, with one survey finding that 75% of cases of depression occurred following another disorder (Robins et al., 1991). Depression and medical illness co-occur frequently, with Freeland and Carney (2010) suggesting a bi-directional influence in terms of causation and impact. Links have been made between depression and illnesses such as cardiovascular disease and cancer (Katon, 2011). This 'two-way street' between depression and physical illness is linked to poorer prognosis and increased mortality rates (Muskin, 2010). 12-month prevalence studies in World Health Surveys (Moussavi et al., 2007) found 9.3-23% of respondents with chronic health conditions have comorbid depression.

On a global scale, major depressive disorder is one of the leading causes of disability (Vos et al., 2015), with the WHO (2017) estimating that 'depressive disorders are ranked as the single largest contributor of non-fatal health loss' (p.15). On a societal level, depression is highly associated with days 'out of role' (with the most influence of all mental health disorders) and low work performance (Alonso et al., 2011; Collins et al., 2005). Whilst loss of employment has been identified as a risk factor for depression (Zuelke, et al., 2018), the reverse is also true (Dooley et al., 1996). Early onset depression (childhood or adolescence) is associated with a variety of negative outcomes including early termination of education, unemployment, and work disability

(Fergusson & Woodward, 2002; Breslau et al., 2008). Multinational studies show premarital depression predicts divorce across cultures (Breslau et al., 2011) and depressive symptoms have been linked to marital dissatisfaction (Whisman, 1999). Depression has also been associated with negative parenting behaviour (Lovejoy et al., 2000) which can impede child development (Tronick & Reck, 2009).

Measurement

Clinician ratings for depression include the Hamilton Rating Scale for Depression (HAMD, Hamilton, 1960). It contains 21 items, of which only 17 are scored, based on a semi-structured interview. Whilst a popular measure, its 'gold standard' status has been challenged. Criticism focuses on inconsistencies in inter-rater and retest reliability at item level and its low correlation with the Structured Clinical Interview for the DSM Axis 1 disorders (e.g., Bagby et al., 2004). The SCID-5 for DSM V (First et al., 2016) offers a standardised interview for differential diagnosis, linked to specific diagnostic criteria. It requires specialist training to administer and can be time consuming to complete (up to 90 minutes). The SCID-5 has been found to have excellent validity and high specificity and clinical validity (Osorio et al., 2019).

One of the most widely used self-report measures is the Beck Depression Inventory II (BDI, Beck et al., 1996). The original measure (Beck et al., 1961) was revised to reflect changes to the DSM. The measure contains 21 items that identify symptoms of depression over a two-week time-frame and can be split into two factors: cognitive and somatic-affective. It has strong test-retest reliability and high internal consistency (Beck et al., 1996) and has been validated in primary care settings (Arnau et al., 2001). Other validated self-report measures include the Hospital Anxiety and Depression Scale (HADS) (Zigmond & Snaith, 1983) and the Patient Health Questionnaire Depression Scale (PHQ-9, Kroenke & Spitzer, 2002). Based on the DSM-IV's nine symptoms of depression, the PHQ-9's scores range from 0-27 and includes cut off points for mild (5), moderate (10), moderately severe (15) and severe depression (20). The measure forms part of the dataset used within the NHS Improving Access to Psychological Therapies (IAPT) services for local and national monitoring (National IAPT Programme Team, 2011). The PHQ-9 has acceptable test-retest reliability and internal consistency (Kroenke et al,

2001) and is a valid method for identifying both major depression and ‘subthreshold depressive disorder’ in the general population (Martin et al., 2006).

Conceptualisations

The following section provides an overview of the varied explanations of depression, focusing on biological and genetic, social and relational, evolutionary, and psychological conceptualisations.

Biological and genetic

Neurobiological explanations and treatments of depression have focused on the role of monoamine neurotransmitters, specifically serotonin, noradrenaline, and dopamine. Since the 1950s, monoamine neurotransmitters have been linked to mood and depression, based on the serendipitous discovery that certain physical health medications which influenced the breakdown of monoamines also impacted mood. By the mid-1960s, the first generation of antidepressants- tricyclic antidepressants and monoamine oxidase inhibitors (MAOIs)- were created to alter levels of serotonin and norepinephrine (Thase et al., 2014). Later, a third monoamine, dopamine, was linked to depression and symptoms such as fatigue and psychomotor retardation. Biological psychiatry has been criticised for making causal biochemical assumptions based on the pharmacological efficacy of drugs (Cowen & Browing, 2015), and these simplistic ‘single’ transmitter models of depression have been refuted by later evidence (e.g., Duman et al., 1997).

Serotonin is associated with affiliative behaviours and is known to modulate goal-directed motor and appetitive behaviour, influencing circadian rhythms (Duncan, 1996; Thase et al., 2014). Receptor imaging studies suggest dysfunctions in serotonin receptors are involved in depression (Drevets et al., 2007) and the disruption of tryptophan (a chemical involved in the making of serotonin) is implicated (Smith et al., 1997). Despite the usefulness of selective serotonin reuptake inhibitors (SSRIs) in treating depression (discussion below), summaries of the literature assert ‘the serotonin hypothesis of depression has not been clearly substantiated’ (Cowen & Browning, 2015, p.158). Decreased dopaminergic activity has been shown to impact on hedonic, motoric, and cognitive symptoms of depression via various pathways (Thase et al., 2014; Argyropoulos & Nutt, 2013), yet the causative role of dopamine on depression is unclear as

chronic stress causes a depletion of dopamine and its transmission is dependent on serotonergic systems (Willer et al. 2012). Sustained chronic stress and hypercortisolism can also cause lasting problems in hypothalamic-pituitary-adrenal (HPA) axis activation, which is associated with depression (Heim et al., 2009; Holsboer & Isling, 2010). Whilst other neurotransmitters (e.g., gamma amino butyric acid), hormones, and hormonal regulatory systems (e.g., thyroid) are also suggested to play a role in depression, the disorder is ultimately regarded as 'biochemically heterogeneous' (Anisman et al., 2012, p.65), involving several neurochemical and receptor changes, variations, and interactions.

Neuroimaging approaches have highlighted structural changes associated with depression. These include changes to hippocampal volume with atrophy in this region estimated to be 8-10% in people with depression (Videbec & Ravnkilde, 2004). Areas such as the hippocampus and medial prefrontal cortex, which play a key role in the regulation of stress hormones, are susceptible to damage from excitotoxicity relating to such hormones (Pizzagalli & Treadway, 2014). Heightened responsivity to emotional stimuli has also been shown in limbic regions in people with depression, specifically the amygdala (Siegle et al., 2007). Other neuronal structures associated with depression include the nucleus accumbens, which has an important role in pleasure and reward, and is less active in people with depression (Pizzagalli et al., 2009). Variation in activity in the anterior cingulate cortex and pre-frontal cortex have also been linked to depression (e.g., Rodríguez-Cano et al., 2014). Brain-imaging studies have highlighted considerable variation in depressed individuals, identifying distinct subtypes in brain patterning that respond differently to physical interventions (Drysdale et al. 2017).

Inflammation has also been found to have an important role in depression. People with major depression disorder display the primary features of inflammation, such as the expression of pro-inflammatory cytokines (Miller et al., 2009). The risk for depression has been found to increase by 44% for each standard deviation in c-reactive protein (acute-phase proteins whose concentration rises in response to inflammation) (Pasco et al., 2010). Polymorphisms in inflammatory genes have also been associated with depression (Bufalino et al., 2013) and non-depressed participants have shown symptoms of depression when inducing inflammatory cytokines (Reichenberg, et al., 2001). Levels of inflammation have also been found to influence

the effectiveness of antidepressant treatment (Leonard, 2001). As a caveat to the findings above, inflammation also has an important role in other disorders, such as post-traumatic stress disorder (Michopoulos et al., 2015), and not all depressed individuals have increased pro-inflammatory markers in their blood samples (Penninx et al., 2013).

In terms of research focusing on genetic factors, first degree relatives of individuals with depression are significantly more likely to have depression when compared to controls (Rice et al., 2002). However, such studies cannot control for the influence and inheritance of other, non-genetic, factors such as family or rearing environment (Lau & Eley, 2008). Twin studies, comparing monozygotic and dizygotic twins, suggests 30-40% of variance in depression is related to genes alone (Shih et al., 2004). In reviewing research on specific susceptibility genes for depression, Lau et al. (2014) suggest that liability to depression is influenced by multiple susceptibility genes, 'each of a small effect that is neither necessary nor sufficient for disease development' (p.167). Studies exploring gene-environment interplay suggest that genetic risk can predict the level of depressive symptoms occurring after aversive life events and long-standing stress (Kendler & Karkowski-Shuman, 1997; Eley et al., 2004). Studies within the field of epigenetics have demonstrated how genetic expression can be modulated by adverse life experience, shaping emergent behaviours and phenotypes, such as depression (Meaney & Szyf, 2005; Vijayendran et al., 2012).

Social and relational

As highlighted above, the study of epigenetics suggests an interaction between nature and nurture, genetic and environmental factors. Social environmental factors and life stress have a considerable bearing on multiple biological systems (e.g., creating HPA overactivity and disruptions in neuroendocrine processes, see above). In their summary, Monroe et al., (2014) estimate that 'approximately 50-80% of individuals with depression report an acute, severe life event prior to onset' (p.298). In nonclinical samples, a severe life event raises the risk of depression at an odds ratio of 9.38 for first onset (Kendler et al., 2000). Recent severe life events were found to be the most predictive of risk factors for depression (Kendler et al, 2002), with such associations indicating a causative role (Kendler & Gardner, 2010). Life stress clearly has a role in triggering depression.

Adverse life experiences and their association with depression can begin as early as the prenatal period, with a mother's prenatal anxiety and health behaviours suggested to be risk factors (O'Connoer et al, 2003; Kovacs et al, 1997). Adverse childhood experiences (ACEs) have been categorised and researched for their impact on adult well-being (e.g., Herzog & Schmahl, 2018). Using this framework, a strong correlation has been found between ACEs and depression, with emotional, sexual, and physical child abuse being the most significant risk factors (De Venter et al., 2013; Nanni et al., 2012). It is of note that perceived social support is a protective factor against such associations (Cheong et al., 2017). Specific styles of parenting are also associated with risk factors that increase vulnerability to depression- this includes intrusiveness or critical parenting where the child feels helpless and lacking in agency (Egeland et al., 1993). When recalling their parents' behaviour, adults with depression report a lack of warmth and affection, increased levels of rejection and overcontrol (Rosenfarb et al, 1994).

Depression is associated with attachment anxiety and insecurity, whilst secure attachment is deemed to be a protective mechanism (Muris et al., 2001; Shaver et al., 2005; Brenning et al., 2011; Groh et al., 2012). Interparental conflict is associated with depression, and the link is strengthened when the conflict is recurrent, intense, unresolved, and occurs early in the child's life (Davies et al., 2012). There is a correlation between the death of a parental figure during childhood and later depression, with stronger associations linked to factors such as disruptions in the childhood routine and lack of supportive others (Brent et al., 2009; Gray et al., 2011). Symptoms of depression in mothers are also predictors of insecure attachment in their children (Graffi et al., 2018). Depression has therefore been conceptualised as a thwarting of attachment and developmental needs, and is associated with experiences of loss, grief, and helplessness (Bowlby, 1980; Gilbert, 1992).

Social-ecological contexts, that are risk factors for depression, can transfer intergenerationally and explain the co-occurrence between attachment problems and depression (Black et al, 2005; Sharkey, 2008). Such social risk factors, that are associated with depression, include low socioeconomic status, minimal support systems, and unemployment status (Montgomery et al. 1999, Gilman et al., 2003; Galea et al., 2005; Paul & Moser, 2009). High expressed emotion in

partners and relatives is associated with depression (Butzlaff & Hooley, 1998) as is the experience of bullying by peers (Klomek et al., 2007; Verkuil et al., 2015) and societal violence (Murthy & Lakshminarayana, 2006). Notably, feeling stigmatised by having depression can prevent people seeking and continuing treatment (Barney et al., 2006).

Evolutionary

Evolutionary psychology focuses on how the human mind has been 'shaped' by evolutionary pressures and processes (Buss, 2019). In the context of depression, evolutionary theorists have explored the adaptive function of depression to understand why such a destructive and disabling pattern of experience has been conserved. Other evolutionary conceptions of depression understand the problem as a byproduct of other adaptions or as a maladaptive state relating to environmental mismatch (Rantala et al. 2018; Del Giudice, 2016).

The incentive-disengagement theory of depression (Klinger, 1975) formulates symptoms of depression as a consequence of giving up or losing major life incentives that are both inherently and personally determined. Disengagement from goal-pursuit can, however, be adaptive when the goal being sought is unattainable; individuals are therefore prevented from a costly expenditure of resources by reducing motivation and positive affect (Nesse, 2000). Whilst depression is conceptualised as an adaptive short-term response (regulating incentive seeking and disengagement), the influence of cognitions can over-stimulate both goal-seeking and disappointment, causing long-term dysregulation of mood and motivation (see discussion of 'old brain-new brain' problems in the following chapter; also Rottenberg, 2014).

Learned helplessness (Seligman, 1975) is a related theory based on findings that animals that pre-received inescapable shocks later demonstrated passivity and deficits in avoidance/escape behaviour (Mowrer & Viek, 1948, Seligman & Maier, 1967). Seligman (1975) clarified that 'controllability' is key to learned helplessness and suggested parallels to depression in human behaviour: 'if the subject learns he cannot control the trauma, fear will decrease and be replaced by depression' (p.54). The theory was later developed to include the role of cognitions and attributional style in determining a person's response to stressors (Abramson et al., 1978). People with depression and helplessness are typically thought to appraise situations in a way that

attributed the events to internal rather than external causes ('it is my fault'); as global rather than specific ('it is a complete mess'); and as stable rather than changeable ('this won't ever change') (Irons, 2014). Such categories of attribution have been associated with depression in meta-analytic reviews (Sweeney et al., 1986).

The arrested defences model of depression focuses on the impact of blocking evolved defences to threat (Gilbert 1992). Threat-reactions typically involve short-term stress-responses and mobilisation before returning to a non-threatened state. However, when fight (anger and assertiveness) and flight (avoidance and escape) reactions are arrested, this can cause chronic activation of stress, creating an experience of 'entrapment' (Gilbert, 1992; 2005). Such entrapment is associated with depression in clinical and non-clinical samples (Gilbert & Allan, 1994; Gilbert et al., 2004), and is linked to suicidal feelings and behaviour (Li et al., 2018). The blocking of core emotions and their related action tendencies feature prominently in the psychological theories described below.

The social competition theory conceptualises depression as an evolved response to social defeat (Price et al., 1994). Symptoms of depression form external signals to powerful others to terminate conflict whilst inhibiting one's own competitiveness (that might result in further defeat and harm). Gilbert's (1992) social rank theory emphasises social rather than physical risk and highlights the association between depressive symptoms and loss of social status, belonging, and attractiveness. A social risk hypothesis suggests that depression, in its milder forms, has evolved to promote group inclusion by sensitising individuals to signals of rejection and by adopting submissive or help-seeking behaviour (Allen & Badcock, 2003; Dunn et al., 2012). Research supporting the role or social rank and comparison in depression has found that people who rank themselves lower in status have higher depressive symptoms and people with depression rank themselves lower than people who don't have depression (Gilbert & Allan, 1994; Allan & Gilbert 1995; Cheung et al., 2004). Research has also found that loss of social rank correlates with shame (see below) and submissive behaviours, both of which are, in turn, associated with higher levels of depression (Allan & Gilbert, 1995; Gilbert, 2000).

Whilst the link between attachment security and depression has been noted above, the evolutionary theory of attachment, as outlined by Bowlby (1969), offers insights into the adaptive function of depression. Human infants (and the offspring of other mammals) have an intrinsic motivation to seek closeness to their care-givers and a repertoire of emotions and behaviours to signal their need for comfort, care, and food (Irons, 2014). Given the survival risk posed by separation, infants 'protest' when being left by their caregivers (Bowlby 1973). Infant protest involves increased arousal, expressions of distress, and seeking behaviour. Whilst helpful as a short-term strategy, such protest reactions can increase multiple risks, including that of bringing unwanted attention from predators. When the protest is unsuccessful, the infant therefore experiences a reduction in activity and demonstrates a form of 'despair' that resembles depressive symptoms. Depression in humans is seen as a conservation of these protest-despair dynamics, created by the kind of attachment disturbances (e.g., parent death) described earlier.

Psychological

Early psychological explanations for depression includes psychoanalytic theories that emphasise the role of loss and mourning (Freud, 1917), and the problems created by repressed and unconscious anger at lost 'objects' (e.g., the representation of the mother) (Horner, 1989). Based on psychoanalytical constructs of the mind, depression is conceptualised as 'diverted rage', blocked from external expression (for reasons such as the child's dependency on the parent) and is internally directed at the ego (causing lowered self-esteem) (Gilbert, 1992). Later object relations theories have conceptualised a 'depressed position' in relation to the parent, whereby the child becomes fearful and guilty in relation to their own aggressive urges towards 'bad' aspects of the 'object', fearing that they may destroy the 'good' and needed parts of them (Odgen, 1983; Greenberg & Mitchell, 1988). Whilst such theories are criticised for their emphasis on over-sexualised terms and a lack of empirical rigour, later research does support the role of inhibited anger in clients with depression (Gilbert et al., 2004). Psychodynamic theorists have also focused on how, via interactions with important others, children develop internal mechanisms or representations (e.g., 'self objects') that impact their sense of self and interpersonal relations (Kohut, 1971). From this perspective, depression can result in losing contact with positive 'self objects' (positive dimensions of one's self) and one's capacity to activate them (Deitz, 1988).

Another model rooted in psychodynamic thinking is the Two Polarity Model of Personality Development and Psychopathology, developed by Blatt and colleagues (Blatt et al., 1976; Blatt et al., 1982). The model conceptualises distinct forms of depression and differentiates two dimensions of personality development: self-definition (one's sense of self) and interpersonal relatedness (one's sense of relationships with close others). Both self-definition and interpersonal relatedness are required for healthy functioning but can become developmentally disrupted causing an over-emphasis on self-definition (an 'introjective personality organisation'), or interpersonal relatedness (an 'anaclitic personality organisation') (Blatt, 2008). Blatt et al., (1976) differentiated depression into subtypes whereby introjective depression was associated with self-criticism, shame, and failure, and anaclitic depression was associated with loss, rejection, and loneliness. Whilst subsequent research has challenged and refined Blatt's definitions, these characteristics appear to be stable personality 'traits' and are associated with specific patterns of psychopathology (Kopala-Sibley, et al., 2015; Kopala-Sibley & Zuroff, 2014).

Cognitive models of depression are underpinned by the concept of schemas: a person's 'underlying cognitive structures' (Beck 1979, p.8) which influence how information is actively processed, evaluated, and organised. In Beck's (1976) cognitive model of depression, negative schemas are expressed as a triad of core beliefs: negative views of the self (e.g., 'I'm useless'), of others (e.g., 'other people are critical'), and of the future (e.g., 'nothing will ever change'). Such core-beliefs influence how an individual interprets their experiences (in the form of negative automatic thoughts), whilst also guiding their behaviours and expectations (in the form of rules and assumptions), impacting their affect and mood. Beck (1967) deemed that depression is maintained by 'primitive', 'extreme', and 'distorted' thinking processes, and that vulnerability to depression can be attributed to 'latent' negative schemas that become 'activated' by external circumstances. Research supports the notion that people with depression experience depressogenic cognitions that can be differentiated from other disorders (Haaga et al., 1991; Beck et al., 1987), but there is less support for dysfunctional beliefs as causative factors in depression.

Earlier behavioural models include Wolpe's (1979) concept of 'neurotic depression' in which depression is driven by anxiety, learnt by classical conditioning. Depression is thereafter maintained by avoidant behaviour which reduces opportunities for positive reinforcement whilst also increasing negative reinforcement (Lewinsohn, 1974). Behavioural theorists have emphasised the importance of functional analysis in understanding depressive behaviour and 'depressive contingencies' (the causes and consequences of depressive behaviour) (Ferster, 1973). Certain environmental factors are therefore deemed to reduce sources of positive reinforcement (e.g., becoming unemployed) whilst increasing 'punishment' or aversive experiences (e.g., feeling pain when trying activities following illness) (Lewinsohn, 1974). Classical conditioning also applies in how low mood can be broadened and transferred via higher order conditioning, and how emotions and desires can become inhibited and conditioned to other emotions (e.g., a client might react with shame or sadness, rather than anger, due to being shamed or rejected for being angry at an earlier age) (Ferster, 1973).

Other notable models of depression include Greenberg's conceptualisation of depression as a 'emotional disorder of the self' (Greenberg & Watson, 2006, p.43). In depression, the self becomes organised around emotional schematic memories of loss, neglect, and failure which, when activated, impairs peoples' ability to process and regulate their emotions (Greenberg & Watson, 2006). Depression is associated with a shutting down of core-affects and associated needs, resulting in an inability to discriminate and access adaptive emotional responses (such as empowering anger) that can transform depressogenic emotional self-organisation (Greenberg, 2017). In support of the model, depression is associated with low abilities to differentiate negatively valanced emotions, which is heightened during high stress exposure (Starr et al., 2020; Demiralp et al., 2012). Lower negative emotion differentiation (NED) also moderates the impact of factors such as rumination on depression (Liu et al., 2020), and is associated with poorer emotional regulation (Barrett et al., 2001). Difficulties with sadness/grief and anger/assertiveness in depression have been discussed above, and there appears to be a common theme in highlighting the emotional complexity beneath the global 'malaise' and affective flattening that is associated with depression (Greenberg & Watson, 2006; Gilbert, 2007).

What helps?

Medication and physical treatments

In their most recent evidence-based guidelines for adult depression, the National Institute for Health and Care Excellence (NICE, 2009) advise against the use of antidepressants for mild depression, but recommend their use for moderate/severe depression, persistent subthreshold depressive symptoms or if such symptoms are unresponsive to other treatments. Similarly, new draft guidelines (NICE 2021) suggest antidepressants are not the first choice for 'less severe' depression. NICE (2009) recommend selective-serotonin reuptake inhibitors (SSRI) as first line choices of medication, with different classes (e.g., MAOIs) suggested only if failing to respond. The period of national lockdown in response to COVID-19 has seen a rise of antidepressant prescription in England to the highest on record at over 6 million people over three months in 2020 (Armitage, 2021). Between 2017-2018 Public Health England (PHE, 2020) estimated that 7.3 million people (17% of the adult population) were prescribed antidepressants. A meta-synthesis of antidepressant effectiveness (Gartlehner et al., 2008) suggests that 63% of people demonstrated a positive response to their use between 6-12 weeks, with 47% achieving remission (with minimal differences between antidepressants). A later systematic review and network meta-analysis (Cipriani et al., 2018) demonstrated all antidepressants were more efficacious than placebo in adults with depression but found significant variation in efficacy and acceptability between medication in head-to-head studies.

For clients with a higher risk for relapse, it is suggested that antidepressant medication is continued for up to 2 years (NICE, 2021). Whilst continued antidepressant use results in reductions of depression recurrence compared to controls (Glue et al., 2010), the majority of clients discontinue maintenance regimes or experience relapse even when continuing antidepressants within 2 years (Bockting et al., 2008). There are also growing concerns regarding acute withdrawal and rebound phenomena following antidepressant discontinuation (Henssler et al., 2019). Guidelines for additional pharmacological treatment include combining antidepressants, adding lithium or an atypical antipsychotic medication depending on depression severity or sub-type (NICE, 2009; 2021). Electro-Convulsive Therapy (ECT), a treatment that stimulates neurological seizures, is reserved for severe or treatment-resistant depression. Whilst a review of ECT's effectiveness found it superior to other treatments for severe depression (Pagnin

et al., 2008), it remains a controversial treatment and is associated with serious side-effects such as memory loss and cognitive impairment (Porter et al, 2020).

Psychological treatment

Whilst recommending psychotherapy for the initial treatment of depression, the American Psychological Association (APA, 2019) were 'not able to recommend specific monotherapies for initial treatment' as 'studies demonstrated similar effects' (p. ES-14). In England, NICE (2009) guidelines and the draft consultation for an updated guideline (NICE, 2021) recommend CBT as the first-line psychological treatment for depression. The draft consultation recommends, in order, the following treatments for 'less severe' depression: group CBT; group behavioural activation (BA); individual CBT; individual BA; interpersonal therapy (IPT); counselling; and short-term psychodynamic psychotherapy. In more severe-depression, the first-line psychological treatments are (in order): individual CBT (plus antidepressant as first choice); individual BA; individual problem-solving; counselling; short-term psychodynamic psychotherapy; and IPT. The above recommendations are based on network and pairwise meta-analysis of 142 RCTs with 20,663 participants (less severe depression) and 534 RCTs with 89,286 participants (severe depression) which included sensitivity analyses for publication bias.

Cognitive behavioural therapy' (CBT) is a term that incorporates a variety of approaches from often contrasting theoretical foundations (as introduced above), but which share common characteristics (e.g., an emphasis on empiricism, collaboration, home practice, and structure) (Kennerly et al, 2016). In cognitive therapy for depression, therapeutic interventions are 'designed to identify, reality-test, and correct distorted conceptualisations and the dysfunctional beliefs (schemas) underlying these cognitions' (Beck et al., 1979, p.4). This might include cognitive restructuring via verbal reattribution using written thought diaries or more active methods such as behavioural experiments or activity scheduling (Moore & Garland, 2003). In contrast, behavioural activation utilises operant conditioning principles to schedule behavioural change to increase contact with environmental positive reinforcers (Martell et al., 2001). The approach is a parsimonious evidence-based treatment, with the benefit of low-cost implementation (Ekers et al., 2014). CBT is typically delivered in a 'disorder-specific', standardised manner, with NICE (2021) recommending that individualised CBT for severe

depression should consist of '12 to 16 weekly or bi-weekly sessions of 60 minutes each, delivered in line with current treatment manuals' (p.31).

There is 'strong evidence' that CBT interventions generate short-term decreases in depression when compared to wait-list controls, whilst costing less than pharmacological treatment and with better relapse rates than discontinued medication (Antonuccio et al., 1997; Hollon, et al., 2005; Lopez-Lopez, 2019). However, there is a high level of relapse in both low-intensity CBT (Ali et al., 2017), and protocol driven CBT (Paykel, 2007). There is also limited evidence of CBT being more efficacious that other psychotherapies (Cuijpers et al., 2013), yet it has the 'greatest weight of evidence' (p.376) as the most studied psychotherapy. The effects of CBT for depression are also deemed to be overestimated due to publication bias (Cuijpers et al., 2010). A meta-analysis of 'well controlled trials' found the pooled effect size of CBT for acute symptoms of depression to be in the 'small range' (Lynch et al., 2009).

Additional treatments advocated in NICE's (2021) draft consultation include behavioural couples therapy for clients with relationship problems contributing to depression. Whilst finding no difference between couples therapy and individual psychotherapies, a Cochrane review highlighted the low quality of evidence supporting the approach (Barbato & D'Avanzo 2020). In terms of therapies utilised for relapse prevention, mindfulness-based cognitive therapy (MBCT) and preventative cognitive therapy have been shown to be as effective as long-term use of antidepressants in preventing further episodes (Breedvelt et al., 2021). Other reviews have highlighted that MBCT was only more effective than controls when clients had three or more previous depressive episodes (Zhang, 2018). Counselling for depression, within IAPT provision, draws upon person-centered and emotion-focused therapy practices (Sanders & Hill, 2014), whilst psychodynamic therapy is represented in various short-term formats (e.g., Fonagy et al., 2020).

IAPT and stepped care

IAPT is the main provider for psychological therapies for clients with depression in England demonstrating a 'recovery rate' of 50% and showing two-thirds of clients have 'worthwhile benefit' (Clark, 2018, p.159). Criticism of IAPT services include the arbitrary limiting of session

numbers (resulting in sub-therapeutic courses of treatment) and the overreliance on CBT (Dalal, 2018). NHS and IAPT services work to a stepped care model whereby patients are initially offered 'low-intensity' measures and then 'stepped up' when treatments are ineffective. A review and meta-analysis on stepped care effectiveness for depression found 'limited evidence' to support the model and noted considerable variation in criteria used within services (van Straten et al., 2015). Initial steps for depression typically include psychoeducation and active monitoring as well as low-intensity psychosocial interventions such as guided self-help (Clark, 2011). The final steps of care for depression can involve combined treatments such as multi-professional or crisis support, and inpatient care (NICE, 2009).

Shame

Distinctions, forms, and phenomenology

Shame is a painful and powerful affective experience that is multifaceted in nature. It has been conceptualised and studied in various forms: as an emotion; as a set of cognitions and beliefs; as a group of behaviours and actions; as an evolved mechanism; as cultural phenomenon; as relational construct; and as trait or state (Gilbert, 1998). This section will explore and clarify these various approaches to shame.

Shame is typically regarded as an emotion (Dearing & Tangney, 2011), yet there remain questions as to its exact nature. Tomkins (1987) initially framed shame as an 'innate affect auxiliary response and a specific inhibitor of continuing interest and enjoyment' (p.143). In this view, shared by Nathanson (1992), shame functions as an affect programme to inhibit and interrupt positive affect and is one which 'rather than a true innate affect…bears all the properties of other affects' (p.138). Whilst shame is deemed to interrupt positive feelings, this is a common quality of many negative emotions (Gilbert, 2015b); equally, interruptions to goals, plans and positive affect can create a variety of emotional responses, not solely shame (Mandler, 1975). Shame is therefore deemed to load more on negatively valanced emotions and to be formed of blends of affective states (Gilbert, 1998).

Anxiety appears to play a central role in shame, creating rapid autonomic arousal, disrupting rational reflective thought, and escalating to panic-like intensity (Lewis, 1986). The similarity

between shame and social anxiety has long been argued (e.g., Gilbert, 2000), due to shared fears and preoccupation of negative interpersonal evaluation, painful self-consciousness, and behavioural disposition for avoidance/escape (Gilbert, 1989; Gilbert et al., 1994). Anger has also been associated with shame in ways that other self-conscious emotions, such as guilt, are not (Tangney et al., 1992). Some researchers argue that anger is a secondary emotion in shame, offering a means to transform, by-pass or 'save face' from the primary anxiety (Scheff, 1988; Tangney et al., 1992). Destructive coping with conflict has also been associated with shame (Tangney et al., 1996). There continues to be debate as to the differentiation between shame-based anger and non-shame-based frustration. It appears that the type of relationship where the anger occurs might have a bearing on the potential for shame (Gilbert, 1998).

Other emotions associated with shame include disgust, specifically self-disgust (Power & Dalgleish, 1997). Gilbert (1992) suggests that disgust may be associated with specific forms of shame; for example, shame related to bodily functions or sexual acts is more likely to elicit disgust rather than anxiety. Other researchers (Tomkins, 1987) conceptualise disgust as a separate emotion to shame. Such debates and questions around shame highlight how difficult it is to experience or study 'pure' affects, the idea of which has been challenged at both a neurological and cultural level (Barrett, 2017). It is therefore helpful to consider affect combinations and the way in which shame can 'bind' or blend with other affects (e.g., one can be both shamed and excited) (Kaufman, 1989). Following the model of emotional co-conditioning offered by Fester (1973), Gilbert (1998) suggests that shame can become classically conditioned to other emotions. Shame is perhaps best seen as emotionally complex and multifaceted, arising as a blend of primary emotions (Matos et al, 2020).

In terms of bodily response, shame is associated with biologically innate reactions and non-verbal displays. The most prominent are eye-gaze diversion, motor avoidance, frowning, lowering of the head, blushing, and shrinking/folding of the body (Tracy & Matsumoto, 2008; Keltner & Harker, 1998; Tangney et al. 1996). This has been linked to the appeasement function of shame (see evolutionary discussion below) (Gilbert et al., 1994). In contrast, smiling and laughing is associated with embarrassment rather than shame (Keltner, 1995). Physiologically, shame is associated with parasympathetic 'freeze' and de-mobilisation, reducing sympathetic

activation (Benau, 2017; Schore, 1994). Others assert that shame also includes autonomic activation and arousal, for example in the case of anger-based responses (Gilbert, 1998). Subjectively, shame is described heterogeneously as a mix of activation and de-activation reactions: as heightened body-temperature and heart-rate, physical weakness, and collapsing of posture (Ablamowicz, 1992). It is notable that nonverbal signs of shame may be more reliable than verbal self-reports, particularly in relation to the resumption of shame-based behaviour (Randles & Tracy, 2013).

Behaviorally, Gilbert (1998) has divided shame responses into four stages: the initial 'hot behavioural reactions that form part of the shame experience; behaviours to cope with or conceal shame as it occurs; behaviours to avoid shame being activated; and behaviours to repair. Typically, such behaviours are associated with efforts to avoid, conceal, or escape the shame trigger and reaction, and to manage reputation (Sznycer et al., 2016). Shame is associated with reductions in expressive behaviour and vocalisations (Scherer & Wallbott, 1994), as well as global avoidance and withdrawal from social contexts. However, the opposite can also be true, with Nathanson (1992) suggesting that shame can lead to over-compensatory drive, positive self-presentation, and behaviours such as hypersexuality. Reparation in shame has been linked to non-assertive and submissive behaviours for damage limitation to the social self (see comparison to guilt below) (Gilbert & McGuire, 1998).

Shame is regarded as the prototypical emotion experienced when the 'social self' is threatened (Gilbert 1989; Kemeny et al., 2004). It is regarded as a 'self-conscious' emotion linked to our core sense of self: how we live in the mind of others and also how we see our self (Gilbert 1998; Tracey & Robins, 2008). As such, cognitions, beliefs, and meaning related to shame are typically associated with perceived or expected criticism and rejection from external sources, as well as self-evaluations of our own inferiority and deficiencies (Gilbert et al., 1994; Tangney et al., 1996). Cognitive themes of shame include perceptions of inferiority, powerlessness, loss of desirability or attractiveness, worthlessness, failure to meet standards/ideals, disconnection, and separation (Gilbert, 1992; Tangney & Fischer, 1995). Shame cognitions can be focused on one's attributes, characteristics or behaviour, and can become fused with our self-identity (Gilbert et al.

2007). Gilbert (1998) has stressed the 'involuntary' nature of inferiority beliefs is central to the experience of shame.

Given the potential for internal and external sources of shame, Gilbert (2003, 2007) has proposed a model that distinguishes shame into three forms:

1. *External shame* refers to how we 'perceive our self as creating negative emotions (anger, disgust, contempt, ridicule) in the mind of the other' (Gilbert, 2007 p.327). In external shame, the focus is on one's social world and the threat of social diminishment, judgment, rejection, or attack (Goss et al., 1994). External shame is associated with stigma (Pinel 1999).
2. *Internal shame* refers to the way shame is internalised and applied to the subjective sense of self. Internal shame is derived from negative self-evaluations and self-affects relating to our own attributes, character, and behaviour. Self-affects can include self-disgust (Gilbert, 2000). Internal shame can be driven by self-criticism and self-judgements comparing oneself socially: e.g., finding oneself inadequate.
3. *Reflected shame* relates to shame via association with others. This is an important consideration in certain cultural contexts (Gilbert et al., 2004). An example is of a one family member feeling ashamed of the actions of another.

Key aspects of shame are revealed when differentiated from other social, self-conscious emotions. While guilt can be fused with shame (Tangney, 1995), Gilbert (2003) has argued that guilt lacks self-devaluation and concerns about external evaluations of self. Guilt is ultimately focused on undesirable behaviors, whilst shame focuses on becoming the undesirable self (Lewis, 1971; Tangney et al., 1996). Rather than the dominant-submissive strategies associated with shame, guilt is focused on harm done to others and is linked to reparation, caring, and co-operative motives (Gilbert, 2007, 2009). In moderation, guilt can be helpful in building and maintaining relationships in ways that shame is not (Beaumeister et al, 1994). Similarly, whilst humiliation has been theorised to be part of shame (Lewis, 1987), Gilbert (1998) suggests there are important differences. Humiliation is associated with being put into a 'lowly, debased, and powerless position' (Gilbert, 1998, p.10) and is linked with experiences of rage. Humiliation, differs from shame in various domains: it is less self-focused and conscious than shame, is more

externalising of blame, and is focused on the other as bad (rather than the self) (Gilbert, 1998). In humiliation, there is a sense of injustice and unfairness and a desire for revenge: '*people do not believe they deserve their humiliation'* (Klein, 1991, p.117).

Shame is regarded as a universal potential: 'it is not an abnormal affect' (Gilbert, 1998, p.27). However there is variation in terms of chronicity, triggering contexts, and intensity (Matos et al., 2020). Shame can be focused on different aspects of the self: for example, on the body, on behaviour, or on character (Andrews et al., 2002). Whilst there is some argument that genetic factors influence sensitivity to shame, shyness, and behavioural inhibition (Gilbert, 1998), evidence supports the notion that 'toxic shame, or a shame-prone sense of self, is interpersonally derived' (Teyber et al., 2007, p.137). Shame can be seen as a consequence of lack of parental mirroring and attachment sensitivity; familial criticism, control and shaming; and childhood sexual and physical abuse (Mills et al, 2008; Schore, 1998, 2003; Andrews 1998a). Shame proneness or vulnerability has been conceptualised in terms of ease of shame triggering and severity of shame response (Andrews, 1998b). Various theories have been used to explain shame-proneness including cognitive vulnerability models (and the development of negative cognitive-affective schemas) or the relationship between shame and low self-esteem (Leary et al, 1995).

Evolutionary perspective

From an evolutionary perspective, human shame can be understood as originating in phylogenetically older mechanisms, evolved to navigate group living and social relationships, (Gilbert, 1992). As social bonds are vital for survival (e.g., access to food and group protection) and provide opportunities for reproduction, humans have evolved a sensitivity to social threat and the associated risks of exclusion or persecution (Buss, 2019). Shame is deemed to be an evolved mechanism for responding to, and monitoring, such social threats (Gilbert, 2003).

Gilbert (1992; 1998) suggests that shame is particularly linked to social rank and has evolved to regulate status behaviour in hierarchical living. Shame is associated with subordinate behaviour and appeasement strategies to limit harm and prevent attacks from dominant others. In animals the function of submissive behaviour is typically to minimise physical aggression, but in

humans, where social status and relationships are grounded in attractiveness, such submission is typically linked to loss of acceptance and approval (Gilbert 1998; Santor & Walker, 1999). The inhibitory and appeasing nature of submissive behaviours and motivational states are also characteristic of shame (e.g., gaze avoidance, desire to hide) (Keltner, 1995). Shame therefore has an adaptive value despite the considerable impact on mental and physical health (Gilbert & McGuire, 1998).

Impact and relationship with depression

Shame is pathogenic and has a mediating role in a variety of disorders and presentations including: social anxiety disorder (Grabhorn et al., 2006); personality disorders (Brown et al., 2009); eating disorders (Steindl et al., 2017); psychosis (Woods & Irons, 2017); body dysmorphic disorder (Veale, 2014); and posttraumatic stress disorder (Lopez-Castro et al., 2019). Shame is also linked with suicidal ideation (Hastings et al., 2002), low self-esteem (Yelsma et al, 2002), substance abuse (Dearing et al., 2005), problems with hostility and anger (Bennet et al., 2005); and dissociation (Dorahy et al., 2017). Psychobiological effects associated with shame include increases in cortisol and pro-inflammatory cytokine activity that, if chronic, can have a deleterious impact on in physical and health outcomes (Dickerson et al, 2004; 2009). Neuroimaging studies have shown that rejection does indeed hurt, with the brain bases of social pain being similar to that of physical pain (Eisenberger et al, 2003).

Depression is associated with both internal shame and external shame (Allan et al., 1994; Tangney et al., 1995). However, the meta-analysis of Kim et al (2011) showed external shame was a more powerful predictor of depression than internal shame or guilt. Shame can also form a central part of one's identity- as unacceptable and inferior- and is associated with depressogenic self-schemas and submissive/avoidant interpersonal coping (Gilbert,1984; 1998; 2007). Shame is also correlated with maintenance factors in depression, such as rumination (Cheung et al., 2004), and has a mediating role between abusive childhood experiences and depression, specifically chronic depression (Andrews & Hunter, 1997).

Measures

A variety of shame measures were reviewed by Goss et al. (1994) and Allan et al., (1994). The following paragraph briefly identifies measures for different aspects of the shame experience.

The Test of Self-Conscious Affect (TOSCA) (Tangney et al., 1989) asks the subject to imagine their responses to 15 scenarios and measures shame, guilt, externalisation, detachment, and pride (in one's behaviour or character). Other measures include The Personal Feelings Questionnaire 2 (PFQ2; Harder and Zalma, 1990) for measuring the frequency of guilt and shame feelings. The Experience of Shame Scale (ESS) (Andrews et al., 2002) measures three areas of shame: character (e.g., shame about personal habits or abilities); behaviour (e.g., shame about doing something wrong); and body (e.g., shame about parts of the body). The Other As Shamer Scale (OAS) (Allan et al., 1994) measures external shame on a 5-point scale indicating the frequency of experiences such as: 'I think that other people look down on me'. The scale has a Cronbach's alpha of 0.92 (Goss et al., 1994). The State Shame and Guilt Scale (SSGS, Marschall et al., 1994) is a self-report measure assessing acute pride, shame, and guilt. Trait shame has been measured by the Internalised Shame Scale (ISS, Cook, 2001), which has been tested in clinical and non-clinical samples.

What helps?

Given its nature, shame is difficult to share and treat within psychotherapy (Tangey & Dearing, 2002; Glazier et al. 2015). The very process of engaging with therapy can be shame inducing (Greenberg & Iwakabe, 2011). As shame is associated with social threat, treatment strategies have focused on facilitating experiences of social safeness and self-compassion. These targets are supported by cross-sectional findings that affiliative memories of connection and experiences of interpersonal warmth buffer against the influence of negative life events and the impact of shame memories (Matos et al., 2015; Atwool, 2006). Programmes integrating mindfulness and acceptance to target shame methods have demonstrated effectiveness in areas where shame is problematic (e.g., substance use) (Luoma et al., 2012). Compassion-based interventions and psychotherapies have also shown promise in treating shame and shame-related pathology (See reviews by Kirby & Gilbert, 2017; Kirby & Gilbert, 2017; Kirby et al, 2017). The contribution of compassion focused therapy will be discussed in depth in the following chapter.

<u>Self-criticism</u>

Conceptualisation

Self-criticism has been variously characterised as 'a reflexive psychological behaviour' (Whelton & Greenberg, 2005, p. 1583), 'a response style to perceived failure' (Ehret et al. 2015, p.146), and a 'form of relationship with the self' (Shahar, 2015, p.5). Self-criticism is generally agreed to be associated with negative self-evaluations, involving cognitive, affective, and relational components (Gilbert et al., 2014). Whilst self-criticism is typically associated with negative cognitions and 'self-talk', the strength of self-directed negative emotion is deemed to drive its pathogenic impact (Whelton & Greenberg, 2005). Emotions associated with self-criticism are typically self-disgust, contempt, and anger (Gilbert et al., 2004). Self-criticism is deemed to be a universal phenomenon, although cultural differences are evident (Heine et al., 2000).

Many authors (e.g., Driscoll, 1989; Gilbert et al., 2004) have argued that self-criticism is not a single process and can have multiple forms and functions. In terms of form, the factor analysis of Gilbert et al. (2004) differentiated self-criticism (which focuses on inferiority, disappointment, and inadequacy) from self-attacking (which focuses on self-hatred and disgust). Alternatively, Thompson & Zuroff's (2004) conceptualise self-criticism as two constructs: comparative self-criticism (focusing on inferiority and comparison to others) and internalised self-criticism (focusing on failing to achieve one's own goals and values and viewing the self negatively). Numerous functions of self-criticism have also been proposed and include: to self-correct, to protect others from one's own anger, to maintain standards and guard against future errors, to generate sympathy, and to harm/destroy part of the self (Driscoll, 1989, Gilbert et al, 2006; Freud 1917/1957). A factor analysis of Gilbert et al.'s (2004) Functions of Self-Criticizing (FSC) measure suggested two factors: self-correction and self-persecution. Research suggests that self-persecution and self-attacking is more pathogenic than self-correction and self-criticism (Gilbert et al., 2004; Castilho et al., 2017).

Self-criticism has been categorised as either 'pathological' or 'constructive' (Bergner, 1995) and is seen as a 'a continuum of healthy to maladaptive aspects' (Kannan & Levitt, 2013, p.166). There is debate as to the relative benefits and drawbacks of both self-criticism and self-enhancement (Chang, 2008) with some suggesting 'adaptive self-criticism' be promoted in

psychotherapy (Bergner, 2008). Neff (2003) in her conception of self-compassion, has proposed that self-criticism and self-kindness can be measured as two ends of a single continuum. In examining the neurophysiology of self-criticism and self-reassurance, Longe et al., (2010) found these processes were associated with distinctly separate brain regions and functions. Self-criticism, for example, was linked to activation of the lateral prefrontal cortex regions and dorsal anterior cingulate, areas associated with error processing and behavioural inhibition. Gilbert, (2010) in his development of Compassion Focused Therapy (see next chapter) has emphasised that self-compassion and self-criticism belong to different motivational systems and related mentalities (see below).

The two-polarity model of Blatt and colleagues (Blatt et al., 2004), drawing upon object-relations and cognitive-developmental theories, has been influential in conceptualising self-criticism. According to the model, self-criticism is a personality characteristic that forms part of the self-definition dimension and is associated with failure, low self-worth, and shame (Blatt & Zuroff, 1992). Whilst self-criticism is understood to be a 'trait', the study by Zuroff et al., (2016) also found evidence of 'state' based differences over time. Shahar's (2015) model of self-criticism (Axis of Criticism Model-ACRIM), focuses on disruptions to an individual's authenticity and self-knowledge, and the disruption this causes to social adjustment and goal-pursuit, creating a vicious cycle of maintenance (Shahar, 2015). Conversely, high self-knowledge and authenticity are deemed to be adaptive and act as a counter to self-criticism. Whilst there is evidence to support elements to the model, such as the reciprocal nature of self-criticism and depression (Shahar et al., 2004), there is limited support for elements of the model's constructs- such as the notion of a 'true' and 'authentic' self'- and their role in self-criticism.

Self-criticism can also be understood from a symbolic interactional perspective: as 'a pathological form of dialogue' between aspects of the self (Shahar, 2015, p.5). Emotion focused therapy (EFT) takes a similar dialectical-constructivist approach to self-criticism (Greenberg et al., 1993). The way in which such internal relationships are conceptualised and understood is largely dependent on the broader theoretical frame in which they are addressed. From within psychodynamic theory, self-criticism is understood as the injunctions from the super-ego or as the internalisation of parent-child relationships (Freud, 1917/1957; Schaff & Tsigounis, 2003).

Interpersonal theorists (e.g., Baldwin, 1997) conceptualise self-criticism as an internalised script, created by the way in which individuals were related to by others. Cognitive therapists, such as Beck et al., (1976), formulate self-criticism as arising from self-other core-beliefs developed from early life interactions, or as interactions of 'modes' or suborganisations of personality. (Beck, 1996). This 'mode' based approach was extended in schema therapy wherein self-criticism is conceptualised as a demanding or critical 'parent mode' which attacks the vulnerable 'child mode' (Artnz & Jacob, 2013).

In an evolutionary conceptualisation of self-criticism, Gilbert (1989, 2000, 2005) has highlighted the influence of evolved and innate role-forming systems which he terms social mentalities. Social mentalities orientate and guide people's cognitive, affective, and behavioural responses to form specific roles with others. Such role-formation is facilitated via interpersonal 'dances' in the way social information is shared, interpreted, and acted on, so that such roles are reciprocated. Examples of reciprocal roles are caring to cared-for, dominant to subordinate, and mutual co-operation. The priming of a social mentality via external interactions has a significant influence in how we then think and feel about ourselves (Gilbert et al., 2006). For example, the study by Baldwin & Holmes (1987) found that participants primed with highly evaluative interactions were more likely to blame themselves personally and make global assumptions about their character when failing at a task. Further experimental research by Baldwin and colleagues (e.g., Baldwin et al., 1996; Baldwin & Sinclair, 1996) highlights how cognitively accessing other-to-self schemas or roles (e.g., via memory prompts) is a key variable in influencing a person's subsequent self-evaluative style.

As will be discussed further in the next chapter, Gilbert (1989, 2000, 2005) also suggests that social mentalities can also be activated within self-to-self relating. People can be reassured by generating caring messages or imagery, or can be stimulated into submissive and defeated responses by their own self-criticism (Gilbert & Irons, 2005; Gilbert et al., 2006). The same affect/response systems and implicit processes are activated whether social cues are externally or internally generated: 'when we attack and criticise ourselves we are probably activating (some) similar brain pathways as if someone else was doing it' (Gilbert et al., 2006, p.185). Systems that originally evolved to co-ordinate and mediate self-other relationships are recruited to form

internal role-formations. A social mentality approach to self-criticism therefore conceptualises the process as the enactment of an internalised social rank mentality, with a part of the self that evaluates and attacks and a part of the self that is evaluated and attacked (Gilbert, 2005). This internal 'social conflict' becomes particularly problematic and depressogenic when the critic is powerful and dominant and cannot be countered by a shift into the caring social mentality (Gilbert et al., 2001; Gilbert et al., 2006).

Origins and development

Parental criticism and emotional abuse are associated with self-criticism in children (Clark & Coker, 2009; Soffer et al, 2008; Soenens et al., 2010). Retrospectively, people with high levels of self-criticism report less satisfactory parenting (Brewin et al., 1992), and recall parents as exerting strict control, offering inconsistent levels of affection, and expecting success and achievement rather than conformity (McCranie & Bass, 1984). A longitudinal study found restrictive and rejecting parenting behaviors were associated with the development of self-criticism, particularly when received from the same-sex parent (Koestner et al., 1991). Individuals with high levels of self-criticism reported more parental absence, antisocial behavior, and neglect, and were more likely to report three or more childhood adversities than individuals with low/moderate self-criticism (Pagura et al., 2006). Self-critical parents reported being less loving and more controlling, which predicted self-criticism in their children (Amitay et al., 2008).

Self-criticism appears to link abusive parenting experiences to adult maladjustment and pathology which, in turn, provides further fuel for self-criticism (Shahar, 2015). For example, self-criticism has been shown to mediate the relationship between emotional abuse and depressive symptoms, body-satisfaction, and impairment in romantic relationships (Dunkley et al., 2010; Lassri & Shahar. 2012). Self-criticism also mediates the relationship between emotional abuse and self-harm (Glassman et al., 2007), and between childhood maltreatment and perceptions of one's own competency at parenting (Michl et al., 2015).

Impact and relation to depression

Self-criticism is a significant predictor and risk factor for developing depression (Carver, & Ganellen, 1983; Brewin & Firth-Cozens, 1997; Blatt, 2004; Campos et al., 2010; Cantazaro, & Wei, 2010; Joeng & Turner, 2015). A bi-directional influence in evident, as a history of depression is also linked to higher levels of self-criticism (Mongrain & Leather, 2006). Both remitted and currently depressed individuals report higher levels of criticism when compared to never depressed controls, raising the potential that increased self-criticism increases the risk for repeated or chronic courses of depression (Ehret et al., 2015; Teasdale & Cox, 2001). Linking to various psychological factors underpinning depression, self-criticism is also associated with involuntary subordination and perceived defeat in multiple domains (e.g., life, relationship, achievement) (Sturman & Mongrain, 2008; Sturman et al., 2015). Self-criticism significantly predicts both social comparison and internal entrapment, and they, in turn, mediate the effect of self-criticism on previous episodes of depression (Sturman & Mongrain, 2005). Self-criticism also mediates the link between attachment anxiety and depression, and attachment avoidance and depression (Dagnino et al., 2017).

Self-criticism is associated with numerous disorders and psychopathology. This includes eating disorders (Dunkley et al., 2010; Fennig et al., 2008), social anxiety (Cox et al., 2000; Lazarus & Shahar, 2018); and PTSD (Cox et al., 2004; Harman & Lee, 2009). Self-criticism is also deemed to increase vulnerability to hypomanic and depressive symptoms in clients with bi-polar mood disorders (Francis-Raniere et al., 2006). Self-criticism also impacts physical health conditions: for example, self-critical perfectionism is associated with increased stress-sensitivity in chronic fatigue syndrome and subsequent depression (Luyten et al., 2011). Self-criticism is also associated with suicidality (Fazzaa & Page, 2003) and mediates the link between insecure attachment and suicidal behaviour (Falgares, et al., 2017). The link between self-criticism and suicidality is particularly evident with more hostile forms of self-attack (O' Neil et al., 2021). Self-criticism is a mediator between shame memories and depressive symptoms and is positively correlated to how 'central' a shame memory feels to one's sense of self (Pinto-Gouveia et al., 2013). Shame and self-criticism appear to have a mutually amplifying influence on both depression and anxiety (Costa et al., 2016; Castilho et al., 2017).

Self-criticism has a significant social and relational impact. A longitudinal study found that self-criticism at the age of 12 predicted less years in education, lower occupational status, social maladjustment, and dissatisfaction in primary relationships by the age of 31 (Zuroff et al., 1994). Self-criticism contributes to the creation of a depressogenic, environment: generating risk factors (i.e., stressful events), whilst restricting protective factors (i.e., social support) (Priel & Shahar, 2000). Self-criticism is related to increased negative cognitive-affective reactions and hostility to partners during conflict resolution (Zuroff & Duncan, 1999, Mongrain et al., 1998). It also correlates positively with attachment anxiety/avoidance and negatively with dyadic adjustment (Martins et al., 2015).

Significantly, the severity of self-criticism predicts poorer treatment responses to psychotherapy (both interpersonal therapy and CBT) in clients diagnosed with depression (Marshall et al., 2008). The study by Rector et al., (2000) is significant in showing that not only did high self-criticism predict poor treatment response in cognitive therapy, but also 'the degree to which self-criticism was successfully reduced in treatment was shown to be the best predictor of treatment response' (p. 571). Self-criticism has also been shown to influence the benefit of evidence-based treatments in presentations other than depression (e.g., Cox et al., 2002). Clients with high levels of self-critical perfectionism also report reduced benefit from Rogerian conditions in therapy (Zuroff et al., 2016). Such findings suggest the importance of targeting self-criticism when considering treatment options.

Measures

As identified by Werner et al., (2019): 'the complexity of self-criticism becomes evident, when looking at self-report measures for self-criticism with different conceptualization of the construct' (p.531). A recent systematic review of self-report self-criticism measures concluded there was no 'gold standard' but advised that 'questionnaire choice should be based on the type of self-criticism being assessed' (Rose & Rimes, 2018, p.450).

The Depressive Experience Questionnaire (DEQ) (Blatt et al., 1976) is based on Blatt's two-polarity model (see above) and evaluates self-criticism as a one-dimensional vulnerability to depression alongside dependency and self-efficacy dimensions. The measure is widely used and

has been adapted as a shorter 6 item version (Shahar et al., 2008). Whilst the study by Shahar et al., (2008) found that each of these three dimensions were supported by confirmatory factor analysis, an earlier critical review of the DEQ (Viglione et al., 1990) found the subtypes of dependency and self-criticism 'do not hold up well in clinical populations' (p. 52). The Levels of Self-Criticism Scale (LOSC) (Thompson & Zuroff, 2004) is similarly based on the Blatt et al., (1976) conception of self-criticism but measures comparative self-criticism and internalised self-criticism. The Attitudes Toward Self Scale (ATSS) (Carver & Ganellen, 1983), is another self-report measure, and includes three sub-scales for measuring global self-worth: self-criticism, high-standards, and negative overgeneralising.

Rather than measuring self-criticism as trait, the Forms of Self-Criticizing/Attacking Reassuring Scale (FSCRS) (Gilbert et al., 2004) assesses responses to difficult experiences, and is based on social mentality theory (Gilbert, 2005). The 22 item-scale contains items measuring self-reassuring responses in addition to self-criticism, which is split into criticism focusing on inadequacy and disappointment, and criticism focusing on self-hatred and wanting to hurt the self. The items are based on a 5-point Likert scale, and all subscales demonstrate good internal reliability (Gilbert et al., 2004). The measure has been validated in a shorter form (Sommers-Spijkerman et al., 2018) and has been explored in clinical and non-clinical populations (Baiao et al., 2015).

What helps?

A review of self-criticism in psychotherapy (Kannan & Levitt, 2013) highlights how psychotherapies do not typically attempt to rid self-criticism but rather build new ways to cope with its presence or develop alternate ways of self-relating. Notably self-compassion and self-reassurance have been found to mitigate the negative impact of self-criticism on depressive symptoms (Zhang et al., 2017), for both internalised and comparative self-criticism (Joeng & Turner, 2015). Individual differences in self-criticism and self-compassion relate to depression status beyond other correlates of depression (Ehret et al., 2015) and fear of compassion has a moderating role between self-criticism and depression (Hermanto et al., 2016). A recent study by Petrocchi et al., (2019) also found that self-reassurance, rather than self-esteem, provides a buffer against self-criticism and depression. These studies suggest the benefit of building self-

compassion, and targeting fears of self-compassion, in clients with problematic self-criticism. Gilbert and Irons (2005) assert that self-compassion provides the antidote to self-criticism by recruiting alternate social mentalities and motives to provide the felt sense of safeness and reassurance lacking in the lives of self-critics. These mechanisms will be discussed further in the following chapter in the context of CFT.

Psychotherapy approaches that have been evaluated in targeting dysfunctional self-criticism include CFT (e.g., Lucre & Corten, 2013) and sub-modalities within the CBT tradition (De Oliveira et al., 2012). Specific interventions shown to decrease self-criticism include a novel, virtual-reality based intervention to 'embody' and apply compassion (Falconer et al., 2014), compassion based 'loving-kindness' meditations (Feliu-Soler et al., 2017; Shahar et al., 2015), and an expressive writing task that decreased self-criticism (Troop et al., 2013). Whilst compassion-focused imagery is often initially frightening and aversive in people high in self-criticism (Duarte et al., 2014), compassionate mind training has been found to decrease self-criticism is various formats: as a 2-week self-practice (Matos et al., 2017), as an online training (McEwan & Gilbert, 2016; Sommers-Spijkerman et al., 2018), as an outpatient group (Gilbert & Protcor, 2006), and as a treatment for severe mental health problems (Ascone et al., 2017). A study by Kelly et al, (2009) found that a compassion-based intervention resisting the self-critic's attack was more beneficial in lowering depression than a self-soothing task. This finding highlights the need for 'enhancing client agency through increasing clients' self-compassion and assertiveness' (Kannan & Levitt, 2013, p.174), countering the sense of defeat and inferiority created by self-criticism. It is of note that the majority of studies evaluating self-criticism in clinical populations have small participant numbers.

Other approaches for self-criticism include emotion focused therapy (EFT) (Greenberg et al., 1997) and related chairwork interventions (Shahar et al., 2017; Shahar et al., 2012). Blatt (2008) has also suggested the open and exploratory ethos of psychoanalysis is helpful to counter the intellectualised and emotionally controlled characteristics of clients with self-criticism, a position supported by comparative studies of mechanisms of action (Blatt & Shahar, 2004). Evidence for other modalities is more indirect and relates to the reduction of symptoms in disorders associated with self-criticism (e.g., depression) rather than measuring self-criticism directly.

Chapter summary and reflection

Depression is a significant global problem with a serious impact on people's psychological, social, and physical wellbeing. This review has focused on major depressive disorder which constitutes symptoms characterised by a loss of motivation and pleasure, negative thinking, and feelings of worthlessness and guilt. Depression is typically a recurrent problem for individuals and can be a chronic in nature.

Depression is understood to be a 'heterogenous' syndrome, created by an interaction of biological, social, evolutionary, and psychological influences. Whilst numerous theories have been proposed to explain the development and maintenance of depression, there is much in common between them, and it is in their interaction that a clearer picture of the condition emerges. For example, social and relational stressors during early life can have a significant influence on physiological maturation and gene expression which, in turn, can increase an individual's vulnerability to depression. Such early life stressors can also influence a person's attachment style, creating learning experiences or internal representations of self and others that influence behaviour and thinking in depressogenic ways. These response styles to physical and social threat can, more broadly, be understood as evolved mechanisms that have been phylogenetically conserved. In summary, it is clear there is a cascade of influences between an individual's biology, psychology, and social world, and the interactions between their genetic potential, individual history, and present environment.

The review suggests that depression is multi-layered, complex, and varied. In terms of emotion, depression has variously been related to conditioned anxiety, to inhibited and internalised anger, and to sadness and grief. Depression has also been linked to numerous motives: for social competition, harm avoidance, group belonging, and the elicitation of care. It too has been associated with a range of behaviours such as avoidance, submissive behaviours, and to arrested 'fight'. Cognitions, appraisals, and schemas also play a role, and the review has highlighted themes of helplessness, failure, and rejection. It is also clear that depression is both interpersonally and intrapersonally shaped and maintained.

Given the varied conceptions of depression, treatment strategies differ in their targets and emphasis. Biological treatments for depression focus on the use of antidepressants which are effective, to varying degrees, but problems of discontinuation and relapse remain. Notably, national guidance suggests psychological treatments should be the first-line treatment, with the weight of evidence supporting CBT and its various modalities and modes of delivery. Challenges to CBT have highlighted the high relapse rates, small effect sizes, and its equivalence when compared directly to other therapies.

One potential way of improving treatments for depression is to understand and target particular patterns, processes, and clusters of symptoms of which it is formed. One such process is shame. Shame too is a complex experience that has been understood and studied in different ways. It is characterised as a 'self-conscious' affective state that blends primary emotions and is associated with a distinctive behavioural profile (e.g., lowered gaze, concealment, and global avoidance). Shame can be both external and internally focused but is fundamentally understood to be related to social threat. Cognitive themes associated with such social threat are fears of negative evaluation and rejection from others, and of one's own failure and inferiority. An evolutionary framework again proves helpful in understanding the function and conservation of such negative experiences in humans. Shame is deemed to relate to the threat of social exclusion, is related to social status and hierarchy, and is associated with subordinate behaviour to appease powerful others and maintain belonging. However adaptive as a short-term strategy, shame is pathogenic and has a mediating role in various mental health problems and problematic coping, including depression.

Another process relevant to depression is self-criticism. Self-criticism has multiple forms but is characterised by negative self-directed affect and self-evaluation. It also has multiple functions, which typically relate to self-correction, self-punishment or self-inhibition following disappointment, failure, or fears of rejection. It has been conceptualised in multiple ways, including as a form of self-relationship that has been shaped by external relationships. From an evolutionary perspective, self-criticism can be understood as internal social conflict, operating through the same mechanisms (or 'mentalities') we would use when competing with others. Like

shame, self-criticism is a risk factor and predictor for depression and various mental health problems.

There are notable similarities between depression, shame, and self-criticism. They are all associated with a profile of internal negative attributions, sensitivity to low social rank and rejection, submissive behaviour, and the inhibition of core affects and external defences. It is therefore not surprising that they interact and are implicated in mutual maintenance mechanisms and meditations. Shame and self-criticism are also of particular importance when considering the treatment of depression as they can inhibit engagement with the therapy process and block the impact of traditional evidence-based treatments. Interventions that target these processes may be of particular benefit for clients with depression where shame and self-criticism are prominent. There is a growing evidence base for using compassion-focused approaches for both shame and self-criticism. The following chapter will therefore focus on compassion focused therapy and a particular method called 'chairwork' that is used to address these problems.

Chapter 3: Compassion Focused Therapy and Chairwork (the Potential Solutions)

Introduction

Whilst chapter two reviewed the problems of depression, shame, and self-criticism, this chapter provides an overview of potential solutions in the form of compassion focused therapy (CFT) and chairwork. The chapter initially focuses on CFT as a therapeutic modality, outlining its theoretical underpinning and clinical applications, before discussing chairwork as a psychotherapeutic intervention. The chapter concludes with a discussion of how CFT and chairwork have been combined and the potential this has for the treatment of depression, self-criticism, and shame.

Compassion focused therapy

Theory and development

CFT is an integrative psychotherapy based on the science of compassion and its therapeutic application. CFT originated in the 1990s from the insights of clinical psychologist Paul Gilbert when delivering cognitive therapy to clients with abusive, neglectful, and emotionally insecure backgrounds. Gilbert (2009) found that whilst such clients were able to generate logical alternative cognitions to answer their negative thoughts, these alternatives were not experienced as emotionally reassuring (a phenomenon known as rational-emotional dissociation (Stott, 2007)). When encouraged to articulate the feeling tone of their alternative thoughts, such clients frequently reported their internal speech to be emotionally 'cold' or 'aggressive' (Gilbert, 2012, p.140). Further insights were gained when inviting the clients to generate self-directed warmth and friendliness, which they experienced as aversive, rather than reassuring or soothing. Such findings raised questions about the possibility of training self-directed reassurance, and the psychotherapeutic strategies required to work with fears, blocks, and resistances to this new form of self-relating.

CFT draws from several theoretical sources. It is grounded in evolutionary theory, with a view of the mind as 'multiple': formed of various conflicting motives, emotions, and cognitive competencies that have developed in a 'piecemeal' way over millions of years (Gilbert, 1989; 1992). CFT includes the distinction between 'old brain' drives, emotions and behaviours that are

shared with other animals, and 'new brain' cognitive competencies such as symbolic thought, systematic reasoning, self-reflection, knowing intentionality, empathy, and mind awareness (Gilbert, 2009, 2014). Old brain and new brain interactions can create loops and glitches so that powerful old brain motives and emotions can shape new brain thinking (e.g., human intelligence can be recruited by old brain 'groupism' to design and build destructive weapons), and new brain competencies can stimulate old brain reactions (e.g., self-reflection and worry can stimulate anxiety and avoidance of events that have not yet occurred) (Gilbert, 2014). The brain also contains motives and drives that can conflict and function beyond our conscious awareness, creating a mind that can be hard to understand and regulate (Bargh, 2017). CFT highlights how the development of the human brain has come with many trade-offs and compromises that lead to human distress; for example, in creating a mind that focuses large amounts of resources on threat processing, accompanied by negativity biases (Baumeister et al., 2001).

Gilbert (1989) has also emphasised how different evolved motives give rise to very different mindsets and archetypal potentials. As introduced in the prior chapter, Gilbert (2005) developed the concept of 'social mentalities' to explain how the mind is organised to co-create social roles in pursuit of specific goals such as reproduction, care, competition, and cooperation (Gilbert, 2005). Social mentalities therefore co-ordinate and choreograph elements of cognition, affect and behaviour in very different ways depending on such goals (Geary & Huffman, 2002; Gilbert, 2017; Hermanto et al., 2017). A person motivated by sex will recruit very different qualities of mind (facilitating different reciprocal interactions) than someone motivated by care. As Gilbert (2000, 2014) has noted, such social role-seeking and forming mentalities can create conflict or become 'encapsulated'. A person may, for example, become caught in competitive, rank-based relating with their family or friends, switching off care-giving abilities to be sympathetic and sensitive to their suffering. The sensing and decoding of social signals to create 'complex interpersonal dances' is important in the development of competencies such as empathy and mentalisation (Luyten et al., 2020). Our environment, however, has a significant influence on the phenotypic expression of social motives and related mentalities; for example, an individual born into a context high in social conflict is more likely to operate rank-based strategies within their relationships and utilise competencies, such as empathy, for competitive ends (Gilbert, 2005).

Gilbert (2005) further describes how social mentalities not only shape, regulate, and texture external relationships but are also incorporated into relating styles with ourselves. With the rise of 'new brain' capacities for self-awareness and self-relating, the mind becomes both sender and receiver of social signaling (Gilbert, 2017). Distressed aspects of the self can therefore be related to competitively, with self-critical domination that stimulates submissive defenses, or be treated with care and self-support, creating feelings of inner safeness (Gilbert & Irons, 2005). CFT focuses on switching between motives and related social mentalities, so that both internal and external relationships can be based on care and compassion rather than competition and hostility. Self-compassion can therefore be conceptualised as a means to engage with, and integrate, various patterns of experience that become conflictual, segregated, or avoided as part of threat-based processing (Gilbert, 2005; 2017).

CFT is also rooted in the evolutionary theory of attachment (Bowlby, 1963; Ainsworth, 1979). Attachment theory highlights how mammals have evolved to be regulated through caring and affiliative social relationships and how the interactions between child and care-giver influence physiological maturation and psychosocial well-being (Hofer, 1984, 1994; Siegel, 2001). The three functions of attachment as outlined by Bowlby (1963, 1973, 1980) are: proximity seeking and maintenance; the provision of a secure base to allow for exploration, play and learning; and the presence of a safe haven to contain, soothe and regulate distress. Our early attachment relationships create 'internal working models' for future relationships, including the relationship we have with ourselves (McFie et al., 2005; Bretherton, 2005 Lathren et al., 2020). Gilbert (2020) asserts that the qualities and functions of secure attachment overlap with those of compassion. CFT therefore involves developing a compassionate self (or imaginal compassionate other) (discussed below) that functions as an internal attachment figure (e.g., both regulating and encouraging). As outlined in chapter 2, disruptions in attachment relationships can create problematic interpersonal as well as intrapersonal relationships (Lippard & Nemeroff, 2020; Thompson & Zuroff, 1999). CFT therefore focuses on the fears and protective strategies, created by the frustration of core attachment needs, that make the giving and receiving of care and compassion so difficult (Gilbert, 2017).

CFT has also been influenced by developments in affective neuroscience. Based on the work of Depue & Morronne-Strupinksy (2005), Panskeep (1998), and LeDoux, (1998), CFT focuses on the interaction between three types of major emotion regulation systems, based on an evolutionary functional analysis. Using this approach, emotions are clustered into groups depending on the primary motives their serve: threat, protection, and harm avoidance; drive-based resource seeking and acquisition; and rest, digest and soothing (Gilbert, 2005, 2009). A course of CFT will include a focus on balancing these emotional systems with an emphasis on enhancing 'soothing' parasympathetic feeling-states and emotions which, in mammals, are interlinked with social safeness and care (Gilbert, 2014; Porges, 2017). Recent research has highlighted the physiological infrastructure required to support compassion and caring motives. The hormones oxytocin and vasopressin have been linked to infant care and pair bonding, and the myelination of the vagus nerve is implicated in the way social engagement and care regulates threat-activation (Stevens & Woodruff, 2018; Porges et al., 2011). A key focus of compassionate mind training (discussed below) is the use of body, breath, and imagery to increase vagal tone, which is associated with heart-rate variability and experiences of social safeness (Geisler et al., 2013; Petrocchi & Cheli, 2019).

Gilbert also acknowledges the influence of Buddhist philosophical traditions, describing his aim to 'marry evolutionary understanding with Buddhist insight and training' (Gilbert & Choden, 2013, p. ix). Buddhist psychology emphasises the importance of mind-awareness and mind-training to prevent the mind from becoming unregulated and ruled by passions and emotions (Dorjee, 2013). CFT emphasises the notion of mind-training and mindfulness to cultivate insight into our mental processes and develop skillful ways with which to relate and work with them (Gilbert, 2009). Compassion and compassionate aspirations are central to Buddhist practices and psychology, as evident in the concept of bodhicitta (a state of mind and intention to pursue enlightenment for the benefit of others) and in the four brahmavihārās (sublime or immeasurable states/attitudes) (Dalai Lama, 2020). As highlighted by Gilbert and Choden (2013), 'Buddhism is a unique resource because it offers practical methods for training the mind in compassion' (p. xxvii). CFT uses many visualisation and contemplative methods that are rooted in Buddhist practices (Tirch et al, 2016; Gilbert, 2009).

Compassion, in CFT, is defined as ‘a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it’ (Gilbert, 2017, p.11). Unlike other forms of compassion training which focus solely on self-compassion (e.g., Neff, 2011), CFT aims to cultivate compassion in its various flows: from self-to-others, others-to-self, and self-to-self. In CFT compassion is conceptualised as an innate motivation associated with brain systems that underpin altruism, affiliation, and care (Gilbert, 1989). Compassion is not viewed as a specific ‘soothing’ emotion- as in some other compassion-based approaches- as the emotions recruited for compassionate action and relating can be varied. For example, a fire-fighter entering a burning building to save another life can be said to be demonstrating a ‘sensitivity to suffering’ and a ‘commitment to try to alleviate and prevent it’, yet their emotions may be textured with threat-related arousal. Gilbert (2020) has recently emphasised the algorithmic nature of motives, and their stimulus- response dynamics: i.e., if *A* then do *B*. For care and compassion, the stimuli are signals of suffering or need and the response is to take action to alleviate it. As Gilbert (2020) has highlighted, there can be many facilitators and inhibitors of caring algorithms, both at the level of stimulus sensitivity or in the competencies or willingness for alleviation.

In CFT, the inhibitors of compassion are explored in terms of developmental, contextual, and evolutionary factors that present in idiosyncratic fears, blocks, or resistances (FBRs) to all flows of compassion (the ‘flow’ of compassion refers to the direction in which compassion is focused: from self-to-others, from others-to-self, and from self-to-self) (Gilbert et al., 2011). *Fears* relate to threat-system activation when engaging with, or anticipating, compassion (and can be related to early life relationships); *blocks* refer to difficulties in cultivating compassion despite the desire to do so (e.g., situational factors such as a lack of opportunity); and *resistances* denote a lack of desire to be compassionate, such as perceiving it as too costly (Matos et al., 2017; Gilbert & Mascaro, 2017; Gilbert, 2020). Such FBRs can be expressed as beliefs (‘compassion is weak and selfish’) and as conditioned emotional reactions to feeling states, desires, and other emotions (Gilbert et al., 2011; Gilbert et al., 2014). Stimuli associated with care and compassion (e.g., via compassion-focused exercises or the attention of the therapist) can be conceptualised as ‘opening the attachment system’, potentially triggering emotional memories (Gilbert 2009). Gilbert (2020) therefore suggests that FBRs offer both insight and potential for change: ‘what is feared is also the source of their healing’ (p19). FBRs are therefore respected as intuitive wisdom and

validated as cautions and protections which become the target of treatment. Fears of receiving compassion from others or self are notably most associated with mental health difficulties and poor heart-rate variability (Hermanto et al. 2017; Kirby et al., 2019; Di Bello et al., 2020).

Compassionate mind training and interventions

As with other motives, compassion can have both external and internal facilitators and inhibitors. Clarifying these processes has allowed for the development of interventions and contexts to stimulate compassion such as the activation of specific 'physiological systems, cognitive competencies and behavioural training, and practicing certain types of meditation' (Gilbert, 2020, p.3). CFT therefore offers a 'menu of interventions' (Gilbert, 2020, p3.) and adopts a multi-modal integrative approach to tailor treatment to the client's idiosyncratic presentation. This might focus on developing empathy, creating feelings of safeness and soothing, or working directly on fears of compassion. CFT builds upon a range of established, evidence-based psychotherapeutic interventions, contemplative practices, and relational approaches with the explicit aim of cultivating and applying compassion.

The initial stage of CFT involves generating insights into the complex nature of the evolved human mind and brain. This includes guided psychoeducation using the old-brain/new-brain framework (introduced above), highlighting how 'loops' can be created between thinking, emotion, and innate motives that extend and amplify human distress. One aim of reflecting on the brain's inherent conflicts is to depersonalise and depathologise these processes and reduce individual attributions of blame. Another is to develop 'mind awareness' to differentiate the various patterns and potentials that texture the mind and ultimately shape its output (Gilbert, 2020). 'Reality checks' in CFT are also used to highlight the influence of social shaping on personality development and epigenetic expression. These insights are supported by mindfulness training, using the various practices outlined in Gilbert and Choden (2013). Within CFT, mindfulness is utilised to cultivate mind awareness into our biological and social 'programming', and to regulate our attention and focus 'away from the unhelpful to the helpful' (Gilbert 2020, p26).

Further insights into such ‘programming’ are developed via formulation. The multiple formulations in CFT include exploring the client’s three systems of emotion and how they are balanced (introduced above). In depression, for example, a client’s threat system might be over-activated, their drive system under-potentiated, and their soothing-safeness system absent. Time is also spent understanding the client’s idiosyncratic threat-system development and how this has textured and influenced self-evaluative processes, such as self-criticism (Gilbert, 2010). A threat-based formulation typically captures innate and historical influencing factors, key internal and external threats and fears, internal and external focused safety strategies, and the unintended consequences they create (Kolts, 2016). The ‘felt sense of the self’ is also explored in terms of emotional memories of the self in relation to others to capture the implicit processes and conditioning associated with shame (Gilbert, 1998; Gilbert, 2010). Such explorations are grounded in Socratic inquiry and guided discovery, allowing clients to create new compassionate narratives for their experiences, identify unmet needs, and build a rationale for developing their compassionate self (Gilbert, 2010).

To balance the three emotional systems and provide the optimal physiological context for compassion to develop, clients are guided in exercises that create feelings of safeness, soothing, and groundedness. One such practice is soothing-rhythm breathing which involves purposely slowing the breath, focusing on the sensation of bodily slowing, and altering various physical inputs such as changing posture or creating a friendly facial expression (Gilbert, 2009). The breathing rate and physical changes adopted are designed to stimulate and tone the vagus nerve, and support parasympathetic regulation (Gerritsen & Band, 2018; Steffen et al., 2021). Clients are also encouraged to explore various physical means to become safely embodied, using practices such as yoga or sensory focusing on external objects. As Gilbert (2020) has stated, such exercises ‘train/use the body to support the mind’ (p.28) and precede any compassion focused practices.

Compassion mind training (CMT) is associated with a suite of interdependent qualities and skills that can be recruited to facilitate care-giving and receiving. The qualities associated with engagement with suffering- the first psychology of compassion- include sensitivity to suffering, distress tolerance, sympathy, empathy, and being non-judgmental (Gilbert, 2009). Such qualities

are mutually supportive: for example, by learning to tolerate distress we are more able to remain sensitive and attuned to our distress and need. In CFT, the skills and competencies involved in alleviating and preventing suffering are common to other therapies but here they are underpinned by a compassionate orientation and motivation (Gilbert, 2020). Such multi-modal practices can be used to train thinking/reasoning, attention, imagery, use of the body/senses, emotions, and behaviour (Gilbert, 2009). Again, training one area of skill can complement another. For example, mindfulness practices have been found to stabilise attention, support emotional regulation, and offer new perspectives on the self that can support compassion (Holzel et al., 2011; Gilbert & Choden, 2012). These core processes can be measured across the three flows of compassion and specifically targeted for training (Gilbert et al., 2017)

Compassionate mind training incorporates imagery to stimulate care-compassion physiologies and states of mind. Imagery is deemed to have 'special relationship' with emotion and the body and is more emotionally potent than verbal processing (Holmes & Matthews, 2005, 2010). CFT imagery exercises, such as safe-place imagery and compassionate colour, are used to access and explore the soothing system (see Gilbert, 2010). CFT imagery is also associated with attachment priming. A recent review on attachment security priming suggested guided imagery and visualisation are 'especially effective ways to prime security…and {are} associated with beneficial effects across a diverse set of domains' (Gillath & Karantzas, 2019; p.86). To practice receiving compassion from others, clients are encouraged to focus on specific memories of receiving care and to create an ideal compassionate figure, also known as the 'perfect nurturer', with whom to interact (Lee, 2005). Alternative flows of compassion can be stimulated in similar ways, such as compassionate focusing on other people (remembered or imagined) via mental imagery (Gilbert & Choden, 2013). Using imagery of compassionate figures and interpersonal interactions complements the relational nature of compassion, allowing new insights to be generated via dialogical means rather than rational reflection (Gilbert, 2020).

CMT is also focused on the development of the 'compassionate self', a version of the self that acts as 'an organising framework' to embody and enact the various compassionate qualities and skills described above (Gilbert, 2014; Kolts, 2016). Typically, the compassionate self is built via imagery and fantasy (e.g., visualising oneself at our compassionate best) and elaborated via

method acting techniques (e.g., acting ‘as if’ and becoming the ‘role’ from the inside-out) (Gilbert, 2009, 2010). As introduced above, the compassionate self is used for multiple functions within CFT, including: to counter self-shaming and criticism, to provide a source of soothing and regulation (safe haven), and also for guidance and encouragement (secure base) (Gilbert, 2020).

Once established, the compassionate self (or compassionate ‘other’) can be strengthened and practiced by focusing compassion on distressed or vulnerable aspects of the self (Gilbert, 2010). Focusing compassion on parts of the self can practiced via imagery, chairwork (described below), and letter-writing (Kolts, 2016). Such practices involve differentiating and personifying specific threat-based patterns and processes, such as self-criticism, so that they can be related to with compassion. The client is ultimately encouraged to take their compassionate self into the world to practice new skills and behaviour, committing to actions that alleviate and prevent their suffering and to foster growth and flourishing. To achieve this, clients might be supported via imaginal rehearsal, exposure or behavioural experiments, or via assertiveness practices (Irons & Beaumont, 2017). The methods for applying compassion, in its various flows, are not limited to specific techniques, but rather are guided by compassionate goals and individual need.

Applications and effectiveness

CFT was originally developed for people experiencing shame and self-criticism, who often came from harsh or emotionally unsupportive backgrounds and were fearful or distrustful of compassion in its various flows (Gilbert 2000, Gilbert et al., 2011). Its application has been broadened across multiple presentations and service contexts. As of 1/12/2021, there have been two main systematic reviews for CFT (Leaviss & Uttley, 2015; Craig et al., 2020), a narrative review (Beaumont & Martin, 2015) and a recent scoping review focusing on outcome research (Basran et al., 2022). A broader discussion of compassion-based interventions, as reviewed in the meta-analysis and narrative summary of Kirby, (2017) and Kirby et al., (2017), are beyond the scope of this current study.

The early review of Leaviss and Uttley (2015) found that CFT ‘shows promise as an intervention for mood disorders, particularly those high in self-criticism’ (p.927). The most recent review of Craig et al., (2020) summised that CFT increases self-compassion and reduces mental health

symptomatology across 'a range of mental health problems, especially when delivered in a group format over at least 12 hours' (p.385). Such improvements were evident among client groups that have shown resistance to traditional evidence-based approaches (e.g., forensic populations). Both reviews highlight the need for treatment manualisation (to address the lack of standardisation in CFT studies) and the deficit of research of individual CFT, as opposed to a group format. An overview of the range of CFT's application is described below.

A variety of anxiety disorders have been addressed with CFT. This includes group-based CFT for treatment-resistant OCD (Petrocchi et al., 2021), with all participants demonstrating reliable decreases in OCD symptomology maintained at 4-week follow up. A pilot group-study for hoarding (Chou et al., 2020) found CFT to be a helpful approach where CBT's effectiveness was limited. For social anxiety, an RCT (Gharraee et al., 2018) and replicated case-series (Boersma et al., 2015) found CFT reduces social anxiety symptoms, shame and self-criticism whilst increasing self-compassion. For clients with depression, group CFT or CMT was associated with significant reductions in depression and anxiety, improved sleep quality, reduced self-hated and fears of compassion, as well as increased self-compassion (Noorbala et al., 2013; Eslamian et al., 2019; Savari et al., 2021). A case study for a client with major depressive disorder, problematic shame, self-criticism, and perfectionism (Matos & Steindl, 2020) demonstrated how CFT can be applied in this presentation.

For clients using community mental health teams, primary care teams, and outpatient services, CFT has typically been studied in a trans-diagnostic group format (e.g., Gilbert & Proctor, 2006; Judge et al., 2012; Bartels-Velthuis et al., 2016; Cuppage et al., 2017; McManus et al., 2018; Scheid, & Singh, 2019; Mernagh et al., 2020). Cuppage et al., (2017), for example, found that clients receiving CFT reported significant improvements in social safeness and reductions in levels of psychopathology and fears of self-compassion when compared to treatment as usual (with improvements in psychopathology predicted by changes in fears of self-compassion and self-criticism). The CFT groups evaluated by Judge et al., (2012) were notable for reporting significant changes in depression for clients 'in the severe category of depression scores' (p. 420). The mixed-methods approach of Mernagh et al., (2020) found that CFT increased participant's sense of body-mind attunement and interoceptive awareness. Transdiagnostic CFT

groups have also been utilised within university counselling setting and were found to be 'feasible, acceptable, and effective' for a transdiagnostic population (Fox et al., 2020; p. 419).

CFT has notably been developed and adapted for eating disorders (Goss & Allen, 2012; 2014). This includes the addition of CFT into standardised CBT treatment for a transdiagnostic eating disorder groups (Gale et al., 2014; Kelly et al., 2017), with evidence of strong acceptability, increases in compassion (in various flows), and reductions in shame and eating distress. CFT has also shown promise in addressing body-weight shame (Carter et al., 2021), binge-eating disorder (Duarte et al., 2017; Kelly & Carter, 2014) and bulimia (Williams et al., 2017). A specific letter-writing intervention was developed for anorexia nervosa (Kelly & Waring, 2018) which increased self-compassion and reduced shame, but did not impact eating pathology.

CFT has also been applied to trauma, violence, and post-traumatic stress disorder (PTSD) (Lee, 2012). Two outcome studies (Au et al., 2017; Grodin et al., 2019) suggest that CFT is effective in reducing PTSD symptoms, shame, anger, and self-blame. Qualitive explorations of client experience following CFT treatment for PTSD have highlighted the importance of group work, to experience multiple flows of compassion, and the benefit of a phase-based treatment that targets shame and emotional regulation before memory-focused interventions (Lawrence & Lee, 2013; Ashfield et al., 2020). Three studies have applied CFT to clients with experiences of emotional abuse and intimate-partner violence (Fatolaahzadeh et al., 2017; Daneshvar et al., 2020; Naismith et al., 2021). Their findings suggest CFT decreases emotional avoidance, suicidal ideation, internalised shame, and self-criticism, whilst increasing self-reported 'meaning in life'. CFT has also been utilised as an adjunct to established PTSD treatments such as trauma-focused CBT (Bowyer et al., 2014; Beaumont et al., 2016) and EMDR (Beaumont & Martin, 2013), with particular benefit in reducing shame and self-criticism.

CFT has been used to treat clients with 'serious mental illness', with five studies evaluating CFT for psychosis or 'Schizophrenia' (Mayhew, & Gilbert, 2008; Laithwaite et al., 2009; Braehler et al., 2013; Kennedy, & Ellerby, 2016; Cheli et al, 2020). In summary, CFT interventions were associated with reductions in shame, psychopathology, paranoia, perceived social marginalisation, and depression. In case-studies (e.g., Kennedy & Ellerby, 2016), clients

benefited from developing and utilising their compassionate self to dialogue directly with their critical voices, an approach elaborated by Heriot-Maitland et al. (2019). CFT has also been piloted for inpatients of acute psychiatric wards (Heriot-Maitland et al., 2014; Stroud & Griffiths, 2021). Despite the brief nature of the intervention and the nature of the context, the group was well received and demonstrated beneficial changes in distress, well-being, and functioning compared to treatment as usual. CFT has also been applied for clients diagnosed with a personality disorder (Lucre & Corten, 2012). This programme was delivered in a 16-week group format and was associated with significant reductions in shame, social comparison, depression, stress and self-hatred, and an increased ability to be self-reassuring.

Other clinical areas of CFT application include groups for clients for intellectual development disorders (Clapton et al., 2018; Cooper, & Frearson, 2017; Goad & Parker, 2020), which have demonstrated benefit in reducing self-criticism and social comparison but have limited effectiveness on core markers for psychological well-being. CFT has been applied to acquired brain injury using both group and individual formats (Ashworth et al., 2015; Ashworth et al., 2011). The results demonstrate significant decreases in anxiety, depression, and self-criticism, and an increase in the capacity to self-reassure. CFT for substance use has been developed with adults (Torbati et al., 2020) and adolescents (Agberotimi et al., 2017), resulting in lower substance use disorder symptoms and increased cognitive-emotional regulation when compared to waiting list controls. Pain and physical illness have been addressed via CFT groups (Parry & Malpus, 2017; Penlington, 2019), with outcomes that suggest decreases in anxiety, depression, and pain interference. Additional clinical areas where CFT has been evaluated are with clients with dementia and their carers (Craig et al., 2018; Collins et al., 2018) and forensic settings (Ribeiro da Silva, 2019; Taylor & Hocken, 2021).

The review by Basran et al. (2022) highlights the variety of non-clinical, community, and student applications of CFT which include: cultural adaptations for indigenous populations in Australia (Bennett-Levy, et al., 2020), self-help public-health initiatives for wellbeing (Sommers-Spijkerman et al., 2018) and CFT training for school teachers (Maratos, et al., 2019), health professionals (Beaumont et al., 2021), parents (Mitchell et al., 2018) and children and adolescents (Lander, 2019). Notably, an 8-week CMT course for the general public (Irons &

Maitland Heriot, 2021) demonstrated increases in compassion, self-reassurance, and well-being whilst reducing self-criticism, attachment anxiety, and distress (amongst other positive findings). The Basran et al. (2022) review highlights the large number of studies focusing on brief CFT interventions, specific elements of CMT, or mechanisms of change. Focusing on compassionate self exercises, the study by Matos et al., (2017) found a two-week practice of 15 minutes per day for clients with depression significantly reduced depressive symptoms, self-criticism, and shame, whilst increasing self-compassion and openness to compassion from others. Notably, changes in depression were mediated by decreases in self-criticism and shame and increases in compassion.

Chairwork

Definition and history

Chairwork can be defined as a group of experiential practices 'which utilise chairs, their positioning, movement, and dialogue to bring about change' (Pugh et al., 2020, p.3). Chairwork typically involves generating and facilitating interactions between aspects of the self which are differentiated and personified on different chairs. The approach has a rich 100-year history within psychotherapy and is now integrated within a variety of evidence-based modalities.

Chairwork has its origins in the psychodramatic method of Jacob Moreno (1889-1974). Whilst trained in psychoanalysis, Moreno rejected its reliance on verbal analysis and discourse and instead sought to externalise and enact intrapersonal conflict via dramatic means: 'I let them act out their conflicting roles and help them put the parts back together' (Moreno, 2011, p.68). Psychodrama is a group-based method, wherein a facilitator directs the group to support a single member ('a protagonist') to bring their problem to life in ways that 'transform the clinical consulting room into a theatrical stage' (Landy, 2008, p.197). Moreno aimed to create a 'surplus reality' wherein reality is enriched, transformed, and 'expanded' by the imagination (Moreno et al., 2000). Psychodramatic interventions include the use of auxiliary egos (where another group member takes the role of someone important in the protagonist's life), auxiliary chairs (the use of an empty chair to stand in for the 'other') and role-reversal (where the protagonist embodies the role of the 'other') (Cruz et al., 2018). Moreno (1953) would often encourage protagonists to enact the role of a problematic 'thing' (be it another person, an internal process, or abstract concept), 'for the purpose of exploring, experimenting, developing, training, or changing role'

(p.722). The psychodramatic method gives primacy to action, creativity, spontaneity, and immediacy (Moreno, 1946; Kellerman, 1992).

Psychodramatic methods were applied within individual therapy by Fritz Perls (1893-1970), the originator of gestalt therapy. Rather than using group members as 'auxiliary egos', Perls (1992) emphasised the importance of the client playing 'all the roles', suggesting that this provides 'a clearer picture than when we use Moreno's technique of psychodrama' (p.143). Perls popularised the use of chairwork via public demonstrations where attendees were invited to take the 'hot seat' and engage in psychodramatic dialogue with aspects of themselves by moving back-and-forth between chairs (Perls, 1969). Like Moreno, Perls emphasised the importance of addressing problems in the 'here-and-now' via direct dramatic action and embodiment that is 'existential-phenomenological, experiential, and experimental' (Roubal, 2009, p. 264). Rather than intellectually talking about a problem, Perls (1969) advocated 'talking to' it, and from it, personified in an opposite chair. In addressing an unresolved issue, Perls (1973) suggested: 'It is insufficient to recall a past incident, one has to psychodramatically return to it" (p.65). Notable examples of gestalt-based chairwork include the use of two chairs to explore self-critical dialogues (between 'top-dog' and 'bottom-dog') and empty-chair procedures (to deal with 'unfinished situations').

Chairwork was further advanced by the work of Les Greenberg and colleagues in the development of process-experiential and emotion-focused therapy (EFT) (Greenberg et al., 1993). Greenberg (1983) conducted the first empirical studies of chairwork in the 1970s and sought to identify specific 'tasks' within chairwork to be studied and taught in a coherent and systematic way. EFT is guided by the identification of specific 'markers' within the therapeutic process (i.e., 'in-session statements and actions that reveal internal client states of readiness' Elliott & Greenberg, 2021, p66). This includes markers indicating the potential for chairwork. For example, if 'conflict splits' are identified between aspects of the self- whereby one part of the self criticises, coerces or blocks another- then 'two chair dialogues' are proposed (Elliott & Greenberg, 2021). Other EFT chairwork interventions include empty chairwork for 'unfinished business' and compassionate self-soothing for 'anguish' (whereby the client embodies and enacts

a caring figure before changing chair to receive the care they generated) (Elliott et al. 2004; Elliott & Greenberg, 2021).

Chairwork also forms part of cognitive and behavioural therapy traditions, as evidenced in recent publications by Pugh (2017; 2018; 2020). The history of behavioural therapy includes in-session assertive 'psychodramas' to inhibit anxiety (Wolpe, 1958), behavioural rehearsal (Lazarus, 1966), and coaching via 'contrasted role-play' (McFall & Twentyman, 1973). Cognitive therapy literature includes 'rational-emotive' or 'lawyer-prosecutor' role-plays to address entrenched, schema-level beliefs (Beck, 2020; Goldfried, 2013; Pugh 2017) and 'historical role-plays' whereby the client re-creates distressing childhood scenes with the potential to intervene from the position of their adult self (Artnz & Weertman, 1999; Beck et al., 2004). Schema therapy, an integrative approach that draws upon cognitive theory, incorporates chairwork as a core experiential technique to 'heal' early maladaptive schemas (Young et al., 2006; Kellogg, 2012). Schema therapy chairwork includes two-chair techniques for mode dialogues, such as utilising the 'healthy adult' to fight' the 'punitive parent' or address the 'detached protector' mode (Arntz & van Gengeren, 2009). Other allied CBT approaches that use chairwork include Chadwick's (2003) emotion-focused chairwork for psychosis and de-Oliveira's trial-based method (de Oliveira, 2008; de Oliveira et al., 2015).

Principles, processes, and process-skills

Given that the last 100 years of chairwork innovation has included multiple therapy modalities, there are multifarious ways in which the method can be conceptualised and understood. To simplify, unify, and integrate the approach, Pugh (2020) and Pugh and Bell (2020) have posited core principles and processes the underpin chairwork practice (table 1).

Table 3.1. Principles and process of chairwork (adapted from Pugh and Bell, 2020)

Principles (SIT)	Processes (SAT)
Self-multiplicity	Separation
Information exchange	Animation
Transformation	Talk

The first principle of *self-multiplicity* refers to a conceptualisation of the self as formed of multiple interactive agentic parts, voices, I-positions, modes, mentalities, or subpersonalities. The notion of the self as 'multiple' and 'modular' is commonly held within psychotherapy and is present in broader scientific discourse (Rowan, 1989; Hermans, 2001; Cooper et al., 2004; Klein, 2010; Stemplewska et al., 2014). Self-multiplicity has been formulated in a variety of different ways: for example, EFT's dialectical constructivist conception of the self is of a 'multi-process, multilevel organisation emerging from the dialogical interaction of many component parts' (Greenberg & Watson, 2006, p.37). In chairwork, parts of the self may refer to internal processes or patterns of experience (such as the 'angry self' or 'detached protector') or internalisations or introjections of other people (such as the 'punitive parent' or the voice of the deceased). They may be familiar or unfamiliar, dominant or silent, well-assimilated or unassimilated (Hermans, 2004). Dialogical-self theory suggests that it is the idiosyncratic dynamics between parts of the self that cause distress and disturbance- e.g., in their restriction, inflexibility, dominance, or disorganisation (Hermans & Gieser, 2011). Depression, for example, has been conceptualised as a monolithic voice that restricts and subsumes self-multiplicity and adaptive variation (Greenberg & Watson, 2006).

The principle of self-multiplicity is supported by the process of *separation*, which typically occurs by positioning different parts of the self onto separate chairs. This process has been proposed to have multiple benefits (Pugh & Bell, 2020). In externalising and concretising parts of the self onto set chairs, such parts can be differentiated, disentangled, and organised. They might be situated in specific positions in the clinic room to depict self-configurations (e.g., the angry self might take a central position) and then moved to explore or represent changes in such configurations. This approach has its roots in Moreno's sociometry methods whereby social relationships were mapped in space using group participants (Dayton, 2005). Separating and situating parts in this way allows for dis-identification from dominant aspects of self, whilst also creating space for other parts that are underdeveloped, unconscious, or disowned (Hermans & Gieser, 2012). As aspects of the self are located in set positions, clients can intentionally modulate their immersion in each part by occupying or leaving the chairs. The physical movement away from each self is proposed to facilitate self-distancing and decentered reflection,

which are associated with cognitive flexibility and emotional-regulation (Chadwick, 2003; Kross & Ayduk, 2016; Barbosa et al, 2017).

The second principle of chairwork focuses on *information exchange*: the notion that internal parts contain and share important information between themselves in a dialogical form. Such dialogical exchanges can become problematic stereotyped interactions which Pugh and Broome (2020) have termed ‘dialogical dysfunctions’. These include ‘conflictual dialogues’, whereby one part of the self persistently attacks another, and ‘disrupted dialogues’, whereby an internal interaction is unresolved or one part blocks another (Pugh & Broome, 2020). These exchanges are brought to life in the *animation* process as clients are invited to enliven parts of the self by personification or embodiment (Pugh & Bell, 2020). Personification requires clients to imagine parts of the self in unoccupied chairs, visualising their physical form, character, and interactions (e.g., ‘how does the critic appear in the chair?’). Embodiment involves changing seat to become the part and to speak from this role (e.g., ‘As the critic, what do want to say?’). A third option is objectification whereby a specific object is imbued with the role and voice of a self-part (Chesner, 2019). Embodied dialogue is the preferred option to immerse clients into the ‘surplus reality’ of the exchange and gain ‘action insight’ by speaking as the part (Blatner, 1988; Kellerman, 1992). Embodiment can also provide access to implicit forms of body-based insight and feedback, in line with research in embodied cognition and the way in which the body can be used to access and influence cognitive states (Whelton & Greenberg, 2005; Shapiro, 2010).

The information exchange between parts can ultimately create *transformation* in the dialogical mind. The type of transformation sought in chairwork is dependent on the modality in which it applied. Common forms of dialogical transformation have been proposed by Pugh and Bell (2020). These include cultivation (the intentional development of new adaptive self-parts) and reconciliation (establishing co-operation between conflictual parts). Typically, transformation is not achieved by creating a ‘homogenous’ single self, but by means of assimilation or integration and an appreciation of self-complexity (Pugh & Bell, 2020). Enactive, emotive, and experiential interventions are deemed to provide more opportunity for holistic, cognitive-affective change that avoids the rational-emotional dissociation introduced above (Epstein, 2014). Chairwork, in its multi-sensory and evocative methods, is well-placed to create such systemic transformation.

The '*talk'* process of chairwork dialogue is facilitated by the process skills of the therapist. Again, the therapeutic modality in which chairwork is applied shapes the form of practice. In schema therapy, for example, the therapist typically enters the dialogue and speaks directly to and for parts of the client (e.g., the therapist might 'limit' and 'fight' the client's punitive parent) (Arntz & van Genderen, 2009). This is in keeping with the notions of 'limited re-parenting', whereby the internalisation of the therapist as a healthy attachment figure is intentionally fostered (Young et al., 2006). Many of the process skills in contemporary chairwork are drawn from the psychodrama tradition. Psychodrama includes processes such as 'mirroring', whereby the protagonist views their own behaviours re-enacted by another group member, and 'doubling', whereby another group member expresses the protagonist's 'inner voice' (Cruz et al., 2018). In individual chairwork, the mirror or double becomes the therapist. 'Doubling' (and the use of 'feeding lines') offers the therapist scope to generate empathic, evocative, first-person statements to clarify and deepen the implicational messages of the client's 'talk'. Rather than asking reflective questions during chairwork dialogue (e.g., 'what is it like to be spoken to in that way?') the therapist might tentatively offer a doubling statement (e.g., 'I feel so sad and hurt when you say that Dad') that the client can repeat or elaborate (e.g., 'If it fits, try saying….'). Using such statements helps the client to 'bring height, depth, and width to their problem, over and beyond what they could do by themselves' (Moreno et al., 2000, p.90).

Other process-skills typically employed in chairwork include 'deepening techniques', as outlined by Greenberg (1979), Kellogg (2015), Perls (1992) and Pugh (2020). These include repetition (asking the client to repeat meaningful vocalisations), changes in speech volume (for emphasis), and encouraging the client to express what they are feeling as they are speaking (for affective amplification and connection). The client can also be encouraged to visualise the appearance of the percept in the empty chair, which can enhance personification and create the experience of a relational encounter. Similarly, encouraging the client to talk 'to', rather than 'about', the imagined other in an empty chair aids immersion in the dialogic exchange as opposed to relying on cognitive-rational processing (Greenberg et al., 1993). Embodiment can also be supported by encouraging clients to adopt the postures and gestures of the self they are enacting (e.g., 'how does the angry self sit and move?') and by giving voice to non-verbal expression (e.g. 'what

would that clenched fist say?') (Perls, 1969). Chairwork is also associated with the verbalisation of unmet needs, prompting adaptive emotional expression, and the use of first-person existential language (such 'I choose' rather than 'I should') to encourage ownership and agency (Greenberg et al., 1993; Perls, 1969).

Procedures and forms

Chairwork has proliferated in a multitude of applications, forms, and procedures that have been categorised in different ways. One example is Kellogg's (2015) taxonomy of 'internal' and 'external' dialogues, which differentiates chairwork by its inter- or intra-personal focus. Earlier paradigms refer to 'two-chair' dialogues (whereby the client engages with aspects of themselves) or 'empty' chair dialogues (whereby the client engages with an 'other') (Kellogg, 2015). However, a chairwork exercise might involve both external and internal foci to capture and address the complexity of inner and outer relating and conflict. For example, an exercise might start with a client processing 'unfinished business' with an old colleague imagined in an empty chair. Such processing might then be blocked by a part of the client that insists anger should be suppressed. The 'blocking' part might then be embodied and enacted in a separate chair, and a dialogue developed between the 'blocking' and 'blocked' parts of the self. During this dialogue the 'blocking' part might then be identified as a parent's voice, and the parent might then be addressed in an empty chair. The creative possibilities for chairwork are extensive.

Forms of chairwork have also been categorised as 'horizontal' or 'vertical' dialogues (Pugh & Broome, 2020). 'Horizontal' dialogues refer to exchanges between the parts of the self, whilst 'vertical' dialogues denote the client standing up and stepping back from the enactment to gain a de-centered perspective. In horizontal procedures, the chairs function like actors exchanging dialogue on stage ('self as content'), whilst vertical procedures offer a means to move into the audience to survey the stage and perhaps direct action ('self as context') (Pugh & Bell, 2020; Hayes et al., 2011). Typically, most chairwork procedures are 'horizontal' in nature as they require parts of the self to be enacted to exchange information. 'Vertical' chairwork procedures, however, offer clients the benefit of a self-distanced, observer perspective to one's own mental processes (Pugh, 2020). It is entirely possible to incorporate a 'vertical' stage to a 'horizontal'

task. Inviting the client to stand and take on the position of a 'compassionate witness' during chairwork is an example of such an approach (Drucker, 2013).

The following table outlines the various forms of chairwork procedures that can be classified under the 'horizontal' and 'vertical' taxonomy.

Table 3.2. Forms of chairwork dialogue (adapted from Pugh & Broome, 2020; Pugh & Bell, 2020)

Type	Form	Description
Horizontal	Interviews	The client changes seat to embody a part of themselves and is interviewed by the therapist. The client can also be interviewed as another person. Example: Interviewing the client as their 'worry'.
	Dialogues	The client dialogues with parts of themselves using two or more chairs, with the potential to play all parts in the dialogue. This can include the client dialoguing with the representation of another person. Example: Enacting a dialogue between the self-critic and the criticised part.
	Dramatisations	The client and therapist role-play events from the past, present, or future. Example: Historic re-enactment of a traumatic memory (with the capacity to intervene and change the events).
	Disclosures	The client recounts, revises, or elaborates various narratives on different seats. Example: Recounting the same experience from a critical or compassionate perspective.
Vertical	Witnessing	The client stands up and steps back from parts of the self held in different chairs. Example: Standing back from the self-critical dialogue and witnessing the relationship enacted.

	Depictions	The client uses the chair as a representational object to map or measure aspects of their internal or external world. Example: Mapping out multiple-voices in psychosis

Evidence and mechanisms of action

As recent narrative review of chairwork (Pugh, 2017), found ‘sufficient evidence to hypothesise that chairwork is a versatile and powerful therapeutic technique’ (p.27). Chairwork is an integral ingredient within evidence-based psychotherapies such as EFT and schema therapy and their treatment of a range of problems including borderline personality disorder (Giesen-Bloo et al., 2006) and depression (Greenberg, 2017). Chairwork interventions have also been adapted to group-based CFT which has demonstrated preliminary effectiveness (Lucre & Corten, 2013). Taken alone, however, such studies do not directly demonstrate the role and effectiveness of chairwork.

Dismantling studies have compared person-centered therapy conditions to emotion-focused interventions (that include chairwork) in the treatment of depression. Goldman et al (2005) found that experiential interventions were superior in reducing depression and global distress whilst Greenberg & Watson (1998) found the experiential arm reduced depression symptoms more quickly than the relationship condition alone, in addition to increasing self-esteem and interpersonal functioning. Using chairwork to facilitate the imaginal confrontation of past abusers has also been shown to be more effective than empathic exploration alone in resolving past trauma (Paivio et al., 2010).

Standalone treatment studies include the use of chairwork to address self-criticism. The EFT two-chair dialogue was effective, at post-intervention and at 6 months, in decreasing self-criticism, depression, and anxiety symptoms, whilst increasing self-compassion and the capacity for self-reassurance (Shahar et al. 2012). The same intervention has also been shown, in a single-session, to reduce global distress, fear, and shame in both anger-prone participants and controls (Kramer & Pascual-Leone, 2016). Chairwork interventions have also been studied within trial-based cognitive therapy (an experiential approach which simulates the judicial process with the client playing the roles of prosecutor, defendant, judge, and jurors) (de Oliveria, 2014). Studies

have shown that a single session of the approach significantly reduces conviction in negative core beliefs and related emotions (de Oliveira 2008; de Oliveira et al. 2012). It is of note that the above studies are based on small sample sizes and student populations.

When comparing chairwork to pen-and-paper methods to address social anxiety, chairwork was more effective in reducing fears of negative evaluation, life impairment, and social avoidance, but equivalent in reducing social anxiety (de Oliveira et al. 2012; Powell et al. 2013). In other technique comparison studies, a two-chair decisional balance method was superior to empathic reflection and problem-solving in addressing indecision (Greenberg & Dompierre, 1981, Clarke & Greenberg 1986). In terms of resolving inter-personal conflict, chairwork role-play was more effective in reducing anger, hostility, and aggression than 'intellectual discussion' or 'discharge' of emotion. The empty-chair method has also been found to be equivalent to cognitive restructuring and chain analysis in addressing problematic anger (Conoley et al., 1983).

The few qualitive studies of chairwork have included client feedback. Chadwick (2003) found that chairwork helped clients to foster a more complex, multi-faceted sense of self (as opposed to a singular, dominant, negative view of self), with benefits that generalised outside of the session. Chairwork was also found to be the 'critical' element of an EFT group for depression and anxiety, with clients emphasising the challenging and intense nature of the approach whilst acknowledging its 'transformative' nature ('*I think everyone should be put through that'*) (Robinson et al., 2014, p.271). A conversational analysis of a two-chair self-soothing task highlighted specific interactional practices that facilitated a shift to and from compassionate dialogue; such practices included the use of pronouns to distinguish between voices and the use of verbal prompts and encouragement ('response tokens') (Sutherland et al., 2014). Particular interactive patterns between therapist and client also foster willingness to engage in chairwork; these include the therapist offering options and rationale for the task, and respecting the client's knowledge and agency (Muntigl, et al., 2020).

The theories regarding chairwork's mechanisms of action are as varied as the therapies in which they are applied. Early practitioners of chairwork emphasised the importance of psychological integration and the resolution of internal conflicts (Perls, 1973), or the transformation of

maladaptive affect via adaptive emotional experience (Greenberg et al., 1993). Pugh (2020) in his summary of chairwork in CBT, suggests that chairwork offers an experiential means to access and modify implicational and holistic ‘heart-level’ meaning as opposed to relying on rational or conceptual disputation of ‘head-level’ propositional knowledge (Teasdale 1993, Teasdale & Barnard, 1993). Using this framework, it is chairwork’s experiential, enactive, and multi-sensory nature that allows for the transformation and encoding of meaning at the level of ‘felt sense’ (Samoilov & Goldfried, 2000; Englekamp, 1998). Emotional evocation is also associated with accessing and altering implicational knowledge structures (Bennett-Levy, 2003) and chairwork is acknowledged as an emotionally charged intervention (Narkiss-Guez et al., 2015). Research also suggests there is a positive relationship between the level of expressed emotion during chairwork and optimal therapeutic outcomes (Greenberg & Malcom, 2002; Carryer and Greenberg 2010).

Pugh (2017; 2020) has posited various other mechanisms of action. These include chairwork’s use of imagery (e.g., imaging the critic in an empty chair), and imagery’s potential to access and adaptively process emotion and memory (Hackmann et al., 2011). Other mechanisms include, the accessing of alternative self-representations (Brewin, 2006) enriched self-complexity (Chadwick, 2003), transformations in intrapersonal dialogue (Stone & Stone, 1989), de-centering (Dimaggio & Stiles, 2007), and emotional exposure and processing (Diamond et al, 2010).

CFT chairwork: bringing chairwork and CFT together

The core processes and mechanisms of chairwork are complementary to the aims and theory of CFT. In a summary of compassion-focused chairwork (Bell, 2022), the author has argued that chairwork in CFT is ‘an ideal match of theory and method’. As introduced above, both chairwork and CFT share an emphasis on self-multiplicity (e.g., CFT’s basis in social mentality theory and the conception of a ‘multi-mind’). Chairwork offers CFT a concrete means for separating and differentiating such multiplicity and exploring conflicts and interactions between patterns of mind. What CFT offers chairwork is the unique focus on ‘the compassionate chair, and building up the feelings, tolerance, insights and strengths of this part of the self’ (Gilbert, 2010, p.167). In CFT chairwork the compassionate self/chair is typically used to address threat-focused processes and self-representations: tolerating, integrating, and ultimately transforming

distressing inner experiences via affiliative, care-based dialogue and relating (Gilbert, 2019). By giving the compassionate self a specific chair in the therapy room, it becomes the literal 'secure base' and 'safe haven' for inner exploration and return in a way that concretises its attachment function.

A key element of chairwork is the use of role-reversal to enact and inhabit both sides of the client's internal dialogue. In CFT chairwork, the role-reversal allows clients to experience both the giving and receiving of compassion within the same exercise (by moving chairs). This allows for the potentiation and practice of CFT's various flows of compassion: compassion from self-to-self, self-to-others, and others to self (Gilbert, 2010). CFT chairwork also typically involves switching motives and related social mentalities, from rank-based relating (e.g., self-criticism) to care-based giving and receiving (e.g., self-compassion). The use of chairwork provides clients with a direct means to compare, contrast, and 'feel' the difference created by this change in relating and motivation.

Chairwork within CFT can also be used to explore and illustrate the role of embodiment. Within chairwork, clients are encouraged to inhabit self-parts via changes in facial expression, posture, gestures, and pace and tone of voice. Similarly, CFT uses body-focused, 'bottom-up', immersive practices to access and apply the compassionate self and mind. CFT chairwork therefore offers a concrete demonstration of the bi-directional influence of body and mind, and how the body can be used to promote particular mental states (Tschacher & Pfammatter, 2016). The explicit focus on embodiment, affective amplification, interoceptive awareness, and kinesthetic expression within chairwork are in keeping with CFT's aim to bridge the rational-emotive dissociation associated with cognitive strategies (Stott, 2007).

Personification in chairwork offers CFT a means to turn problematic parts of the self into relatable 'person-like' figures. One such example is the personification of the 'self-critic' in an empty chair. Personifying the critic in this way- giving it symbolic form and expression- allows clients to explore its nature and character, gaining new insights into its qualities, relative strength, and way of relating (Gilbert & Irons, 2005). Because of imagery's close link to autobiographical memory, the use of imagery can encourage new connections between internal

and past external relationships (e.g., ‘the critic looks and sounds like my dad’) (Pugh, 2020). From clinical experience, externalising aspects of the self also allows clients to transfer social-relational competencies from their external world into their internal relationships. For example, clients appear to be more able to mentalise and be empathic with themselves when addressing the ‘self’ on a separate chair (creating an experience of the self as ‘other’). This mechanism may, in part, explain how clients can side-step habitual blocks to self-compassion during chairwork.

Key CFT chairwork practices

Whilst there is limited literature on CFT chairwork, there are a number of established ‘set pieces’ in clinical practice. These include: two-chair self-compassion, chairwork for self-criticism, and ‘multiple-selves’ for addressing threat-based emotions.

The two-chair self-compassion task involves a dialogue between the client’s compassionate self and a part of the self that experiences or typifies their vulnerability or distress (Gilbert, 2010; Kolts, 2016). The exercise allows clients to practice self-compassion with the therapist coaching and clarifying the enactment of compassionate qualities and skills. Given the dialogic nature of the exchange, clients can be encouraged to swap chairs to receive their own compassion. An adapted version of the two-chair approach is provided below, outlining how FBRs to compassion can also be addressed as the client moves back and forward between chairs.

Table 3.3. Steps within the two-chair self-compassion task (adapted from Bell, 2022).

	Two-chair self-compassion
1	The client identifies a current life difficulty and is supported to clarify the prominent threat-based reaction (e.g., a specific emotion).
2	Two additional chairs are set up facing one another. In one chair the client is encouraged to embody and give voice to their threat-based experience (as fully as possible).
3	Taking the opposite chair, the client is supported to access and embody their compassionate self. This typically includes previously practiced soothing-rhythm breathing, changes in posture and voice tone, clarification of compassionate qualities and insights, and the harnessing of a desire to be helpful and supportive.

4	As their compassionate self, the client relates back to the threat-based 'self' in the opposite chair. Such compassionate relating might include: validation, empathic understanding, compassionate reasoning regarding the reaction and problem, refocusing, encouragement/support, and care-focused suggestions.
5	The client returns to the threat-based position to receive the compassion. The benefits of compassion- as well as fears, blocks, and resistances (FBRs)- are explored and expressed.
6	The client switches back to their compassionate self and addresses any FBRs (e.g., 'knowing what you know about yourself, why might it make sense that he finds it difficult to accept care and support? Given that, what does he need? Tell him').
7	The client finally returns to the original chair facing the therapist and reflects upon the process.

CFT chairwork for self-criticism is an experiential means to bring compassion to the self-critical relationship (Gilbert, 2010; Kolts, 2016). The CFT approach adapts and extends the two-chair 'conflict-split' task of EFT whereby the client dialogues between the 'critic' and 'experiencer' (Greenberg et al., 1993). Elliott & Greenberg (2021) suggest the EFT task includes the following stages: identifying and separating aspects of self; deepening emotional experiencing and expression; expressing primary underlying feelings and needs; softening and negotiating between parts; and post-dialogue creation of meaning. In CFT, the compassionate self is added in a third chair and is used to relate to the criticised self and the self-critic in turn. Rather than seeking a 'softening' within the critic-criticised exchange, the incorporation of the compassionate self creates both the physiological and motivational grounding to understand and work with both parts. The compassionate self is utilised to understand the function of the self-critic as part of the threat-protection system. Typically, the critic's role relates to monitoring for error (at failing to meet one's expectations or losing security in the social domain), to themes of personal disappointment, and to fears of rejection, harm, or criticism from others (Gilbert & Procter, 2006). The client is guided to such insights by asking questions such as: 'what is the self-critic most afraid of?' The stages of this intervention are outlined in table (5.2) within the method section.

The CFT self-critic intervention can be conceptualised as the switching and contrasting of social mentalities. The initial stage of the exercise involves the enactment of the competitive rank-based mentality as the self-critic reacts to signals of distress with aggression and dominance (frequently causing the criticised self to submit) (Gilbert & Irons, 2005). Accessing the compassionate self requires a shift to a care-giving mentality which facilitates the identification of distress-signals beneath the critic's threat-based attack (e.g., 'I can see the critic is frightened of rejection and is lashing out'). Such care-based relating can transform the self-critic from a figure of hostility to one of vulnerability and fear, representing an unmet need for safeness. From the compassionate self's care-giving mentality, the criticised self can then be supported with encouragement, compassionate self-correction, and reassurance. Finally, the rank-based and care-based mentalities can be directly compared in their responses to distress, fears, set-backs, and goal-attainment.

CFT's approach to self-criticism differs from modalities such as schema therapy where the goal is to 'fight' the self-critic (typically framed as the demanding or punitive parent mode) (Arntz & Jacob, 2013). From a CFT perspective, seeking to counter an internal threat-based response with a threat-based solution would potentiate internal conflict and rank-based reactivity ('fighting fire with fire') (Gilbert & Irons, 2005). Within CFT, an exception is made when the voice and nature of the self-critic is identifiable as the introjection of an abusive other or as an intrusive re-experiencing from a traumatic encounter. Kolts (2016) has suggested the presence of self-disgust or self-hatred is a good marker to assess for this phenomenon. If identified, Gilbert (2010) proposes the use of trauma-focused interventions, such as re-living or re-scripting, may be indicated. As chairwork role-reversal typically creates empathy for the persona inhabited, embodying the role of an abusive figure can unhelpfully cause over-identification with the abuser and block healthy expressions of anger (Kellogg, 2015, Pugh, 2020).

The CFT self-critic exercise can be prefaced with a verbal analysis of the critic's function. Client ambivalence about reducing self-criticism typically relates to perceptions that it maintains motivation or offers protection (e.g., 'If I didn't criticise myself, my flaws will show and I'd be rejected'). The first stages of the chairwork exercise, where the impact of the self-critic is

experienced, can therefore be framed as a ‘discovery experiment’ to assess the critic’s true impact and utility (Bennett-Levy et al., 2004).

The final CFT chairwork ‘set piece’ is a multiple-chair procedure that focuses on emotional conflict and complexity in the threat-system (Gilbert, 2010; Kolts, 2016). The exercise, known as ‘multiple selves’, explores the reactions of the client’s various ‘emotional selves’ to a set scenario (typically an interpersonal dispute). The exercise focuses on the client’s ‘angry self’, ‘anxious self’, and ‘sad self’, embodied in different chairs. As each emotional self, the client is encouraged to experience, elaborate, and express the thoughts, feelings, action impulses, motives, needs, and memories associated with each emotion (e.g., ‘what do you think about the argument angry self?’). Following this process, the client then adopts a reflective position in an additional chair, capturing the benefits of the ‘vertical’ chairwork procedures introduced above. From this position, the complexity and idiosyncratic configuration of the client’s threat emotions can be examined. Finally, the client is supported to access their compassionate self, and the same situation is processed from a compassionate perspective with an enhanced capacity for empathy and mentalisation. The compassionate self is then focused on each of the emotional selves in turn, offering understanding, validation, and care-based regulation. The stages of the intervention are further outlined in table (5.3) within the method section.

Gilbert (2020) asserts that our emotions operate like ‘mini-selves’ (p.14), organising our mind and shaping our reactions in distinctive ways for different functions. The contrasting ways in which each emotional ‘self’ influences and textures our experience can create confusion and concern, challenging our sense social agency (Irons, 2020). As Gilbert (2010) has highlighted, the same event can also stimulate multiple-threat emotions that arise simultaneously, in conflict or in undifferentiated form, making them harder to understand and manage. As introduced in chapter two, emotions can also become ‘fused’ together via classical conditioning, with one emotion acting as the conditioned stimulus to another (Ferster, 1973). Gilbert (2007) suggests that such conditioning can cause certain emotions to become blocked and absent in our conscious awareness.

The multiple-selves exercise is therefore focused on utilising compassion to differentiate, tolerate, and integrate affective patterns (Gilbert, 2020). Differentiation is supported by the chairwork process of separation, whilst toleration is facilitated by offering clients choice and agency in how to access, 'sample', and then leave emotions by moving to and from set chairs. Integration is hypothesised to be achieved by the compassionate self dialoging with each emotion and reflecting on their function, history, and interaction with other emotions and motives. The multiple-selves method illustrates the role of the compassionate self as the metaphorical 'captain of the ship' (Kolts, 2016), acting in its superordinate role to manage difficult passengers whilst steering an intentional course of travel. The compassionate self can be used to regulate high arousal whilst also encouraging the amplification of emotions that have previously been restricted or silenced. This might, for example, involve accessing and practicing assertive anger in clients with depression who are trapped in patterns of subordination and defeat. Gilbert (2020) also suggests that 'over time, clients begin to recognise their multiplicity, which is also extremely beneficial for mindfulness' (p.15).

There has been no prior research focusing solely on CFT chairwork. The current project is therefore exploratory in its aims and methods, and ultimately seeks to understand how best the approach can be delivered, developed, and further researched.

Chapter summary and reflection

This chapter began with an introduction to compassion focused therapy (CFT) and highlighted the multiple influences that informed the therapy's development. CFT is an integrative model that draws on evolutionary science, attachment theory, affective neuroscience, and Buddhist psychology. The therapy was developed for the very problems outlined in chapter one: i.e., for clients with experiences of self-criticism and shame, who have lacked the positive attachments that protect again depression. An initial aim of CFT is to de-shame and de-pathologise such problems by offering an evolutionary perspective on how they originated as human potentials.

A core element of CFT is the focus on evolved motives, and the resultant social mentalities that arise in pursuit of core bio-psycho-social goals. Social mentalities can create and maintain reciprocal interactions based on various socially-mediated motives: to give and receive care, to

foster cooperation, to have sex, and to compete. Such social mentalities organise our mind, shape our behaviour, and process information in very different ways. Whilst originating to form and regulate external relationships, the same mentalities are recruited in our own self-to-self relating. This provides a key insight into how CFT addresses and understands self-criticism as an internalised competitive mentality. The therapy is essentially focused on motive-switching, for both internal and external relationships, moving from a competitive, rank-based motive to one based on care.

The review also defined compassion and outlined the therapy's distinctive features and methods. These include body-focused practices, mental imagery and method-acting techniques that are part of compassionate mind training. CFT is notable for its emphasis on cultivating compassion- and the associated affective, psychological, and physical contexts that support it- as an antidote to threat-based experiences and coping. In this way, CFT aims to create care-based experiences of safeness, support, and encouragement that are associated with secure attachment. Research suggests that compassion can be trained and applied to relieve various mental health problems, including those outlined in chapter two. In CFT, compassionate competencies and motives are operationalised using the framework of the 'compassionate self' which can then be directed to the client's distress and unmet needs. One method to facilitate the use of the compassionate self is chairwork.

Chairwork is an experiential psychotherapeutic method with a rich 100-year history. It essentially involves the use of chairs, their positioning, and movement between them, for various therapeutic ends. Despite the wide variety of chairwork applications, in service of a multitude of different modalities, there are some core underpinning principles and processes. These include self-multiplicity, animation of parts of the self via personification and embodiment, and 'talk' or dialogue between such parts. Chairwork procedures can also be grouped into various categories and their application is facilitated by distinctive process skills. The method is multi-sensory, enactive, and emotionally evocative, all factors associated with its effectiveness. The review of chairwork's evidence-base highlighted its use for self-criticism and its superiority compared to verbal-based cognitive methods.

CFT and chairwork appear to be a perfect match of theory and method. For example, CFT's conception of the mind and self as 'multiple' is complemented by the way in which chairwork differentiates parts of the self by placing them on separate chairs. Similarly, the dialogical process of chairwork offers CFT a vehicle to concretise and enact various social mentalities for both inner and outer relating. Both CFT and chairwork also emphasise the body, affect, and experiential learning. The review introduced core CFT chairwork interventions which form the focus of the thesis: chairwork for self-criticism and the multiple-selves exercise for threat emotions (they are operationalised, in a step-by-step format, in the method section).

Whilst CFT chairwork has not previously been researched, it appears to be particularly well-suited to address self-criticism, shame, and depression. For example, the multiple-selves exercise is used to explore the kind of emotional complexity, conflict, and inhibition that was shown to characterise depression in chapter two. The exercise involves the differentiation, toleration and articulation of threat-based emotions and their associated needs, motives, and defensive actions which can become blocked in clients with depression. The self-critic exercise also offers a means to experience, understand, and answer the hostile internal attack, negative self-evaluations, and rank-based reactions associated with all the problems outlined in chapter two. CFT chairwork is also fundamentally focused on applying compassion- which is associated with effective outcomes in depression, self-criticism, and shame- directly into the client's internal world.

The following chapters outline the methodology used to research how clients with depression, self-criticism, and shame experience CFT chairwork.

Chapter 4: Methodology: Theoretical background

Introduction

This chapter presents the theoretical background to the research methodology whilst the following chapter outlines the applied design of each study. The first section of this chapter describes the rationale for adopting Interpretative Phenomenological Analysis (IPA) as the research method. The next sections involve a critical discussion of the epistemological foundations of IPA- focusing on phenomenology, hermeneutics, and idiography- whilst reflecting on their implications for the current study. The chapter ends with a consideration of criticisms of IPA and how they are addressed and managed in this project.

Rationale for research methodology

As introduced in chapter one, the research question for the project is: 'how do clients with depression, self-criticism, and shame experience chairwork interventions in CFT?'. The research is therefore focused on 'lived' experience and subjective phenomena and the personal interpretations or meaning given to these phenomena. Such a focus is suited to a qualitative approach whereby 'understanding of experience and processes' (Thompson & Harper, 2012, p.5) is given salience over the establishment of causal relationships, prevalence, or general scientific laws. Qualitative research is typically committed to 'exploring, describing and interpreting the personal and social experience' of participants (Smith, 2003, p.2), whilst being concerned with the 'quality and texture' of such experience (Willig, 2008, p.8). The attention to rich, idiographic detail is in keeping with the project's ultimate aims and values: to learn directly from clients' experience and understanding.

Qualitative approaches are also apposite where the researcher is 'interested in complexity or process or where an issue is controversial or personal' (Smith 1995, p.10). The current project meets all these criteria: it focuses on an unconventional conception of the 'self' (as multiple) and on the complex relational and intersubjective experience of psychotherapy. An 'open' and 'exploratory' stance is also well suited to under-researched and novel subjects, such as CFT chairwork, whereby a positivist approach might 'foreclose' on the generation of new theories and unexpected insights (Pope & Mays, 1999).

The current research utilises the qualitative methodology of IPA. The rationale for selecting IPA involves several factors. In particular, IPA's phenomenological orientation and privileging of the embodied, sensory, and affective experiences of participants (Smith et al., 2009) complements the experiential, multi-sensory, and enactive nature of the chairwork method. IPA also seeks to balance phenomenological description with interpretative insight, requiring an inductive 'double hermeneutic' process that systematises the researcher's interpretative role (see below) (Smith & Osborne, 2003). This aim of negotiating subjective, and inter-subjective, meaning-making overlaps with the focus of the current study: the personal experience of participants as they engage in an intervention that is both intrapsychic and relational in nature, within a wider interpersonal therapeutic frame.

IPA has an idiographic commitment to a case-by-case analysis of each participant's experience, allowing for individuals' voices to be heard in the development of broader group themes for wider discussion, conceptualisation, and application (Larkin & Thompson, 2012). This idiographic sensitivity and interest in theoretical transferability is appropriate for this project which seeks to understand individuals' lived experience whilst generating broader insights into psychotherapy process and provision. IPA is an approach that is also focused on the active role participants play in giving meaning to their experiences (Smith & Osborn, 2003). One of the salient motivations for this research is to fore-ground service user-experience when developing interventions. This motivation is echoed in IPA's commitment to 'give voice' to the concerns of participants (Larkin et al., 2006) and focus on lived accounts of phenomena, which can help service-providers develop or re-evaluate treatment (Larkin & Thompson, 2012).

IPA has been termed the 'qualitative methodology of choice in health-care research' (Biggerstaff & Thompson, 2008, p.173). As Brocki and Weardon (2005) suggest, this may relate to a growing acknowledgement of the constructed nature of illness and the limitations of the biomedical model. Phenomenological and hermeneutic methods can be used to explore the intersection and interrelationship between 'symptoms' of an illness and the way in which we experience and understand them- our associated thoughts, feelings, memories, verbalisations, perceptions, and imagery (Conrad & Barker, 2010; Carel, 2016). IPA has been used to explore experiences of

emotional and mental distress (Eatough & Smith, 2006; Fox & Diab, 2015) and there are precents of its use to understand client experiences of psychotherapy, including CFT (Lawrence & Lee, 2013). IPA has also been used to explore the experience of self-compassion in individuals with depression and anxiety (Pauley & McPherson, 2010) and to understand the impact of novel CFT adaptations (Bell et al., 2016).

Other approaches that focus on the content and construction of a client's narrative account were initially considered. This included discourse analysis (Georgaca & Avdil, 2012) and thematic analysis (Braun & Clark, 2006). IPA was ultimately chosen to prioritise individual experience (rather than wider societal constructs) and produce a context-sensitive interpretative analysis that reaches beyond 'standard' description (Brocki & Wearden, 2006). Reflexive-relational approaches, such as the relational-centred approach of Finlay and Evans (2009), were also considered but not used, due to the ethical concerns of a therapist asking their own client to become a participant in their research.

Epistemology

It has been argued that the general quality of qualitative research could be improved by researchers providing greater clarification of their epistemological position and how it relates to their methodology (Willig, 2008). Qualitative research has also been criticised for an overreliance on analytic method, creating a form of 'methodolatry' that neglects epistemological concerns (Chamberlain, 2000). The following sections therefore focus on articulating the epistemological position of IPA and its relevance to the current project.

Phenomenology

This current section offers a brief outline of phenomenology, both as a philosophy and discipline, before exploring the key concepts and historical developments most germane to the current research. The contributions and theories of three philosophers (Husserl, Heidegger, and Merleau-Ponty) are discussed to illustrate the evolution of phenomenological thought and practice, and their implications for IPA.

Outline

Phenomenology, by definition, is the study or science of 'phenomena': 'appearances of things, or things as they appear in our experience, or the ways we experience things' (Smith, 2018, p1.). Phenomenology is essentially concerned with the nature or 'structure' of consciousness and the phenomena that appears to consciousness. It is concerned not only with *what* appears to consciousness but *how* it appears (Lewis & Staehler, 2010). In this sense, phenomenology is the study of conscious experience as we engage with the world.

Phenomenology, as a term, describes a diverse philosophical tradition and a discipline or method of enquiry. As a philosophical tradition, phenomenology was developed by Husserl (1927/71), with a focus on consciousness and the 'essence' of phenomena. Successive philosophers have developed and expanded the focus of phenomenology to include hermeneutic, existential, embodied, and temporal concerns (Smith et al., 2009). Despite such developments, the phenomenological philosophical tradition is identifiable by its emphasis on what being human is 'like', particularly in terms of the texture and nature of experience, the essential qualities and character of our 'lived world', and the meaning things have in our experience (Finlay, 2011).

In terms of a method of enquiry, phenomenology has been described as an attempt 'to do justice to everyday experience, to evoke what it is to be human' (Finlay, 2011, p3.). The phenomenological method is a 'human science' and is characterised by reflexivity, interpretation, and shared meanings. It is a method of engagement with, and description of, human experience of the world, rather than an attempt to get to the 'objective' physical world explored by natural sciences. As will be discussed below, the method also involves efforts to 'bracket' prior expectations, assumptions, and categorisations in order to be fully alive to phenomena as it manifests itself. Phenomenological enquiry is therefore interested in capturing the richness, contradictions, ambiguity, depth, and sensuousness of experience (Langridge, 2007).

Husserl, 'essences' and the phenomenological attitude:

Credited as the founder of modern phenomenology, Husserl sought to establish a new science of human experience, based on the principle that 'experience should be examined in the way that it occurs, and in its own terms' (Smith et al., 2009, p.12). With this aim, Husserl moved away from

the Platonic, metaphysical, tradition of seeking to understand the 'pure' and 'timeless essence' of a world which exists beyond our senses (Husserl, 1913/82). Husserl sought to focus on 'how things show themselves to us' (Finlay, 2011, p.44), which includes how the world appears to our consciousness and the very process or 'structure' of consciousness (i.e., its intentional, relational nature). Rather than seeking to understand what 'objectively' exists beyond human consciousness, Husserl focused on the nature of conscious experience itself.

Husserl (1900/2001), famously, called for a return 'to the things themselves', away from our 'natural attitude' shaped by our habits and prior expectations. This new phenomenological orientation required a 'reflective move, as we turn our gaze from, for example, objects in the world, and direct it inward, towards our perception of those objects' (Smith et al., 2009, p.12). To return to the 'things themselves', the phenomenological method involved a 'reduction', 'epoche' ('suspension of judgement'), or 'bracketing' of presumptions and a redirection of awareness towards phenomena as it appears to consciousness (Husserl, 1913/82). The 'bracketing' involved in this approach can be seen as a 'radical form of self-questioning' (Moran, 2000, p.126), to challenge one's own preconceptions about the objective world. It calls for 'disciplined naiveté': to perceive experience directly and afresh without recourse to abstract reasoning or theory (Giorgi, 1985).

Husserl (1913/82) asserted that investigating one's own experience in this phenomenological manner allows for the 'essence' or essential qualities of a given phenomenon to be identified. This 'essence' might then 'transcend' the specific circumstance and 'illuminate a given experience for others too' (Smith et al., 2009, p.12). In this way, the universal essence of a phenomena is deemed graspable via individual intuition (eidetic intuition or essential seeing). Whilst Husserl's notion of essences has been criticised for Platonic transcendentalism (Moran, 2000), the notion allows phenomenologists to engage with wider implications and insights from the study of individual experience.

Husserl's ideas remain relevant to IPA and the current study, particularly in the importance given to the 'attentive and systematic examination of the content of consciousness and lived experience' (Smith et al., 2009, p.16). The phenomenological turn- away from attempts to access

‘objective’ reality and towards phenomena as it arises to consciousness- is significant when considering this project’s focus on ‘internal dialogues’ and introspection. Moran (2000) asserts that, in phenomenological enquiry, the question of whether the experience is materially or factually representative of the external world can be ‘disregarded’ (p.130). As Husserl (1900/2001) stated: ‘the conceptual pairs of inner and outer, and of evident and non-evident perception, need not coincide at all’ (p. 345). Such a stance is particularly helpful when considering how to explore phenomena such as the ‘self’ in its multiple aspects, or when examining psychological interventions where the boundaries between self and other, past and present, are blurred.

Whilst Husserl was a philosopher undertaking phenomenological enquiry into his own first-person experience, modern psychological research typically focuses on the experience of other people. For such a purpose, phenomenological enquiry requires a pragmatic compromise (in terms of methodology) and an acknowledgement of the role of interpretation (discussed below in the context of Hermeneutics). Willig (2008) also highlights that most contemporary researchers would acknowledge the impossibility of laying aside all presumptions and expectations. However, as Giorgi (1997) asserts, ‘no work can be consider[ed] phenomenological if some sense of the reduction is not articulated or utilised’ (p.240). As suggested by Finlay (2011), the phenomenological attitude can be described as ‘a kind of dance between reduction and reflexivity’ (p.74), between bracketing pre-understandings and utilising them for insight and reflection. Such issues of reflexivity will be covered in chapters five and ten.

Heidegger and being in the world

The philosophy of phenomenology was expanded by the work of Heidegger (1927/62), whose contributions include the development of a hermeneutic/interpretative approach discussed below. A key element of Heidegger’s approach was to challenge ‘the possibility of knowledge outside of an interpretative stance’, whilst also acknowledging that any interpretative stance is inherently grounded in the ‘lived world’ (Smith *et al*., 2009, p.16). For Heidegger (1927/62) this ‘lived world’ consisted of being in a nexus of relationships with objects, other people, language, and culture: a world in which *meaning* was important. As Drummond (2007) has suggested,

consciousness makes possible a '*significant* world', even when the question of an externally existent world is not answered or addressed.

Heidegger (1927/62) described human beings as 'Dasein' ('there being' or 'being in the world'). He states that human beings are fundamentally 'thrown' into this pre-existing world and cannot, in any meaningful way, be separated from it. From this stance, an attempt to bracket oneself from the world 'will not do justice to man's specific mode of existence' (Lewis & Staehler, 2010, p.69). Such bracketing would cut off the contingent and contextual nature of human life: the context that ultimately gives phenomena its meaning. In this sense, Heidegger is calling for an appreciation of the 'situated' quality of being human.

Heidegger's ontological questions were posed from a 'worldly' position, with each human being seen as 'an embodied, intentional actor' with a range of 'physically-grounded' (what is possible) and 'intersubjectively-grounded' (what is meaningful) options (Smith et al., 2009, p.17). Our relatedness-*to*-the-world and our 'inter-subjectivity' are therefore deemed constitutive parts of our being (Larkin et al., 2006). Self, world, and others are inextricably linked: the 'self and world are not two beings, like subject and object' (Heidegger, 1927/62, p.297). Heidegger also emphasised the time-bound nature of our being-in-the-world (our perpetual 'becoming'), highlighting how our experience is shaped by our temporal location.

In terms of IPA and the current research project, Heidegger's phenomenology highlights the need for greater awareness of how human existence, by nature, is immersed in a nexus of relationships (e.g., with objects, people and language) that shapes how phenomena are experienced and found meaningful. As Smith et al. (2009) also emphasise, this conception of being-in-the-world as perspectival, temporal, and 'in-relation-to', suggests that 'the interpretation of people's meaning making is central to phenomenological inquiry in psychology' (p.18). IPA, in its extension beyond descriptive phenomenology, allows for an engagement with interpretative aspects of experience and a dialogue with the individual's context and constituent influences.

Heidegger's perspectival stance is also suited to the nature of the intervention under investigation. As highlighted above, 'self' and 'other' are not deemed dualistic and dichotomous

but as intertwined and inextricable. Such a conception overlaps with the way in which psychotherapists conceptualise an individual's 'internalisation' of another's voice and relating, viewing the 'self' as essentially 'co-created' by others (Gomez, 1997).

Merleau-Ponty and embodiment

Merleau-Ponty further explored our 'situated' nature by focusing on human embodiment and our relationship to the world as 'body-subjects' ('flesh-of-the-world', rather than Heidegger's 'being-in-the-world'). In giving primacy to our physicality and bodily engagement with the world, Merleau-Ponty (1945/62) emphasised the body could no longer be 'conceived as an object in the world, but as our means of communication with it' (p.106). In this way, Merleau-Ponty gives priority to the incarnate affordances and relations of the body-in-the-world, over that of logical or abstract thought (Anderson, 2003). Merleau-Ponty suggests that the world becomes knowable as our experience is 'connected to and simultaneously evoked in the lived body' (Finlay, 2011, p.55). Perception is therefore conceptualised as dynamic and interactive, rather than simply involving the passive reception of data by the senses. Accordingly, our body offers us not only a way to *be* in the world but also a way to understand it: the body as 'anterior to every determining thought' (Merleau-Ponty, 1945/62, p.92).

Merleau-Ponty's ideas complement this project's focus on how different emotions and motivational systems are 'embodied' via physical movement, gesture, and vocalisation. As highlighted in chapter three, chairwork is focused on articulating the 'psychosomatic language' of parts of the self (Perls, 1969; Pugh et al., 2020). The multiple-selves intervention, for example, explores the enactment of 'emotional selves' whereby bodily experiences and somatic markers are emphasised. As Smith *et al.* (2009) observe, in phenomenology 'the place of the body as a central element in experience must be considered' (p.19).

Merleau-Ponty also identified the paradox that whilst we are engaged in giving the world meaning, the world can never be 'brought to conscious immanence and transparency' (Lewis & Staehler, 2010, p.162). The world is excessive to our ability to contain or comprehend it (e.g., an object can never be seen from all sides at once, in its totality, due to our incarnate, situated nature). This has important implications for research, in that it reminds researchers to be tentative

in their conclusions and respectful of the limits of their corporeal perspective. Merleau-Ponty also adopted the method of 'examining breakdowns in the bodily circuit which bring to light routines and procedures which are hidden and assumed' (Moran 2000, p.419). There are perhaps echoes of Merleau-Ponty's method in the focus of this research. By studying the failures of habitual systems (e.g., mood disturbance and the extremes of self-criticism and shame) it is hoped that the systems themselves will be illuminated. For example, this project involves the exploration of self-to-self relating and self-multiplicity which might not be immediately apparent without experiencing the self's 'malfunction' (e.g., self-criticism).

Hermeneutics

The second theoretical framework utilised by IPA is hermeneutics. This section offers a brief outline of hermeneutics before exploring key concepts relevant to the current study. The section is structured, as per the example of Smith et al. (2009), by focusing on the ideas of three significant theorists: Schleiermacher, Heidegger, and Gadamer.

Outline

Hermeneutics can essentially be defined as the theory of interpretation. Historically, hermeneutics has its roots in the discipline of biblical interpretation but has since been applied to a variety of interpretative practices, including the way unwritten sources are 'read' (Crotty, 1998). The origin of the word derives from the Greek 'to understand' and 'to interpret', echoing notions of 'explaining' and 'translating' (Crotty, 1998). Extending the notion of interpretation to 'deciphering', hermeneutics has also been described as a method for uncovering indirect meaning: 'a reflective practice of unmasking hidden meanings beneath apparent ones' (Kearney, 1991, p.277). Ultimately, hermeneutics conceptualises humans as *languaged* beings, enmeshed in the social and cultural contexts where 'the interpretation of messages is central to our existence' (Packer & Addison, 1989, p.1).

The goal of hermeneutics has been defined as an 'understanding' reaching beyond the explanation of shared information. In this context, understanding is a deeper form of knowledge and way of organising facts into an integrated, meaningful whole (Zimmerman, 2015). Understanding therefore requires more than analytic rules and principles of science; it demands

engagement with the symbolic, poetic nature of language and an appreciation of the fluidity of context and interpretation (Steele, 1989). This endeavour is paralleled with the process of psychotherapy and its integration of psychological science with the poetics of therapeutic discourse and relation (Gendlin, 1997).

Schleiermacher

Schleiermacher is regarded as a founder of modern hermeneutics, developing a theory of interpretation beyond biblical exegesis (Thistleton, 2009). Schleiermacher sought to create a systematic means to integrate theories of human knowledge: a form of philosophical hermeneutics to outline the universal conditions of understanding (Zimmerman, 2015).
As Crotty (1998) asserts, Schleiermacher's hermeneutics is both grammatical and psychological: *grammatical* in framing the text within a wider literary context (including the 'shared rules' of language); and *psychological* in that, on the basis of a shared language, the hermeneuticist can 'divine' and 'elucidate' the intentions and assumptions of the author. Smith et al (2009), regard this as a 'holistic' conception of the interpretative process, bridging 'the essentialist and discursive divide' (p.23). Whilst a text is shaped by the 'linguistic community' in which it was formed, individual authors create particular and 'unique' meaning or form so that their 'intentions' can be discerned (Smith et al., 2009).

For Schleiermacher, interpretation ultimately involves an understanding of the writer as well as the produced text. He goes as far as to suggest that interpretation of a text can provide 'understanding of the utterer better than he understands himself' (Schleiermacher 1838/1998, p.266). Adopting Schleiermacher's position allows IPA researchers to generate insights which 'exceed and subsume' the participants' explicit claims (Smith et al. 2009). The potential for this form of interpretation also depends on the acknowledgement of intersubjectively: 'that everyone carries a minimum of everyone else within themselves' (Schleiermacher, 1838/1998, p.23). For Schleiermacher, there is an engagement with the 'author' as well as the 'text' which requires an empathic turn, in the way a live speaker-listener relationship is developed (Crotty, 1998). Such a conceptual frame has echoes of the way in which a therapist 'understands' the client via the living text of the client's speech and body-language and can utilise such understanding to go beyond the client's self-awareness.

Heidegger

Heidegger unites hermeneutics with phenomenology. For Heidegger, hermeneutics is not simply a methodology for interpretation, but a way to 'make explicit what is implicit and grasp the meaning of Being itself' (Crotty, 1998, p.97). Heidegger (1927/62) suggests that appearance (of our being) has a dual quality: containing both visible and hidden meanings, surface and latent form. Phenomenology can therefore be seen as a discipline for examining and interpreting *being* as it becomes manifest to us (as it appears or is presented to our awareness). It is only by interpretation, and our understanding of language, that our being-in-the-world can be revealed (Finlay, 2011). The place of language in Heidegger's philosophy is captured in terms such as 'language speaks us' and 'language is the house of being' (cited by Zimmerman, 2015). Language is deemed to be a symbolic matrix in which we are thrown and which we use to interpret the world.

Heidegger suggests that our understanding and perceptions are fundamentally shaped by our pre-understandings, our historicity, and our 'horizons of experience': when 'we *experience* a thing as something- it has already been interpreted' (Finlay, 2011, p.52). Heidegger (1927/62) states that interpretation is never without supposition and is founded upon 'fore-having, fore-sight and fore-conception' (p.191). Whilst such fore-structures are inevitable they can be developed and realised in relation to the things themselves, rather than being imposed by abstract 'fancies and popular conceptions' (Heidegger, 1927/62, p.195). In applying a form of the hermeneutic cycle (see below), Heidegger suggests we begin with, and from, our preconceptions, but we make sense of such fore-structures in terms of the thing itself. As Smith et al. (2009) state, 'while the existence of fore-structures may precede our encounters with new things, understanding may actually work the other way, from the thing to the fore-structure' (p.25). The cycle therefore moves between implicit fore-structure and explicit understanding- between interpreted and interpreter- to form a reciprocal relationship and an iterative movement.

In terms of IPA research and the current project, this cyclical conception suggests that in approaching the participants' texts, my fore-structures may be revealed in a way that is not accessible from isolated reflection alone. The process is dynamic in terms of the reflexivity

involved (see chapter five), suggesting a more 'enlivened' form of bracketing that is only ever partially achievable (Smith et al., 2009).

Gadamer

Gadamer, like Heidegger, focused on the historical and cultural embeddedness of understanding which he described as 'historically effected' consciousness (Gadamer, 1960/90). He used the concept of 'horizon' to emphasise the situated nature of one's location within time and place, suggesting that the 'horizon' open to us offers us the possibility of understanding (our 'vantage point') but also imposes limits ('the range of vision') (Gadamer 1960/90). Gadamer argued that historical texts can only be understood from the horizon of the interpreter, their temporal position, and their frame of languaged meaning, replete with 'prejudices' that are 'hidden' from our awareness (Finlay, 2011). For Gadamer, we stand in a tradition, and that tradition is transmitted and married to language. The interpretations and conclusions produced in this project are therefore by necessity indefinite, partial, and bound to the particular 'horizon' available to the interpreter.

In an echo of Heidegger's analysis of fore-structures, Gadamer warns that a person trying to understand a text is 'always projecting…a meaning for the text as a whole as soon as some initial meaning emerges from the text' (Gadamer 1960/90, p.267). In this sense, the interpreter's fore-projection requires ongoing revision as the meaning of the text is further explored. Gadamer suggests that multiple fore-projections can co-exist as competing 'projects' that can be compared and contrasted until a 'unity of meaning' becomes clear (with unsuitable fore-projections being replaced or revised). He suggests that this 'constant process of new projection constitutes the movement of understanding and interpretation' (Gadamer 1960/90, p.267). In terms of textual interpretation, Smith et al. (2009) understand this as a means of engaging in dialogue: between an 'old' fore-understanding and a 'new' phenomenon in the text itself. For the qualitative researcher, the process of monitoring and reflecting on the influence of one's own biases and preconceptions is not simply a problem to be overcome or guarded against, but rather *it is* the process of understanding and interpretation. There are perhaps similarities to the dynamic, dialogic process in which therapists understand their client's by being touched and changed by the 'live' process of empathic engagement (Grant & Crawley, 2002).

Idiography

Idiography is the third significant influence on IPA (Smith et al. 2009). Idiography is associated with the study of 'individual' persons in psychology (Smith, 1995) but was originally used to differentiate the study of 'specifics' from the study of 'things in general'. In contrast, 'nomothetic' inquiry is concerned with population level assertions and general laws of human behaviour, which is typically achieved via numerical measurement and inferential statistics. One of the critiques of nomothetic psychology is that it facilitates only actuarial or 'group' level claims, so that data is transformed in a way that nothing specific can be said about the individual participants who have provided it (Lamiell 1987; Smith et al., 2009).

Idiographic research therefore values case-studies and single case analysis (Smith, 1995). A fundamental principle of idiographic research is to examine every single case before generating general statements (Pietkiewicz & Smith, 2012). Case-studies can highlight gaps or problems within existing group-based theories (Yin, 1989; Stoecker, 1991), thereby 'troubling our assumptions, preconceptions and theories' (Smith et al., 2009, p.30). The level of detail of the case-study is deemed justified (and of value) when describing unique occurrences (Smith, 1995).

Conclusions from single cases-studies can be generalised (and drawn together) via the process of analytic induction or quasi-judicial approaches. Analytic induction involves posing, testing and revising hypotheses via the comparison of single cases (Robson, 1993). A quasi-judicial approach draws on parallels with the progressive development of case-law (Bromley, 1986). In describing IPA's approach, Smith et al (2009) highlight the way in which the general and the particular are inter-related and correlated, suggesting that shared 'universal' elements can be revealed when bringing a sensitive attention to an individual person or occurrence.

IPA

IPA is an approach that integrates the above three strands (phenomenology, hermeneutics, and idiography) into a research methodology. The approach was first described by Smith (1996) and was operationalised in later texts (Smith et al., 1999; Smith & Osborn, 2003; Smith et al., 2009;

Smith et al., 2022). IPA has subsequently developed to become both ‘a theoretical foundation and detailed procedural guide’ (Brocki & Wearden, 2006, p.87).

IPA is a ‘bottom up’, inductive approach where prior assumptions and hypotheses are avoided (Reid et al., 2005). As a methodology it remains concerned with individuals’ subjective accounts rather than producing objective reports (e.g., Flowers et al., 1999). IPA is therefore deemed to be a suitable approach to explore participant’s experiences, perceptions and understanding, aiming to ‘access the participant’s personal world’ (Smith et al., 1999, p.218). IPA acknowledges that access to another person’s ‘world’ is reliant on, and complicated by, the researcher’s own perceptions and understanding. The research process is therefore conceptualised as dynamic in nature, requiring interpretative activity to produce a shared analytic account of the phenomena under study (Osborne & Smith, 1998). The name ‘Interpretative Phenomenological Analysis’ is used to capture the dual nature of the approach (Smith et al., 1999).

IPA researchers are interested in how individuals are ‘making sense of their personal and social world’ (Smith & Osborne, 2003, p.53). In IPA it is assumed that participants seek to *interpret* their experiences ‘into a form that makes sense to them’ (Bocki & Wearden, 2006, p.88). IPA is therefore interested in the products of an assumed human inclination towards self-reflection; in research practice this requires a focus on verbal accounts of an experience, to understand the meaning the experience is given and ultimately the interpretative process of ‘sense-making’ (Smith et al., 1997).

In IPA, the researcher collects detailed first-person accounts from individuals, typically on a one-to-one basis, about an experience, or set of experiences, that are particular to a wider participant sample (Larkin et al., 2006). The analytic processing of these accounts is systematic and rigorous, balancing a focus on what is distinct (i.e., idiosyncratic) with what is shared, whilst grounding the write-up in the rich quotations of individual participants (Smith et al., 2009). The practical, analytic, and sampling procedures of IPA research, detailed in chapter five, show a commitment to idiography at each stage and level. Smith et al (2009) describe the ‘modest’ ambitions of IPA as essentially idiographic: ‘attempting to capture particular experiences as experienced for particular people’ (p.16).

IPA and phenomenology

At the heart of any IPA research is a 'clearly declared phenomenological emphasis on the experiential claims and concerns of the persons taking part' (Larkin et al., 2006, p.104). The most relevant strands of phenomenological thought have been described above, but it is of note that Smith et al. (2009) stress the call to go 'back to the things themselves' essentially requires a return to 'everyday' lived experience rather than philosophical account of such experience. IPA requires a systematic engagement with lived experience which can be either 'first-order activity or second-order mental and affective responses to that activity- remembering, regretting, desiring' (Smith et al 2009, p.33). IPA researchers are particularly interested in experience that is of significance to a person: i.e., an experience that has been found meaningful by the subject. The approach is therefore concerned with where and how everyday occurrences become 'an experience' of note and the related sense-making reflection ('hot cognition') on its significance (Smith et al., 2009).

IPA draws upon the various phenomenological positions and developments (described above), viewing them as 'complementary' and as collectively contributing to a 'holistic' phenomenology (Smith et al., 2009). As is common in contemporary phenomenological psychology, IPA is interested in diversity, plurality, and ideography, rather than accessing Husserlian 'essences' (Spinelli, 2005; Larkin & Thompson, 2012). The aim is not to gain transcendent knowledge or a reduction to the 'abstract'. Instead, IPA utilises the various developments from the field of phenomenology to gain a 'multi-dimensional' appreciation of another person's experience: emphasising the *situated, embodied,* and *encultured* nature of human experience and the resultant *interpretative* aspects of phenomenological enquiry. Similarly, in IPA 'bracketing' is not sought in absolute terms but is viewed as a means of self-reflection which forms part of the hermeneutic circle.

IPA and hermeneutics

As introduced above, IPA combines both phenomenological and hermeneutic insights. Smith et al. (2009) identify how these philosophies and epistemologies have historically overlapped, particularly in the 'hermeneutic phenomenology' of Heidegger and Gadamer (see above). In

integrating these philosophies into a research methodology, Larkin et al. (2006) describe IPA as having two complementary commitments: the phenomenological demand to '*give voice'* to the specific participant's experience and the interpretive necessity to *'make sense'* of these accounts and contextualise their meaning. Whilst the researcher's commitment might be to gain an 'insider's perspective' of an experience (Smith, 1996), a genuinely first-person account cannot be reached. IPA's objective here is to produce a 'coherent, third-person and psychologically informed description' (Larkin et al., 2006, p.104). The IPA researcher's commitment to 'make-sense' of a client's experiences involves a patently interpretative analysis which contextualises the initial 'description' in relation to wider societal and cultural influences.

IPA takes a 'middle position' between an empathic and questioning hermeneutics (Smith et al., 2009). As defined by Ricoeur (1970), a hermeneutics of meaning-recollection (or 'empathy') is associated with 'faithful disclosure' and a descriptive approach to 'bringing out' the meaning of an experience (Finlay, 2011). A hermeneutics of suspicion, however, views meaning as hidden and latent; interpretation is therefore required to reveal the 'illusions and lies of consciousness' (Ricoeur 1970, p.32) by applying an external theoretical framework such as psychoanalysis. IPA does not seek to 'import' any external theoretical frame to challenge the participant's account and instead attempts to allow experience to be 'expressed in its own terms' without recourse to predefined categories (Smith et al., 2009). However, Smith et al. (2009) utilise Heidegger's notion of *appearing,* whereby the phenomena that appears to consciousness requires 'detective work' to bring it fully into awareness and subsequently 'to make sense of it' (p.35). As this enquiry process is essentially interpretative in nature (for both subject and researcher), a 'questioning', contextual, and relational approach is adopted.

IPA involves a 'double-hermeneutic': a dual interpretative process involving a participant making sense of his or her own experience and a researcher trying to make sense of the participant's meaning-making (Smith & Osborn, 2008). At the same time as this process occurs, IPA researchers are required to be reflexive about their own interpretative process and to 'bracket' their preconceptions to engage with the participant's own world. As considered above in the context of Gadamer, the 'dynamics of preconception' takes place within a hermeneutic cycle so that, for example, the researcher's preconceptions may only become available via the

encounter with the participant (Smith et al., 2009). As part of this cycle, the researcher's own assumptions, meaning-making and analytic activity become both the gateway and the limiting frame: the imperfect and dynamic means by which the participant is understood. The idea of a hermeneutic cycle is also used by Smith (2007) to describe the dynamic process of interpretation between part and whole at varying levels. Smith et al. (2009) suggest that 'to understand any given part, you look to the whole; to understand the whole, you look to the parts' (p.28). This conception of the hermeneutic cycle captures the iterative nature of the analysis of IPA and the way in which participants' 'texts' are repeatedly engaged with over time.

As the interpretative cycle turns, interpretation within IPA can be made at different 'levels' with more interpretation being utilised as the research process deepens and wider themes are identified and synthesised (Langdridge, 2007). In IPA, data is dealt with speculatively, by considering ''what it means' for the participants to have made these claims…*in this particular situation*' (Larkin, et al. 2006, p.104). Whilst interpretation moves beyond mere description (with multiple interpretative stances possible), interpretation in IPA remains grounded in the participant's lifeworld (Smith & Osborn, 2003). The inductive and interpretative nature of IPA (its 'second-order' exposition) allows for dialogue with existing psychological interpretations, models, and theories so that IPA researchers can produce a theoretical framework that 'may transcend or exceed the participant's own terminology and conceptualisations' (Larkin et al., 2006, p.114). Smith & Osborne (2003) suggest that successful IPA research can be judged by 'the light it sheds' (p.54) within broader contexts of extant literature and personal or professional experience.

Criticisms of IPA

Whilst IPA has been described as an accessible phenomenological methodology with transparent, systematic guidelines, a number of perceived conceptual and practical limitations have been raised, including a lack of critical language awareness. Willig (2008) suggests that when IPA engages with 'texts' to access lived experience, it assumes language can represent and describe reality rather than conceiving language as constructing and constituting our reality. In answer, Smith et al. (2009) assert the interpretative epistemology of IPA directly engages with the problems of language, reiterating Heidegger's conception of Dasein and the way in which

experience is ‘enmeshed with language and culture’ (p.194). Whilst IPA does not have the same deconstructive aims as discursive methodologies, its focus is contextual and hermeneutic, and is consistent with positions of symbolic interactionism and cultural psychology (Blumer, 1986; Cole, 1996). IPA can be seen to reveal a ‘person’s positionality’ and ‘current subjective mode of engagement’ (Smith et al., 2009, p.195). In this way, IPA does subscribe to social constructionism; Smith et al., (2009) reference Mead (1934) to assert that whilst humans are shaped by pre-existing cultural forces, ‘they have the possibility to rework the constitutive material’ as individuals (p.196).

In terms of the current research, I have sought to reflect on participants’ use of language as shaping, limiting, and enabling their understanding, identification, and expression of ‘experience’ and engaged with the questions this poses via the hermeneutic cycle of IPA analysis.

Willig (2008) also questions whether a participant’s ‘account’ (of an experience) is a suitable focus for phenomenological investigation. As phenomenology focuses on direct experience (rather than ‘opinion’ or ‘description’), the participants’ ability to articulate the subtleties and richness of their physical and emotional experiences is an important limiting factor (Baillie et al., 2000). Issues relating to the individual’s interpretation of their own experience, and the possibility of accessing that experience via external enquiry, is addressed by the double-hermeneutic of IPA methodology and the tentative aims of IPA. The current project perhaps benefits from participants being engaged in a form of psychological therapy that seeks to access, acknowledge, and articulate inner experiences in a non-judgemental way (Gilbert, 2009).

A further criticism of IPA relates to the perceived emphasis on ‘cognitions’ (Willig 2008), which has been deemed incompatible with phenomenology’s emphasis on non-propositional, pre-cognitive knowledge (Brocki & Wearden, 2005). Whilst IPA is interested in cognition to understand a participant’s thoughts and beliefs about the phenomena of focus, Smith et al. (2009) suggest the phenomenological ‘natural attitude’ has a ‘bandwidth’ of interactive reflective levels and contains ‘both pre-reflective and reflective activity’ (p.188). The conception of cognition in IPA is embodied, active and situated, and differs to that of mainstream psychology (Larkin et al.,

2011). The current study includes formal ‘phenomenological reflection’ as part of the research interview but is also interested in cognitions as ‘pre-reflexive reflexivity’: the informal, spontaneous and undirected contents of awareness during the interventions (Smith et al., 2009).

Chapter summary

This chapter provided a rationale for an explorative, qualitative approach to the subject and sought to justify the use of IPA as the chosen methodology. Such justifications included IPA’s idiographic sensitivity, it’s privileging of embodied, sensory, and affective experiences, and its framework for negotiating subjective and inter-subjective meaning-making. The epistemological position of IPA was then expounded, locating the approach within broader phenomenological, hermeneutic, and idiographic traditions. The chapter focused on the contributions of specific philosophers to clarify key concepts and their relevance to the current project.

The chapter ended with a discussion of IPA: its integration of the philosophical traditions described above, its practical development as a research method, and the implications it has for the researcher (e.g., in terms of reflexivity. The criticisms and limitations of IPA are acknowledged, and I have outlined ways in which they are addressed within the project.

The following chapter, chapter five, outlines the method of the project and how IPA has been used to structure the research design and conduct the data analysis.

Chapter 5: Methods

Introduction

This chapter describes the methods used to address the research questions posed in chapter one. The research design is discussed first, followed by an outline of the interventions and a description of recruitment and data collection. Details of the participant sample are then reported. The chapter also clarifies the analytical process undertaken, including a discussion of reflexivity and validity. The chapter ends with an overview of the ethical considerations addressed in the research.

Research design

The research is structured around two core CFT chairwork interventions: chairwork for self-criticism and 'multiple-selves' chairwork focusing on threat emotions (see section below). As outlined by Smith et al, (2009), the design of IPA studies typically involves the recruitment of a small, homogeneous group of participants, 'collecting data from them once' (p.52) via one-to-one interviews. The research therefore involved the recruitment of two groups of different participants, one for each of the interventions, for a one-off individual interview.

In IPA, participants are selected to gain access to a 'particular' perspective, with the aim of 'representing' this perspective, rather than a population (Smith et al., 2009). A degree of homogeneity is therefore sought in the sample so that something meaningful can be said about a specific phenomenon in a specific context (Smith et al., 2009). Smith et al. (2009) pose this as both a pragmatic problem (e.g., how accessible is a given client group?) and an interpretative question (e.g., how much variation is there in the client group, and how much of this variation can be contained within an analysis of this phenomenon?). This research focuses particularly on participants with symptoms of depression, problematic self-criticism and shame, and their experience of a specific chairwork intervention (see below for eligibility criteria). The research setting was restricted to NHS primary care psychology services which, concomitantly, provides a degree of ecological validity as such services are the main national providers of psychotherapy for depression (Clark, 2018). Narrowing the research focus in this way created a homogenous sample so that subtle patterns of convergence and divergence could be identified. Such sample

specificity is also important in the context of theoretical transferability, allowing the research to be replicated to build towards more general claims (Smith et al., 2009).

Whilst Smith and Osborne (2003) state ‘there is no right answer to the question of sample size’ (p.54) in IPA, participant numbers are typically ‘small’ to facilitate an in-depth, case-level exploration of individual experience and meaning-making. It is suggested that such a concentrated focus is justified ‘given the complexity of most human phenomenon’ (p51, Smith & Osborne). Brocki & Wearden (2006) highlight the large variety in sample size in published IPA studies, but re-affirm smaller sizes are more congruent with the idiographic aims of the approach. A sample size of twelve participants was chosen for the initial study. This relatively large sample size for IPA was selected to ‘capture’ the complexity and variety of experience in people with depression, whilst remaining small enough to allow detailed attention to each case. The number of 12 participants has also been used in IPA studies when interviewing client groups about their mental health experiences (e.g., Mjosund et al. 2015). The initial study generated a large data set and an analysis that spanned two published papers (see appendices) and which are represented in chapters six and seven. The second study was limited by COVID-19 restrictions to nine participants. The second study’s analysis is limited to a single chapter (eight) as the smaller sample echoed, supported, and developed similar themes generated from the first study. Chapter nine presents an analysis of themes pertaining to relational factors and the role of the therapist and covers the total data-set from both studies.

Table 5.1. Overview of studies

Study no.	Study focus	Analysis	Participants no.	Site of recruitment	Location of analysis/results
Study 1.	CFT chairwork focused on self-criticism	IPA	12	NHS IAPT primary care psychology services	Chapters 6 and 7. Chapter 9 covers both studies
Study 2.	CFT chairwork focused on	IPA	9 (due to impact of COVID-19)	NHS IAPT primary care	Chapter 8. Chapter 9

	multiple emotions ('multiple-selves')			psychology services	covers both studies

Interventions

The background to the two chairwork interventions was introduced in chapter three. To ensure therapist fidelity to the model, and standardisation of delivery, training was offered to local NHS primary care psychology services and written guidance was provided, devised in discussion with the originator of the CFT model (see Tables 5.2 and 5.3). Therapists were required to audio record the intervention with participating clients. The audio recordings were reviewed by the author to determine the presence of all core stages.

Table 5.2. Intervention outline for study 1: self-criticism chairwork

Core stages of self-criticism chairwork	
1	Two additional chairs are set facing one another and the client is invited to recall a recent incident of self-criticism
2	The client embodies and enacts their critic in one of the additional chairs and expresses their criticism to the opposite empty chair (imaging that in this chair is a part of themselves they want to criticise). The client is encouraged to connect to the voice-tone, emotion, and motivation of the critic
3	The client changes chair and responds as the recipient of the criticism (becoming the criticised self). The client is encouraged to explore the experience of being criticised
4	This client is then be asked to repeat the above process. This involves moving back to the chair of the critic to re-engage with its thoughts and feelings (responding to the reaction of the criticised self) before returning to the criticised self and the experiences this creates
5	The client then takes up an additional third chair and is encouraged to reflect on the nature of the interaction they witnessed and experienced
6	In the third chair, the client is supported to access and embody their compassionate self via soothing-rhythm breathing and compassionate mind focusing
7	As the compassionate self, the client relates compassionately to the criticised self: demonstrating empathy, care, and support in contrast to the critic's attack

8	As the compassionate self, the client relates compassionately to the critic: recognising the fears and unmet needs that drive the critic and its defensive function
9	Returning to the client's original chair, the exercise is reflected on and de-briefed with the therapist

Table 5.3. Intervention outline for study 2: multiple-selves chairwork

Core stages of the multiple-selves chairwork	
1	A recent interpersonal difficulty is identified
2	Additional chairs are provided for three threat emotions and labelled: anxious self, angry self, and sad self. The client is supported to embody the role of each emotional self and complete the following steps in relation to the interpersonal difficulty: -Thoughts (including tone in which they are expressed): e.g. *'what do you think about the situation angry self? What do you have to say?'* -Bodily experiences (including posture, gestures, felt sense, facial expression): e.g. *'how do you feel in the body? Show me'* -Action impulse: e.g. '*if you had complete control angry self what would you do?'* -Associated emotional memories: *'what memories do you have of thinking and feeling this way?'* -Best outcome/what does the self really want: e.g. '*what do you see as a good outcome to this situation?'* When moving between chairs the client is encouraged to stand, take a breath, and de-role
3	The client returns to their original chair and reflects on the process. Differences and internal conflicts between emotions are explored
4	In the original chair, the client is supported to access their compassionate self via soothing-rhythm breathing and compassionate mind focusing. The situation is then experienced and viewed from the compassionate self (working through the same steps as the emotional selves above)
5	The compassionate self is finally focused on each of the emotions in turn: validating, empathising, and regulating
6	Returning to the client's original chair, the exercise is reflected on and de-briefed with

	the therapist

For both the interventions, the therapist was left to decide the direct placement of additional chairs. For the self-critic exercise, the self-critic chair and criticised-self chair are typically placed facing one another and the compassionate chair is brought in between them. In the multiple-selves exercise, the chairs holding the three emotions do not typically face one another and the compassionate chair is again placed centrally (facing them all). Very little has been written to guide clinicians in the specific placement of chairs.

Inclusion criteria

Participants

To be eligible for inclusion in the study, participants were required to be receiving CFT as part of their routine treatment within a primary care IAPT psychological service. They were also required to be treated for depression and have a 'provisional diagnosis' of Major Depression Disorder (MDD). The Beck Depression Inventory (BDI-II) (Beck et al., 1996) was used to determine levels of depression at the time of the intervention and clients were required to have scored 10 or above on the Patient Health Questionnaire (PHQ9) (Kroenke et al., 2001) at commencement of treatment. The PHQ is used throughout primary care services (Gyani et al., 2013) and identifies the presence of 'major depression' utilising DSM-IV related criteria (APA, 1994). The same symptom-clusters for MDD feature in the DSM-V (APA, 2013). Within IAPT services, a score of 10 or above is used as a 'cut off' for clinical depression, whilst the use of provisional diagnosis is routine practice for IAPT therapists (National IAPT Programme Team, 2011)

To ascertain levels of self-criticism and shame, the following measures were taken at the time of interview: Forms of Self-Criticizing/Attacking and Self-Reassuring Scale (FSCRS) (Gilbert et al., 2004) and Other as Shamer Scale (OAS) (Goss et al., 1994). The OAS was chosen to measure external shame, whilst the FSCRS was selected to capture internal processes of self-criticism and attacking that are associated with internal shame (see chapter 2). The FSCRS also assesses self-reassurance, allowing for a measurement of the sample's capacity for self-to-self relating based on reassurance, care, and compassion (Castilho et al., 2015). At the

commencement of this research, the Self-Compassion Scale (SCS) (Neff, 2003) was the only self-report measure for self-compassion. The study did not use the SCS due to the differences between its definition of compassion and that of CFT and the continued challenges to its theoretical foundations and psychometric validity (Muris & Petrocchi, 2016; Williams et al., 2014; Lopez et al., 2015). One such criticism is the SCS's use of a 'total score' for self-compassion which collapses together positively and negatively formulated items that relate to distinct and separate processes (e.g., self-kindness and self-criticism).

Therapists

Eligible therapists were required to have undertaken basic training in CFT (typically 3 days in length) and specific training in the chair-work interventions. Additional training and supervision was offered to participating services by the author. Eligible therapists were also required to have a core-profession (e.g., mental health nursing or clinical psychology) and/or be accredited by a therapeutic or professional body (e.g., British Association of Behavioural and Cognitive Psychotherapies). Therapists taking part in the research were required to provide a summary of the CFT work undertaken before the intervention to ensure a basic standard of CFT had been provided. This included the requirement for the therapy to have included soothing rhythm breathing and 'compassionate self' imagery and focusing practices prior to the intervention (see Gilbert, 2010). The chairwork interventions were required to be planned as part of the client's routine course of treatment.

Recruitment

Consistent with IPA literature, participants were selected 'purposively', via 'referral' methods, whereby managerial gatekeepers cascaded information to therapists. Posters and information sheets were created for therapists and participants, with eligible therapists sharing information sheets with their clients.

Participants were required to have a week's 'cooling off' period between agreeing to participate and the intervention and interview taking place.

Data collection and interview schedule

Data collection took place via face-to-face interviews which is deemed to be the 'gold standard' method in qualitative design (Novick, 2008). Individual, face-to-face, interviews, rather than focus-groups, are the norm in IPA research and fit the commitment 'to the detailed exploration of personal experience' (Smith, 2004, p.50). Whilst interviews reduce anonymity and raise potential difficulties in terms of the client group's level of shame, the format allowed the researcher, who specialises in working with shame, an opportunity to be responsive and sensitive to each individual (a 'strength' of the interview format; Braun & Clark, 2013). Face-to-face interviews also allow for rapport to be built with participants which is deemed to be an integral component in facilitating interactive data collection and client disclosure (Reinharz, 1993).

The current research utilised a semi-structured ('interview guide') format which has been described as the 'exemplary method' for IPA research (Smith & Osborn, 2002). As outlined by Smith (1995), the semi-structured format provides participant-led flexibility: 'the interviewer is free to probe interesting ideas that arise' (p.12), and respondents can provide fuller responses and discuss issues of personal significance (which links to the aims of phenomenological enquiry). The interview schedule (see tables 5.4 and 5.5 below) was structured on the stages of the exercise, rather than using pre-conceived categories, to manage the influence of prior expectations and assumptions. The core questions of the schedule were asked at each session, but prompts were used responsively. Such responsiveness also included the use of facilitative silence and sub-vocal encouragement, and the request for examples, clarification, specific details, and further information (suggestions by Rubin & Rubin, 1995; Fielding & Thomas, 2008; Kvale & Brinkmann, 2009). Whilst remaining personally engaged with the participant's experience, the researcher refrained from self-disclosure, evaluative comments, and empathic statements to avoid shaping the participants' answers (Rubin & Rubin, 1995). The interview schedule was developed in practise with colleagues, integrating the feedback given (as suggested by Smith, 1995). The interview also included 'clean up' questions to allow participants to raise issues of personal salience that hadn't been anticipated or covered in the schedule (Braun & Clark, 2013).

The interviews were conducted by the author at the participants' clinic, immediately after the session when the intervention was delivered. The interviews varied in duration from 24-39 minutes and were recorded digitally for verbatim transcription. The participants' personal

information was anonymised during transcription. Whilst opportunistically scheduled, the interviews were conducted, where possible, once weekly. This allowed for transcription of the recordings between interviews which, as Rubin and Rubin (1995) suggest, facilitate reflection on, and adjustment to, interview technique and questions.

Table 5.4. Interview schedule for study 1

Interview schedule and examples of questions
Introductory question
Can you tell me about your overall experience of the exercise?
Questions regarding the 'critic' part of the exercise
E.g., how would you describe what it was like being your critic?
Questions regarding the 'compassion' part of the exercise
E.g., what was it like to bring compassion to different parts of yourself?
Questions regarding chairwork
E.g., how did you find using different chairs to explore different aspects of your 'self'?
Questions regarding the exercise overall
E.g., have your experiences during the exercise influenced the way you understand compassion or self-criticism? If so, how?

Table 5.5. Interview schedule for study 2

Interview schedule and examples of questions
Introductory questions
Please tell me about your experience of the exercise.
Questions about enacting different emotions selves
E.g. please describe what it was like to act out the different emotions during the exercise?
Questions about enacting the compassionate self
E.g. what was it like to act out your compassionate self in the exercise?
Questions regarding chairwork
E.g. how did you find using chairs and moving position during the exercise?
Questions regarding the exercise overall
E.g. what will you take from the exercise? Is there anything important that you have learnt or

will remember?

Sample

Demographic information was systematically collected from both therapist and client participants. As Braun & Clark (2013) suggest, such data collection in qualitative research acknowledges the 'situated' and encultured nature of any sample. The selection of demographic information was informed by the aim of 'describing' the characteristics of participants. Questions included asking participants, in their own words, about ethnicity, gender and age. In addition to demographic information, clients were asked contextual questions about their previous therapy. Therapists were asked about their CFT training experience and profession.

The participants characteristics from study 1 and 2 are outlined in tables 6 and 7.

Table 5.6: Participant characteristics from study 1: self-criticism

Participant Pseudonym	Age	Gender	Ethnicity	Prior therapy
1. Elena	36	Female	White-Bulgarian	Counselling
2. Anita	39	Female	Asian-British	CBT and counselling
3. Jenny	26	Female	Chinese	Counselling
4. Simon	24	Male	White-British	CBT and counselling
5. Claire	29	Female	White-British	CBT
6. Michael	47	Male	White-British	Counselling and EMDR
7. Diana	34	Female	White-British	Counselling
8. Sarah	19	Female	White-British	No prior therapy
9. David	22	Male	White-Irish	Counselling
10. Helen	41	Female	White-British	CBT and counselling
11. Susan	53	Female	White-British	Counselling
12. Jean	49	Female	White-British	CBT and counselling

CBT (cognitive behavioural therapy) EMDR (eye-movement desensitisation and reprocessing therapy)

Table 5.7. Participant characteristics from study 2: multiple selves

Participant Pseudonym	Age	Gender	Ethnicity	Prior therapy

1. Chris	54	Male	White-British	Group therapy (unclear modality)
2. Kerry	38	Female	White-British	CBT
3. Anya	39	Female	Mixed-Other	Counselling and psychology
4. Tim	53	Male	Black-British	Counselling
5. Emma	26	Female	White-British	CBT
6. Alice	26	Female	White-British	No prior therapy
7. Charlie	36	Female	White-British	Counselling
8. James	53	Male	White-British	CBT and counselling
9. Amy	30	Female	White-British	EMDR, CBT, and counselling

CBT (cognitive behavioural therapy) EMDR (eye-movement desensitisation and reprocessing therapy)

The measures completed by participants are presented in table 5.8 alongside available 'norms' or guidelines for each measure.

Table 5.8. Measures: participant sample and norms

	BDI-II	FSCRs	OAS
Study 1	M=25.75 (SD=12.16)	Inadequate self: M=28.83 (SD=6.44) Hated self: M=8.25 (SD=4.09) Reassured self: M=15.33 (SD=3.82)	M=41.17 (SD=14.43)
Study 2	M=26.88 (SD=14.53)	Inadequate self: M=28 (SD=6.65) Hated self: M=8 (SD=4.47) Reassured self: M=12.22 (SD=6.62)	M=37.33 (SD=17.21)
Non-clinical sample	M=9.14 (SD=8.45) (Whisman & Richardson, 2015)	Inadequate self: M=17.72 (SD=8.29) Hated self: M=3.88 (SD=4.59) Reassured self: M=20.27 (SD=5.77) (Baiao et al., 2015)	M=20 (SD=10.1) (Goss et al., 1994)

Clinical sample/ guideline	Beck et al. (1996) guidelines: minimal range= 0-13; mild depression= 14-19; moderate depression= 20-28, and severe depression= 29-63	*Mixed diagnosis* Inadequate self: M=27.47 (SD=7.51) Hated self: M=12.26 (SD=5.67) Reassured self: M=10.66 (SD=6.51) (Baiao et al., 2015)	*Depression (out-patient)* M= 27.08 (SD=12.39) (Yadav et al., 2019).

The results of the BDI-II suggest that, on average, participants were experiencing 'moderate' depression at the time of interview (Beck et al., 1996). The mean of participants in both studies was higher than non-clinical and clinical (depressed) samples in terms of external shame (OAS). In terms of the FCRs, the participants of both studies scored higher, on average, than clinical and non-clinical samples for 'inadequate self', lower than the clinical sample on 'hated self' but above the non-clinical sample. This suggests that the sample for both studies was high in self-criticism, but that self-hatred was not at the level of previous clinical samples. In terms of the 'reassured self' item, the average of participants was below a non-clinical sample, but above the mixed clinical sample.

Eight therapists were involved in study 1. The characteristics of the therapists included: six females and two males; seven White-British and one White-Irish; and an age range of 30-60 (M=41). All therapists practiced CBT, in addition to CFT, as their main modality of therapeutic practice. The session number when the intervention took place varied between cases, ranging from session six to seventeen (M=11.08). In terms of the therapy received by the participants prior to the chair-work intervention, all therapists reported: formulation and psychoeducation, soothing-rhythm breathing and 'compassionate self' induction.

The six therapists involved in study 2 included: four females and two males; four White-British, one British-Pakistani and one White-Other. There was an age range of 30-63 (M=40.83). All participants practiced CBT, in addition to CFT, as their main modality of therapy. The intervention took place at various points in treatment ranging from session seven to seventeen

(M=12.77). Prior to the intervention, all participants had completed CFT psychoeducation and formulation, soothing-rhythm breathing and 'compassionate self' induction practices.

No therapist or client withdrew from the study and none were declined from participating. No therapy session was found unacceptable (via the standards set out above).

Data analysis

Data were analysed using the structured six-stage process described by Smith et al. (2009) and outlined in table 9. In summary, the analysis proceeded on a case-by-case basis, initially involving close line-by-line reading and written notation. Salient themes were identified, refined, and integrated into super-ordinate themes. The sequence of analysis was repeated for each case before a master-table of superordinate themes was created. The writing up process involved developing a narrative account of the final themes, supported by verbatim extracts from the text. The notion of 'stages' suggests a linear progression, but Smith (2007) stresses that the analytic process is essentially inductive, iterative, and cyclical in nature.

It is acknowledged that there has been a change in terminology used within IPA literature following the revision of IPA's seminal text (Smith et al., 2022). I have followed the authors' advice that for established projects, originating before the new publication, 'you can use either the old terminology or change to the new' (Smith et al., 2022, p.76).

Table 5.9. IPA analytic stages (adapted from Smith et al., 2009)

Stage	Key features and tasks
1. Reading and re-reading	This stage requires immersion in the original data via repeated reading of the written transcript. Salient personal recollections and observations of the interview are recorded (to 'bracket' or manage).
2. Initial noting	The initial analysis involves an exploratory examination of semantic content and language use. 'Anything of interest' is noted with an 'open mind'. The aim is to produce a detailed set of comments or notes, with a focus on the things that matter to the client and the meaning attributed to

	them (including interpretative noting). Descriptive, linguistic, and conceptual commentary is also included.
3. Emergent themes	This stage involves analysing exploratory comments for interrelationships, connections, and patterns. The aim is to produce concise statements of what is important in segments of the original data (involving the analyst's active interpretation). The themes are ordered chronologically in statements alongside the text.
4. Connections across themes	Connections between themes are developed and organised. Emergent themes can be absorbed, discarded, or clustered into 'super-ordinate' themes. 'Super-ordinates' can also be developed via processes such as abstraction, subsumption, and polarisation. The structure of the emergent themes is graphically represented (e.g., in a table).
5. Moving to the next case	The above process is repeated with each participant's transcript. Attempts are made to bracket the ideas from the previous analysis to allow for new themes to emerge.
6. Patterns across cases	Connections across cases are developed. Themes can be re-labelled and reconfigured. A master table of super-ordinate themes is created.

IPA's idiographic commitment is evident in the case-by-case analysis. When moving between cases the researcher attempts to 'bracket' insights gained from the previous analysis (see discussion in reflexivity). In terms of initial noting (stage 2) comments were made at varying levels of analysis and interpretation: descriptive, linguistic, and explanatory (Smith et al., 2009). Descriptive comments, for example, focus on the content of a participant's talk, whilst explanatory comments involve the researcher engaging with the data on an interrogative and conceptual level. Smith et al. (2009) suggest different ways to integrate and explore these different levels in the initial noting. The method chosen involved re-reading and commenting on the transcript at least four times (initially a free textual analysis before focusing on each of the levels in separate readings).

In the analytical process, IPA researchers are interested in 'both convergence and divergence, commonality and nuance' (Smith et al., 2009, p.79). The earlier stage of 'noting' therefore

involved a focus on similarities and differences, amplifications, and contradictions. Themes were later integrated by processes such as abstraction (putting like with like to develop new thematic labels), subsumption (one theme absorbing others), polarisation (examining oppositional relationships) and contextualisation (identifying contextual or narrative similarities) (Smith et al., 2009). Other processes, included in the project, involved numeration (considering the incidences of each theme) and an examination of function (assessing themes for their role within the wider text- e.g. positioning the participant in a passive role). As suggested by Smith et al. (2009), each emergent theme was written down and 'cut up' into a separate slip of paper; the pieces were then moved around to explore thematic connections in a spatial way, leading to new links and associations.

Stage 3 requires an 'analytic shift' as the researcher's own notes and comments become the primary source of analysis (Smith et al., 2009). Whilst the focus is on the lived experience and meaning-making of participants, IPA acknowledges that any outcome is 'always an account of how the analyst thinks the participant is thinking' (Smith et al., 2009, p.80), illustrating the 'double hermeneutic' discussed in the previous chapter. In IPA there is a demand to move beyond the descriptive into deeper levels of interpretation (Smith, 2004). Levels of interpretation can, for example, involve the micro-analysis of a few words: analysing metaphor, imagery, or temporal framing (Osborn & Smith, 1998). Again, the hermeneutic cycle is evident in how the analysis of specific textual extracts are understood within the whole text, capturing the 'psychological essence' of the extract in the labelling of themes. As Smith et al. (2009) suggest, the tension is to ensure themes contain enough 'particularity to be grounded and enough abstraction to be conceptual' (p.92). The participant's chronological 'narrative' can be fragmented at this point as the researcher reads across themes, breaking down and reorganising into a new whole. The researcher takes a 'central role' in organising and interpreting the analysis and such interpretation becomes a 'particularly creative task' as super-ordinate themes are identified across cases (Smith et al., 2009, p.100).

In practical terms, the analysis was captured using tables. As suggested by Smith et al. (2009), each transcript was placed in the central column of a table with the column to the right used for exploratory noting/comments, and the column on the left used to identify emergent themes.

There is an example of this table in appendix eight. Additional tables were created to collate emergent themes for each case, with 'evidence' provided by textual extracts (appendix 11). Finally, master tables were created to capture super-ordinate themes across cases which were evidenced with salient quotes (appendix 12).

The writing up process is governed by two main objectives: firstly, to give account of the overall set of data (a sense of what it is like); secondly, to offer an interpretation of that data (a sense of what it means) (Smith et al., 2009). This was achieved by creating a narrative account of the study's analysis, outlining each superordinate theme (and related sub-themes) and how this applies to participant group. Each theme was 'evidenced' by verbatim textual extracts which served to illustrate the theme whilst allowing the reader to check the evidence for the interpretative claims being made. As per Smith et al.'s (2009) suggestion when working with larger samples, a table was created to measure 'recurrence' across all cases (these tables are included in the following four chapters). Such a measurement is seen to enhance validity when working with a large corpus of participants.

Reflexivity

In IPA, the analytic process is acknowledged as inherently interpretative and personal. Given the researcher's access to the participant's experience and meaning is via their own horizon of experience and meaning-making, Smith et al., (2009) assert that 'reflective practices, and a cyclical approach to bracketing, are required' (p.35). Reflexivity requires an exploration of 'the ways in which a researcher's involvement with a particular study influences, acts upon and informs such research' (Nightingale & Cromby, 1999, p.228). This commitment to reflexivity is in keeping with the hermeneutic nature of IPA, with the researcher forming an essential part of the 'double hermeneutic' (i.e., researchers making sense of the participant's sense-making) (Smith & Osbourn, 2003). The aim of reflexivity in IPA is not to 'screen out' personal involvement in the interpretative process, but to use the identification and revision of fore-structures, in an ongoing 'dialogue' with the data, as an integral illuminating process in the analysis (Finlay, 2008). Whilst IPA acknowledges the impossibility of fully 'bracketing'

personal beliefs and prior knowledge, there remains the commitment to meet the participant's experience on its own terms (Finlay, 2011).

A reflective diary was kept to identify and monitor implicit 'fore structures', expectations and biases- exploring their impact whilst also noting the dynamic way in which the analytic findings changed and shaped them. The process of diary keeping was particularly useful when moving to new cases (managing the assumptions made from the prior participant's analysis), and when reviewing, and extrapolating from, the 'free-coding' of stage 1 analysis (to examine and justify initial coding before moving to deeper stages of interpretation). An example of the use of my reflective diary was identifying my assumption that the self-critic's anger would be feared or negatively judged. Once identified, I returned to the raw data to explore potential exceptions and contradictions to this expectation (and indeed found examples of clients welcoming and prizing their anger). In supervision, the reflective diary was used to reflect on my personal role in the research process and explore alternative interpretations of data.

Despite the importance given to the researchers' interpretative role, a criticism of IPA publications has been the lack of acknowledgement of researchers' preconceptions, beliefs and aims (Brocki & Wearden, 2006). Accordingly, appendix nine includes a reflective summary of the author's fore-structures and their relevance to, and interaction with, the research process. This summary also includes engagement with my own 'positioning' and relationship to the topic (e.g., insider/outsider status) (Gallais, 2008). A reflexivity statement is included in the final discussion (chapter ten) and the project is reviewed utilising the newly published quality guidelines on IPA research (Nizza et al., 2021).

Validity and quality checks

Criteria for judging the quality and validity of qualitative research have been defined by authors such as Henwood and Pidgeon (1992), Yin (1989) and Elliott et al., (1999). In devising and undertaking the current project, the criteria of the above authors have been engaged with and pursued. This has included 'owning one's perspective' (Elliott et al., 1999) by acknowledging and recording the role of the researcher (see reflexivity section); documenting the process of research and interpretation (see analysis section); and by 'grounding in examples' by using

verbatim examples to demonstrate the ‘fit’ of analytic categories to raw data (see chapters six, seven, eight, and nine). Issues relating to ‘transferability’ (Henwood & Pidgeon, 1992) and ‘situating the sample’ (Elliott et al., 1999) were addressed via the collection of, and reflection on, contextual, demographic details for both client and therapist participants, whilst methodological ‘rigour’ (Spencer et al., 2003), has been pursued in the systematic completion of each stage of IPA analysis (see above)

Theoretical ‘coherence’ (Yardley, 2000) is evident in IPA’s integration of phenomenological and hermeneutic epistemologies into a systematic research ‘method’ that focuses on both ‘lived’ and interpreted experience (Smith et al., 2009). Sensitivity to context (Yardley, 2000) is also evident in the matching of exploratory research questions (and the limited research-base on the subject) to the qualitative approach used. In terms of ecological validity (Willig, 2008), the interviews for the data collection took place in the ‘real-life’ setting: i.e., the specific clinic where the client routinely receives treatment.

‘Credibility checks’ (Elliot et al., 1999) were carried out by discussing, reflecting on, justifying, and revising examples of analysis with my supervisors. Supervisors were also utilised to analyse examples of raw data to compare with my own analysis, in addition to matching data extracts to superordinate themes (to ensure broader thematic labels/units were grounded in raw data). The above measures can be understood as independent ‘mini-audits’, with the aim of ensuring the analytic process is both systematic and transparent (Yin, 1989; Smith et al., 2009). The integration of theory is another criterion used for judging research quality (Henwood & Pidgeon, 1992). The research provides a clear explication of the relationship between units of analysis via tables linking individual-level themes to their evidence within the data and to broader group-level super-ordinate labels (see appendix 12). A reflective diary was also kept to demonstrate the process of thematic integration and justify the reasons for my decision-making.

Ethical considerations

The study was approved by the University of Derby Psychology Research Ethics Committee and the NHS Health Research Authority (IRAS no. 250657 and 188390).

The British Psychological Society's (2018) code of ethics and conduct (and their principles of respect, competence, responsibility, and integrity) were strictly adhered to throughout the research. This included respecting the right to self-determination and informed consent via the use of detailed participant information sheets, signed consent forms (checked with peers for clarity), explicit permission to decline questions, and the right of withdrawal (within a clearly defined time-limit). As highlighted by Weatherall et al. (2002), the issue of informed consent can be complex in qualitative research due to the open-ended nature of the interview process. To manage this, a semi-structured interview format was adopted and checked by qualified therapists for the potential to cause distress (the interview questions also formed part of the NHS ethics application). Attention was also given to the safety of participants in the planned management of risk: i.e., the limits of confidentiality were clearly stipulated in the information leaflet, outlining the potential for risk related information to be disclosed to the participant's therapist.

The author is a registered mental health nurse (Nursing and Midwifery Council- NMC) and accredited member of the British Association of Behavioural and Cognitive Psychotherapists (BABCP). Throughout the project, the ethical codes of both organisations were followed without exception (NMC, 2018; BABCP, 2016). When considering the potential vulnerability of the client group, Braun and Clarke (2013) suggest that interviewing 'vulnerable groups' requires professional experience with the participant group, which the author has. A decision was made not to interview clients that the author had personally treated in order to avoid hierarchical relationships, dual-roles, and coercion into participation (Braun & Clark, 2013).

Issues of confidentiality and privacy were also considered in detail and The Data Protection Act 2018 (UK) and the NHS Code of Confidentiality (DOH, 2003) were adhered to at all times. The audio recordings from participant interviews were encrypted before leaving NHS premises and were stored in locked containers before being transferred to secure storage. Written information about the participant was kept in a separate locked container, with ID numbers and pseudonyms created for transcription and presentation. Participants were also given the option of receiving the final results of the research and any resultant publications.

Other ethical considerations included the use of a 'cooling-off' period of a week between their decision and the interview. De-briefing was offered after each interview but was not utilised by participants. Each project received NHS ethical approval via the Research and Ethical Committee (REC) of the NHS Health Research Authority (HRA). Ethical approval letters are included in the appendices. Ethical approval was also sought and gained at a Trust level via local NHS Research and Development offices.

Chapter summary

This chapter has described the research methods used within this project. It included an outline of the project's design which is to explore client experiences of the self-critic or multiple-selves chairwork, in clients with depression, shame, and self-criticism, as delivered in an NHS primary care psychology service. The chapter summarised the core stages of both CFT interventions, the recruitment process, and the eligibility and exclusion criteria (relating to participants and their therapists). The process of data collection was also outlined, and the interview schedules for both studies is included. The personal characteristics of all participants were presented to describe the sample, and their scores on related measures of shame, depression and self-criticism have been contextualised and explained.

The chapter then focused on the structured and sequential analytic procedures of IPA. This included a summary of the case-by-case analysis undertaken in IPA (e.g., the development of emergent themes into case-level super-ordinate themes) and the creation of cross-case superordinate themes. The final sections of the chapter discussed the role of reflexivity within IPA and the way in which qualitative validity criteria is addressed within the project.

The following four chapters (from chapter six to chapter nine) contain the analysis from both interventions. Chapter six and seven cover the self-critic chairwork, chapter eight covers the multiple-selves chairwork, and chapter nine covers themes that relate to the therapeutic relationship across both interventions.

Chapter 6: Self-Critic Study Analysis 1.

Introduction

This chapter contains three themes from the analysis of study one: CFT chairwork for self-criticism. As outlined in chapter five, the analysis was based on the transcribed interviews of 12 participants following the self-critic chairwork intervention. The IPA analysis of the resultant data progressed on a case-by-case basis before developing of group-level superordinate themes. The three themes described below relate to participants' experiences of chairwork processes. The themes are: embodiment and enactment; externalising the self in physical form; and emotional intensity (accessing and experiencing emotion, and overwhelming emotion and avoidance). The analysis was presented in the published paper: Bell et al. (2020) (appendix one). An additional three themes from study one are presented in chapter seven.

Analysis

The analytic process outlined in chapter five created three superordinate themes relating to chairwork processes, their impact on participants, and the meaning they gave to their experiences. The number of participants for whom the theme is present has been tallied and totaled to provide an overview of occurrence in the sample.

Table 6.1. Summary of themes and occurrence for self-critic study analysis 1

Superordinate and sub-ordinate themes	**No. of participants for each theme**
1. Embodiment and enactment	12/12
2. Externalising the self in physical form	12/12
3. Emotional intensity	
-Accessing and experiencing emotion	12/12
-Overwhelming emotion and avoidance	7/12

Theme 1: Embodiment and enactment

The physicality of the exercise was given importance by all participants, specifically the way in which each self was embodied and enacted. Distinct postures and expressions were associated

with each self, and such embodiment was used to define and differentiate their qualities and character. For example, Anita identified:

'There was a huge difference between the critical and the being criticised: the criticised as being slumped, as being down, as being depressed, as hurting was basically trying to cover or trying to find some form of comfort'

As in Anita's example, each self was realised by internal sensation and external expression. Internally, specific selves were frequently associated with particular body locations, such as the compassionate self as a calm 'at the top of my head' (Anita). Other participants reported powerful changes throughout their whole body; Sarah, for example, described a sense of total immobility when enacting the criticised self ('I couldn't move, I felt trapped'). In terms of external expression, each self was experienced as a set of particular physical movements, facial gestures and the contraction or expansion of the upper body. Notably, such changes were also enacted by participants during the research interview to help them access and communicate their experience of each self. Claire, for example, demonstrated the following as she spoke:

'I probably just sat a bit like this. Just scrunched my shoulders and pulled my tummy in and pulled my face'

Such physical changes initially occurred automatically and without conscious creation, yet such embodiment became elaborated and practiced in an intentional manner to get further into 'role' (e.g., consciously making a fist to connect with the critic's aggression). When accessing each self there appeared to be a dynamic, iterative interaction between participants' automatic bodily sensations, their awareness of such reactions and their conscious amplification through further physical movement, creating a recursive cycling between reaction, awareness, and conscious action. Whilst deepening the participants' affective connection to each self, such enactment also led to new insights into each self's function and motivation, and the kind of internal relationships they continue to create, as illustrated by Simon:

'So when I'm critical I'm hunched forward, very aggressive towards the person, like in my body language, and then I'm getting as far away from the person as possible when I'm criticised'

As Simon highlighted, the 'acting out' of each self emphasised their specific action impulses (e.g., the body literally moving 'forward' or 'away'). Such experiences provided participants with tangible insights into how they might typically react when operating from each self in their daily lives. The experience of physical transformation and inhabitation during the exercise also added credence to the intervention by creating a sense of 'realness' and therapeutic endeavour, as identified by Michael:

'I was pleasantly surprised that things were manifesting themselves in the way they were, because I thought well I'm in this now, this is me in the therapy, this therapy is going to have an effect, and again it reinforces, I was in that virtuous circle of reinforcement through it'

For Michael such 'manifesting' created an absorption in the experiential process of the therapy ('I'm in this now' as opposed to talking about his experiences from a disconnected position). Similarly, other participants utilised body movement and posture to return to, or remain immersed in, each self. Simon, for example, said:

'I got into that position and I stayed there, that allowed me to stay in that role physically, which kept me emotionally and psychologically there'

Simon particularly identified the use of his body to anchor himself to various patterns of experience, and to re-access the psychological reality of each self. For other participants, importance was given to the physical vocalisation of each self, both in expressing and then hearing different voice tones 'out loud'. The power of vocal enactment was frequently contrasted with written means of expression, as described by Jenny:

'When you are writing it down you can't really express it as much. Tone of voice you can kind of use like harsher words or negative words but it is still hearing your own voice out loud it is a lot different to reading something you've written on paper'

As Jenny suggests, the physical act of vocalisation created a speaker and hearer so that each self was both and literally and metaphorically 'heard'.

Theme 2: Externalising the self in physical form

Externalising 'parts' of the self in the form of chairs allowed participants to understand and interact with their inner experiences in a new way. The siting of a self in a separate chair, as a concrete entity in a fixed position, allowed participants to gain both physical and psychological 'space' and 'distance' from parts of themselves as they moved between chairs. This very movement, from one chair to another, acted to break participants' connection with each self (a 'stepping out'), whilst facilitating the capacity to 'look back' at 'the self from a new perspective.

'It accessed the different other sides of you and moving, I think it was helpful to change, you kind of visualise changing position, so you are changing, you are changing those different parts of you in your brain' (Claire)

As in Claire's example, the movement between chairs acted as holistic and experiential change of mind, whilst each chair provided a material form or frame on which to build a coherent impression of distinct internal parts. Participants noted a degree of internal and external correlation in the way they gained a sense of mental or inner 'order' by organising and arranging their externalised selves in chairs across the room. Similarly, the way in which the chairs had been placed by the therapist, in relation to one another, gained a degree of symbolic importance: the critic and criticised parts were identified as being at 'opposite' ends, whilst the compassionate self was frequently referred to as being positioned 'in the middle' (linking physical positioning to the role of mediation and integration):

'Then from sitting here in the neutral place and looking at why the critic did what the critic did and how that effected the criticised, from a place of understanding' (Susan)

As with Susan's example, participants frequently used figurative language linked to 'place' and 'position', as if the physicality of the exercise provided a means to articulate and symbolise inner

experience. Susan continued to describe how she planned to develop a ‘map’ in her mind to visually represent how the chairs were placed in the room, allowing her to imagine moving ‘positions’ to carry out the exercise at home.

‘When I have those thoughts, those critical thoughts, I will jump to the other chair now, because in my mind that is what I’ll be doing and then I’ll be in this chair’

Focusing on an externalised self, in the form of a chair, also facilitated vocalisation and expression during the exercise. Participants identified the importance of speaking *to* something, *to* another chair, rather than speaking in abstract:

‘So rather than speaking to friends, countryman, romans, it was speaking to speaking to the chair, speaking to the person in the chair, the voice in the chair, the sense of that character in the chair’ (Michael)

Speaking ‘*to*’, in the way Michael describes, highlighted the relational nature of these expressions. It was notable that when enacting these self-relationships externally, participants began to draw parallels to the kind of relationships they have with other people. In this way, the chair-work facilitated a direct contrast and comparison between internal and external relating. This phenomenon was particularly helpful when attempting to generate self-compassion. Participants found themselves able to overcome their habitual blocks to self-compassion by treating their self (externalised in the form of the other chair) ‘as if’ they were another person, thereby recruiting their capacity to care for others when relating to themselves:

‘So it is nice with a separate chair if you like, separate people, and you can almost imagine what it would be like said to another person and yeah, suddenly it becomes a lot nicer, easier’ (David)

A similar process was evident when participants expressed self-criticism ‘outward’ (to a ‘separate’ chair), creating a sense of shock at their treatment of an ‘other’. As shown by Jean below, participants were able to acknowledge the distress caused by their self-criticism when experienced ‘as if’ expressed to another person in the external form of a chair.

'I thought she was a bitch, the critical women, I'm not pointing at you, it was that chair, that she was a bitch and she (other chair) needed to pull herself together, why let someone treat you like that, and then I started crying because I realised, literally I would never do that to anyone else. I would never do that to anybody' (Jean)

As in Jean's quote above there was a merging of the inner and outer worlds (mental and physical; self and other) mediated and mapped by the chairs and their positions in the room.

Theme 3: Emotional intensity

Accessing and experiencing emotion

All participants emphasised the intensity and variety of their emotions during the exercise. Such emotions were felt at a 'whirlwind' intensity, with Claire describing the session as *'table-tennis in the emotions'*. Whilst accessing conflicting emotions at a heightened level, the majority of participants noted the way in which they could, with minimal prompting, shift in and out of powerful emotional states by moving chairs and enacting a different self (see themes above). Such a capacity to change and 'leave' an emotion in this way fostered an openness and willingness to feel each emotion to a greater degree. Therefore, whilst finding their emotional reactions 'extreme' and surprising in their acuity, participants also identified a degree of agency over them. Susan, for example, reported a sense of achievement at having accessed and experienced her emotions at such intensity:

'I can't believe the extremes of emotions that I had in the three chairs, it was bizarre, and I know I've said that before. I've never looked into myself that far before. So I'm quite impressed with it actually. I think I'll remember these blue chairs for the rest of my life.'

Participants spoke about accessing their emotions as a form of discovery, particularly in connecting to emotions they had not previously associated with self-criticism or their general character. Participants were struck not only with the depth of experiencing, but also the variety of emotions present. This was particularly relevant for Michael:

'It came from a place of fear, underneath the anger was fear, and I felt the anger. I physically felt the anger. I felt the physical sensations of anger in the same way as you would with rage, you get that rrrrghhh, and the heat and then tension in the centre of your chest. And the fear was more that visceral, gut, abdominal kind of squirming, clenching.'

Michael found the exercise uncovered various over-lapping layers of emotions, providing insight into the way in which one emotion had previously covered another in a protective capacity. The intense nature of such physical experiences also helped participants to clarify and label the emotions that were present and to differentiate between each self. All participants identified anger in the self-critic chair. Whist such anger highlighted the 'attacking' nature of the critic and the kind of internal relationship it created, four participants framed their experience of anger in relatively positive terms: as a form of release and relief. Elena, for example, identified that her 'powerful' anger could be utilised and redirected for an alternative purpose:

'It works out that you could use that energy and maybe, just, you know, to create something with it, as a drive rather than something destructive to yourself'

Similarly, Anita was surprised at the presence and potential of her anger ('*you don't see yourself as having a huge amount of power within you'*). After experiencing the negative impact of her anger when self-directed, she too identified the potential to focus it externally to assert herself and her needs.

The 'criticised self' was associated with, and identified by, feelings of sadness and anxiety, in addition to social emotions such as shame and embarrassment. For half the participants these emotions had previously been unacknowledged in the context of self-criticism. Participants understood this in relation to their previous over-identification with the critic rather than the criticised part of themselves. Sarah, for example, explained how her anger as the critic had obscured her awareness of more vulnerable emotions in her everyday life:

'I only ever hear my self-critic, so hearing my vulnerable side it is not something I'm used to. So being in the position where I do hear it and I recognise that I'm sad or upset or whatever, it was

scary to see that that side of me is so shut off that I don't even realise it is there most of the time so it was sort of, it was like a brick wall that had hit me in the face, it was so effective, I was really moved by it.'

Participants contrasted such emotional connection during the chair-work to previous cognitive or lexical exercises that had focused on rational challenge and change. Helen identified how the chair-work had allowed her to by-pass previous blocks to her emotions:

'And that was a definite feel-it moment. Whereas I could talk to you about it all day long, that was a definite feel-it. I get it in here what is happening and having had CBT I get it up here but I do need to feel it and I definitely felt it today'

Such emotional engagement helped Helen to 'feel' change at a 'heart' rather than 'head' level. Other participants similarly identified the emotional nature of the exercise as an essential part of the therapeutic process, creating a 'deeper knowing' where previously an emotion might have been avoided. This was most apparent in the participants' emotional experiences in the compassionate chair, which focused on being emotionally 'moved' and feeling 'warmth'. Sadness was frequently experienced in the compassionate chair in the context of sympathetic feeling. The compassionate self's capacity to soothe and be 'comforting' was also felt as a significant shift in emotion, which reinforced the participants' faith in compassion and its cultivation.

Overwhelming emotion and avoidance

Whilst the intensity of emotion during the exercise was generally well tolerated, participants gave examples of finding their emotions overwhelming. Claire interpreted the intensity of her emotions during the exercise as an indication of imminent relapse or lack of progress, whilst David found the presence of sadness particularly aversive and embarrassing. Such concerns and distress were ultimately short-lived, with the intensity of experience deemed cathartic and helpful. David, for example, 'felt' the benefit of expressing and processing emotions he had previously avoided:

'This is the calmest I've been all week, I've been so anxious and felt horrible all week and I'm just like now I feel calm, so it is has like an immediate impact and effect on me which is good'

Blocks to emotions during the exercise were idiosyncratic in terms of participant's aversion to a particular self. For four participants, the critic was the most difficult aspect of the self to acknowledge and enact and this was linked to an avoidance of anger (with participants disowning their capacity to be aggressive, 'negative' or cruel). Sarah's experience differed from other participants in the way her hostility to the critic escalated her own feelings of anger, reducing her capacity for compassion:

'I couldn't connect to it, it is like, it felt like when you meet someone and everyone has that one person who you just can't connect to, it is horrible to say but it felt like a physical hatred'.

In contrast, three participants voiced antipathy towards the criticised self, finding its anxiety and vulnerability more difficult to own and explore. For Jean, this difficulty was identified as a fear of becoming emotionally moved by her own distress. Here she describes a process of subtle disengagement by diverting her gaze from the 'criticised self' personified in the opposite chair:

'I didn't want to meet the eyes because I didn't want to see the effects of what I was saying…I didn't want to see the effects on what was happening for myself, so that's why the emotions started coming through even though I focused over there. In case I felt sorry'

For Jean, as for all other participants, 'feeling' the distress caused by the critic's attack was integral to understanding the nature of self-criticism and its full impact. However, in the process of experiencing such distress, four participants described the intensity of emotion in the criticised chair as 'too much' and temporarily beyond their capacity to tolerate.

Chapter summary

This chapter has presented three themes from the analysis of the initial study: CFT chairwork for self-criticism. The initial theme of embodiment and enactment highlighted the importance given to the exercise's physicality and emphasis on bodily sensation, movement, and expression.

Encouraging participants to ‘become’ different selves created various somatic and affective markers that were used to differentiate each self’s motivation and mentality. Participants also noted how they intentionally used aspects of embodiment (such as changing their posture) to access each self. The physical experience of becoming each self also created a new sense of authenticity and absorption in the therapy process.

The second theme, externalising the self, highlighted how concretising parts of the self on a chair created a degree of psychological separation. This ‘distance’ created the opportunity to relate back to parts of the self from a new ‘position’. The analysis emphasised how space in the therapy room became charged with meaning and symbolism: for example, re-arranging parts of the self on different chairs correlated with an experience of inner organisation. Externalising internal dialogues also encouraged participants to compare how they treat themselves to how they treat others. This allowed clients to relate to themselves as if an ‘other’, which facilitated self-compassion.

The final theme of emotional intensity emphasised how the chairwork process allowed participants to shift in and out of strong emotion, creating a degree of agency. The variety and acuity of emotions associated with self-criticism surprised participants and created insights into its nature and impact. Whilst for some participants the strength of emotion helped participants to ‘feel’ and believe the benefit of the intervention, for others the emotional intensity was initially overwhelming and aversive. Idiosyncratic aversion to specific emotions was also evident.

The implications and significance of these findings are discussed in chapter ten. The following chapter presents three further themes from study one.

Chapter 7: Self Critic Study Analysis 2

Introduction

This chapter presents three additional themes from the analysis of study one: CFT chairwork for self-criticism. The methodology used for the study is detailed in chapter five. This chapter is an analysis of data created by interviewing 12 participants (the same as the prior chapter) following the self-critic chairwork intervention. The themes presented here relate to self-multiplicity and integration. The themes are: differentiating selves (from singular to multiple and developing new selves); mental imagery of selves (the benefit of 'seeing' selves and linking them to memories); and integrating and transforming selves with compassion (moving from conflict to integration, and transforming the critic). The analysis was published in the paper: Bell et al. (2021a) (appendix two).

Analysis

The three distinct, but interconnected, super-ordinate themes presented below relate to self-multiplicity, changes in internal relationships and their integration with compassion. These themes, and related sub-themes, are shown in Table 7.1. Occurrences for each theme across the data set are also given.

Table 7.1. Summary of themes and occurrences for self-critic study analysis 2

Superordinate themes	Sub-themes	No. of participants for each theme
1. Differentiating selves	-Singular to multiple -New selves, new potential	12/12 9/12
2. Mental imagery of selves	-Seeing selves -Past selves (memory and imagery)	10/12 6/12
3. Integrating and transforming selves with compassion	-From conflict to integration -Transforming the critic: fears and function	12/12 12/12

Theme 1: Differentiating selves

Singular to multiple

All participants reported an expanded sense of 'self' during the exercise: an experience of the self as formed of multiple parts and elements that could be separated and differentiated. With one exception, this was experienced as a novel phenomenon, one at odds with participants' 'everyday' perception of their self as singular, stable, and fixed.

'It did feel weird because on a daily basis you just have the one mind' (Elena)

Whilst Elena experienced this process as 'weird' other participants found the idea of multiplicity helped them to rationalise experiences they had previously found 'illogical' and confusing: i.e. their experience of the self as inconsistent, contradictory and variable. In this way, participants spoke of becoming 'enlightened' to their own nature and existing complexity, as well as being reassured that their lived experience of having multiple aspects of themselves was a shared and normal human experience.

'So I think that is just the normal function of your brain to have different roles, so it is okay, so it makes it a bit more normal.' (David)

Whilst reassuring for some participants, the process of encountering multiplicity was extraordinary for others, with four participants using spiritual terms, such as being a conduit or '*a bloody medium*' (Jean), channeling the voices of something hidden or beyond their normal awareness. In these descriptions the 'self' was experienced as mouthpiece for something 'other', to whom they were allowing access. Similarly, the various parts of the self were frequently perceived to be functioning autonomously like '*separate entities*' (Michael). They were often described as different 'voices' and were frequently personified and imagined (see theme 2).

Participants also identified that by undoing what had previously been 'tied up' in their notion of self, they were able examine and explore its composition in more detail. Others described a more active process of 'splitting' and 'separating' the self into parts (as if the 'normal' conception of the self required a degree of forceful opening) which increased their ability to clarify and

organise their internal experiences. Two participants used the analogy of separating the self into smaller 'boxes'. The boxes analogy captures the process of containing, naming and providing structure for experience, even as the sense of self was expanded and multiplied. For Simon this created a new sense of pride in self-organisation, and managing the '*conglomerate mess'* of his mind:

'It develops your understanding, you have got a lot of different emotions and inclinations and, you know, there's lots pulling you in different directions and the self is very messy…I feel like I'm doing well to organise such complex thoughts now, there is a sense of pride in that I guess.'

New selves, new potential

The identification of different 'selves' also created (in nine participants) a sense of expanded potential, as if new options or ways of being were introduced into their repertoire. Participants particularly identified the potential to change 'role' or switch 'modes' as an alternative to enacting their self-critic. In this way, separating aspects of the self allowed for certain parts to be given voice whilst at the same time quietening others. A shared metaphor involved the changing of clothes to the changing of self, capturing the sense of choice and agency over what self was picked up and put on:

'It is a lot easier to jump into it, like jumping into another outfit or something and then you can quickly and more effectively deliver some compassion and then you can obviously when you isolate when you criticise yourself, I can recognise that, oh it is just that part and set it aside.' (David)

Participants reported 'relief' at 'shedding' the part of the critic, highlighting the 'temporary' nature of each self and the way in which they had over-identified with a particular version of the self. For Elena, the identification of alternative, distinct parts of the self offered choice where no prior option had been recognised.

'Because then if you didn't differentiate between those parts then you might not even think that you could try and step out of this and into this'

Similarly, Susan identified that the active process of separating the 'self' into multiples cleared new potential paths and a space to reflect and make choices:

'For so long I've been so muddled, I've got all these things jumbled up, a mess in my head, and it is like being in a forest, you can't make your way through it, but all of a sudden, I'm able to chop away at it. I can make a pathway for myself. I can think better'

The creation of such space where separate aspects of the self are given form, position and voice also allowed participants to discover the relationships between selves, and the potential to choose or change such relationships (see theme 3)

Theme 2: Mental imagery of selves

Seeing selves

Participants reported spontaneous mental imagery of their different selves when looking towards the various empty chairs or when picturing themselves in each role. The imagery frequently took the form of 'versions' of the self: the self as younger or older, taller or smaller, in specific bodily positions (e.g. '*hunched'*) or as emotional personifications of each self ('*me but a very angry me'*, Simon). Such imagery became a means of differentiating each self as they occurred in contrasting but connected forms, often as opposites, which allowed for clear distinction and comparison. Claire, for example, described the contrast of ages in her images:

'When I did the critical me, I kind of visualised me a bit older but when I was doing the criticised me I kind of felt like I could see, maybe it was like a younger child almost'

Whilst the imagery was frequently identifiable as the participants' 'self' in form and features, other imagery was of a fantastical nature: as monstrous, metaphorical or caricatured. Simon, for example, experienced vivid imagery of figures that symbolised and personified the nature and function of each self:

'I imagined it as this sort of cave man, this was the sort of character. A well-meaning but thick person with a club, fending off all of these threats'

Such spontaneous imagery acted to capture and extend the participants' experience of each self: offering both a manifestation of metaphorical and implicit meaning and a means to reflect on such meaning (e.g. the cave man's primitive and undeveloped 'defenses' were linked by the participant to evolutionary and developmental insights). Similar realisations into the nature, impact and role of each self were generated when *seeing* the critical self variously as a teenage 'bully', a 'school marm', a 'shadow' and a 'devil' or evil 'creature'. In contrast, the criticised self was imagined as a child (either one's self or another) by five of the participants, whilst Helen pictured herself as a '*curled up hedgehog'*. Similarly, the compassionate self was visualised in a way that embodied its qualities and attributes. This included imagery of Jesus, a 'motherly figure' and a large sculpted angel, with most participants picturing the compassionate self as altered version of one's self: as older, stronger and wiser (looking like '*the full version of myself', David*).

Linking to theme 3 (which focuses on the theme of compassion as means of integration and transformation), it is of note that participants' imagery transformed, involuntarily, when the critical and criticised selves were related to with compassion. For example, Jean's imagery of the critic as a large bully turned into a frightened child, with its actions and appearance changed (no longer '*sniggering in the corner*'). These interrelated shifts in imagery, mindset and motivation, again highlights how participants' mental representations both symbolised and supported wider psychological processes and change. Simon particularly captured how his imagery transformed in parallel to changes in self-to-self relating and inner emotional tone.

'I think I just saw myself in this very idyllic setting, helping someone up and as I was helping them up they kind of turned into me, I was looking at myself, and I was, I felt kind of strong and looked very shiny'

As in Simon's example, imagery facilitated a greater capacity to focus and express emotions and motivations, as the recipient of their criticism or compassion became life-like, 'real' and human.

Seeing oneself, or the personification of oneself, in an externalised imaginal form increased participants' capacity to mentalise, 'be objective', empathise and generate compassion with themselves whilst also increasing emotional connection.

'Because until you see that vulnerable self, you don't realise how sad you are when you are listening to that self-critic' (Sarah)

Both quotes above highlight how the use of imagery acted to blur the sense of self and 'other', seeing and being seen, speaker and listener ('*you visualise it like you are a different person'*, Claire). In the context of the exercise, this allowed for the flow of compassion outwards, 'as if' to another, to be focused back towards the self.

Whilst mental imagery was most frequently experienced as spontaneous in nature, participants also reported a more intentional and active use of imagery to connect with the 'self' they were enacting. This included participants picturing themselves as the critic or compassionate self when speaking from that position, visualising the character they were trying to create in the chair (modelling themselves on its postures and gestures), and then, for Anita, '*looking through its eye*s'. Imagery was also intentionally used to access compassion when language proved unhelpful or inadequate, with two participants reporting to imagine the 'touch' and 'physical support' from compassionate figures.

Past selves (memories and imagery)

Six participants identified their imagery as directly linked to either distinct memories or amalgamations of life events. Such imagery was linked to experiences of shame and criticism from specific others (for example, being laughed at during a school play). The feeling of being child-like and '*at my most vulnerable*' (Jean) was frequently cited and related to the timescale of the memories recalled (predominantly in childhood or early adolescence). The presence of imagery, linked to memory, intensified the emotional impact of the exercise, whist creating a vivid felt sense of re-experiencing the past. This was captured by Sarah, who described the interaction between imagery, memory, and emotion:

'Memories come up, so you're thinking of things that happened that made you angry and made you sad and whatever, and you are picturing yourself as that memory, as a child, as a teenager, everything that was going round in my head I could see, I could visualise it and it was fuel to the fire, it made it ten times worse, you didn't picture yourself as how you look everyday, your sort of normal self, you were small'

Whilst distressing and intense in nature, such associations were identified as useful and helpful in clarifying the relational context in which specific self-parts developed. For some participants the links between historic events and current self-criticism were novel and surprising. Diana notably experienced auditory imagery of her self-critic as a male voice during the chairwork, providing new insight into the interpersonal origin of her self-to-self relating.

Theme 3. Integrating and transforming selves with compassion

From conflict to integration

The exercise, in framing the self as comprised of inter-related 'self-parts', also highlighted the kind of relationships that existed between them. Participants were shocked at the intensity of internal conflict when externalised and enacted between chairs, referring to the self-criticism as a form of 'fighting', 'battling' and 'attacking'. Anita initially compared this experience to '*two people having a fight in the street'* before expanding her description to emphasise the animalistic, primitive nature of such exchanges:

'It's ridiculous, I put it akin to two animals fighting, say like a tiger and a bear, and they continue. So have you seen Game of Thrones? At the beginning of the Game of Thrones there's a spinning thing and it gives a history of all the Games of Thrones, and it's like that with two animals constantly going round and round for all eternity'

Anita's description also captures the repetitive nature of such conflict, here portrayed as two forces locked in an internecine, unwinnable war, cyclical to the point of tragedy or parody. For other participants, the conflict resembled that of an abusive relationship between adult and child, bully and bullied, taking the dynamic of dominant to subordinate with the criticised self scared, defeated, and appeasing.

The compassionate self was initially experienced as form of external position away from such conflict but with an internal 'viewpoint' back towards the struggle. Participants reported the compassionate self was the only self '*that could see the both'* (Claire) and gain a '*total view'* (David). This observational capacity, or reflective space, allowed participants to re-engage with the conflict but with an alternative way of relating to each self. The compassionate self was experienced as parental in its caring intention, differentiated from the critical interactions by its motivation and emotions:

'It is just how it felt being the compassionate one, it just felt like, you know, wise and knowing and love, pure love. Whilst those two were fighting out of fear, the compassionate self was just pure love and so wise. A wise part of me' (Elena)

In Elena's description the compassionate self also embodied specific qualities that supported its care for the other selves. Such qualities frequently included wisdom and authority, with participants comparing the compassionate self to a judge adjudicating on disputes, demonstrating a capacity for reason and balance.

'Then as the compassionate self, you know, because you feel so strong and confident, you can talk to the person over there in the critical chair and you talk to the person over there in the criticised chair: it's almost like suddenly you are King Solomon' (Simon)

As in the above extract, participants stressed the compassionate self's willingness to open dialogue with the other parts: to listen, learn and respect their contributions whilst maintaining benign strength and oversight. There was a repeated desire for integration and inclusion, to 'work together' rather than reject or exclude, which was captured in a linguistic shift from 'I' to 'we'. This motivation extended to a wish to provide physical comfort and connection to the conflicted selves by means of a '*group hug'* or soothing touch. The integration between selves appeared to be supported by (or perhaps represented by) the identification of profound similarities between the core fears and needs of the criticised self and the critical self.

‘Actually they overlap and become the same voice.’ (Simon)

As identified by Simon, such apparent ‘opposites’ were transformed in the process of integration, as if clarified into a single ‘voice’ of fear, shame and disappointment. Such transformation highlighted a degree of unity beneath the internal conflict and hinted at the potential for self-compassion to foster a deeper coherence of self.

Transforming the critic: fears and function

The transformation described above was most striking when relating to the critic from the compassionate self. The critic’s attack was ultimately recast as a signal of fear and distress by identifying the fears driving the critic and understanding the function it serves. Participants universally reported an ability to see the critic as a protective reaction to threat: specifically, the threat of being ‘vulnerable’ to external criticism, rejection, or harm. The critic was understood as blaming, attacking, and scrutinising the self for potential signs of weakness with the function of reducing external exposure and increasing self-control.

‘The intention is to protect myself, so if I say it first whatever you say is not going to…I’ve already prepared myself for it so that’s fine’ (Helen)

Half of all participants also identified the use of the critic to motivate and maintain personal performance and standards, yet there was a clear acknowledgement that the critic was focused on preventing or avoiding performance failure (and its feared consequences) rather than promoting a value, aspiration, or positive attribute. Having understood the critic’s protective function, four participants were able to make links to its origin, providing further contextualisation and increasing empathy:

‘Actually a reasonable response based on situations that I’ve been in before. I’ve been in a similar situation where something bad has happened so naturally I’m going to be, my defense system is going to be kicking in, so in that sense, it was helpful in legitimising the voice’ (Simon)

Participants were able to balance such validation for the distress driving the critic (and the adaptive role it once served) whilst also acknowledging it was now '*the wrong way to go about things'* (Elena). Consequently, the critic's presence was ultimately reappraised as a prompt to 'switch' to the compassionate self to address this need for safeness and support. As introduced in theme two, by viewing the critic in this empathic way, the critic was transformed from attacker to 'injured' and from aggressive 'enemy' to 'someone that needs help':

'When you are looking from it from your compassionate side you see where it comes from and what it is trying to do, you see it is part of you, you see it is kind of just like a kid almost, like a kid who grew up with a bunch of negative experiences to deal with stuff and you are there like, it is fine, I'll help you out' (David)

As in David's example, four participants described how the critic metamorphosised into an archetype of vulnerability, a child in distress, providing a unique means and focus for self-compassion that linked both personal and universal, self and other, past and present-day needs.

Chapter summary

This chapter has presented the second set of themes from study one: CFT chairwork for self-criticism. The initial theme of differentiating selves provided an account of how participants experienced separating the 'self' into multiples. Whilst some participants perceived self-multiplicity as 'weird' and counter to 'normal function', it was also experienced as a helpful explanatory framework to make sense of contradictory and illogical experiences. Separating selves also created an expanded sense of self and with that, a broadened sense of self-potential and the possibility of a revised self-organisation.

The second theme, the mental imagery of selves, highlighted how participants experienced spontaneous symbolic and metaphorical imagery of different selves during the intervention. These images provided new insights into the nature and function of each self; their transformation during the intervention also mirrored and represented changes in participants' motivation and mentalities. The images were also linked to specific memories of self and others, helping participants to discern the origins of their self-criticism.

The final theme presented experiences of transformation and integration via compassionate self-relating. Participants initially reported shock at the intense level of internal conflict and the animalistic hostility expressed in their self-criticism. The compassionate self was, in contrast, experienced as caring, wise, and parental: able to step back from conflict and relate to both parties with an understanding of their fears and function. This compassionate orientation acted to transform distressed parts of the self and offered a means of identifying and addressing vulnerability.

Chapter ten contains of an in-depth discussion of these themes, linking such findings to extant literature and evaluating their implications for CFT theory and practice. The following chapter is an analysis of the second study: 'multiple-selves'.

Chapter 8: Multiple Selves Analysis

Introduction

This chapter presents the analysis from study two: multiple-selves chairwork. The analysis generated three super-ordinate themes that echo, complement, and elaborate the themes of the prior chapters. Given the intervention's emphasis on emotion, the analysis highlights how chairwork principles and processes were experienced when applied to affect and emotion and how they facilitated compassion towards the participants' 'emotional selves'. As outlined in chapter five, the analysis was based on the interviews of nine participants following the multiple-self intervention. The superordinate themes are: appreciating emotional complexity (multiplicity and differentiation, and the way in which emotions interact, dominate, or are absent); the role of chairwork process (embodiment and movement between chairs); and compassionate integration of emotions. The analysis below forms part of the published paper: Bell et al. (2021b) (appendix three).

Results

The analysis generated three interconnected super-ordinate themes that focus on emotional complexity and integration. The overall occurrence of each theme across the data set is provided.

Table 8.1. Summary of themes and occurrences for multiple selves analysis

Superordinate themes	**Sub-themes**	**No. of participants for each theme**
1. Appreciating emotional complexity	-Multiplicity and differentiation -Dominance, absence, and interaction	9/9 9/9
2. The role of chairwork process	-Embodiment to identify and access selves -Standing up, looking back: the benefit of moving chairs	8/9 9/9
3. Compassionate integration of emotions	-Empathy, acceptance, and integration	8/9

Theme 1: Appreciating emotional complexity

Multiplicity and differentiation

All participants were able to access and express experiences from each emotional 'self' in a way that highlighted distinct mind-body patterns for each emotion. The identification of such individual patterns gave rise to an impression of the self as multifarious: formed of agentic 'parts', separate 'mind-sets', 'mind-frames' or 'modes' of being. These emotional selves were found to offer differing perspectives and ways of reasoning, alternate behavioural impulses and motivations, in addition to separate feeling states. Such selves were frequently referred to as autonomous 'characters', with Alice making repeated reference to the personified emotions in the film 'Inside Out' (Docter, & Del Carmen, 2015). In relation to the problem chosen for the exercise, these selves offered new perspectives and potentials, and a focus on alternate aspects of character (it '*really opens your mind to different facets of your personality'*, Amy). The movement between different mind-sets and motivations helped to break down 'bad' global experiences that were previously indistinct, undifferentiated, or singular. For Charlie, the sequential and structured separation of emotion was key to deciphering the initial 'jumble' of her reactions to gain a 'pinpoint' clarity:

'It is hard for me to decipher, I feel all of these things at the same time, hard to pick it all out I just need to filter it a bit more…because I feel everything is like a whirlwind, my brain is like a hurricane, going round at once, maybe slowing down or like you are in the middle so you can pinpoint the bits' (Charlie)

Charlie's metaphor of hurricanes and whirl-winds captures the common experience participants had of being swept up in the force of their feeling. For Charlie the separation of emotions during the chairwork task provided a psychological grounding, 'a middle' in the eye of the storm, to observe the variation in emotional weather. Similarly, Anya outlined how the process of slowing down and separating her '*mish-mash'* of experience helped her to '*unravel'* her emotions in a way that brought clarity and options. Universally, participants identified how the ordered nature of the exercise allowed for a deliberate analysis of their reactions to 'hone' in on the particular:

'Break it down into its building blocks, instead of just thinking I've just got anxiety, well at least break it down, to actually address it at a more basic level' (Chris)

Chris' repetition of 'break it down' captures the active nature of such separation and the force required to reduce something large and powerful to its constitutive elements. The notion of building blocks also captures the sense that something seemingly whole has been revealed as summation of parts that can be handled piece-by-piece and perhaps even re-ordered. Such focused analysis helped participants to distinguish between emotions where before they had been confused ('*because of the crossover between them'*, James). In learning to 'appreciate' the nuance and detail of greater emotional complexity, there was a sense of curiosity, discovery and even playfulness:

'Literally within the matter of a few minutes, it is quite fun to see how much your brain can just flip like that really' (Emma)

Emma captures the surprise participants felt at their ability to shift emotion so rapidly, but also the novel way in which they could relate to their emotions with interest rather than avoidance.

Dominance, absence, and interaction

Having separated emotions, participants identified that specific emotions were dominant and instantly available whilst others were absent, difficult to access, or avoided. Anxiety was the most dominant (n=5) followed by anger (n=3); whilst sadness was the most absent or avoided (n=5), followed by anger (n=4). Participants presented with idiosyncratic emotional profiles, revealed by their experiences in each chair: e.g., the chair/emotion that was easier to sit with or leave:

'Those are my default modes so they are the easiest to slip into…but for the sad self it takes a lot of analysis' (Anya)

As in Anya's reflection, such in-session experiences were deemed indicative of broader personal patterns and tendencies. For some participants this provided new insights and ways of

languaging their daily functioning; Alice, for example, used the metaphor of drivers and passengers to describe how her life was directed by anxiety '*in the driving seat the whole time*'. For others, emotions were acknowledged as completely absent from their lives and awareness or, as Tim explained, were actively '*controlled'* in ways that had interpersonal consequences (e.g., difficulty being assertive when anger was restricted). Participants also identified their emotions could be internally or externally focused and therefore dominant or absent inter- or intra-personally. Chris, for example, identified his anger was blocked externally but expressed inwardly in the form of self-criticism.

'No, always anger at myself. I very rarely get angry at other people'.

Emotions were also experienced as interactive and dynamic, with one emotion 'overriding', 'overwhelming', or reacting to another. This was again experienced as an in-session process as selves morphed into others and 'voices' battled to be heard. As Amy explained, this process made the exercise feel like an 'explanatory' means to 'assess' and witness emotional conflicts in real time. Participants experienced various emotional sequences that highlighted the cyclical nature of their reactions, with each emotion acting as 'fuel' to the other. Such cycles included self-focused anger at the vulnerability of anxious self, or in turn, anxiety at the destructive urges of the angry self. For Charlie, sadness was freighted with anxiety due to the fear of becoming subsumed in the emotion:

'Sadness, because I find myself going more into that emotion and it frightens me how I can become so sad…it feels like swimming and you are just sinking and you can't swim to the top' (Charlie)

Charlie's description captures a particular fear of sadness, as a feeling with vast depths and a danger of drowning. This effort to stay afloat, at the surface of the sadness, was shared by Tim, who identified avoiding sadness due to his grief from multiple bereavements. For other participants, certain emotions could only be accessed after experiencing and expressing other emotions, with the exercise offering a means to access the emotional 'root' of the problem ('*where is it actually coming from', Emma)*. One of the benefits of the exercise was felt to be the

active exploration of emotional conflict to look below the ‘surface’ emotion and give voice to aspects of the self that had been inaccessible or disowned.

‘It has been a long time with one side being dominant, so I really appreciated that, giving the sides of myself that don’t have a dog in the fight because they are never around’ (Amy)

For Amy, the conflict was welcomed, as a sign of her ability to provide opposition to the power and demands of her anxiety.

Theme 2: The role of chairwork process

Embodiment to identify and access selves

Participants particularly valued chairwork’s emphasis on embodiment and enactment. When prompted to ‘become’ each emotional self, participants universally reported an ability to ‘tap into’, identify and explore associated bodily experiences. Such sensations were experienced intensely, in an immediate ‘amplified’ manner: as if ‘*you could flip a switch*’ (*Charlie*). Participants also noted how being each emotional self impacted upon the whole of the body and shaped its expression.

‘Everything from body language to the tone of my voice changed because I was accessing a different emotion, it was quite marked…you can very much see and hear the difference in my voice and the difference in how I was sat and my movements were very noticeable’ (Kerry)

As in Kerry’s description, such tangible expressions offered additional insights into the nature of each emotion as they were literally seen and heard by both participant and therapist. The emotional selves became known and differentiated by their specific somatic makers, helping participants to identify and separate each self via the changes in body sensation. Participants also reported a greater awareness of corresponding changes in mindset, motivation, and ‘function’ via changes in physical tensions and urges (e.g., the angry self *‘wanting to smash things’*, *Charlie*). The compassionate self was notably identified by a ‘lighter’, ‘brighter’ feeling tone and sense of ‘peace’.

The exercise was experienced as a shift away from cerebral and abstract discussions of emotion towards an exploration of feeling grounded in the body and present-moment sensations:

'You start to feel, really genuinely. In the exercise it wasn't just hypothetically, it was something that was real, it did make me feel sad, in the exercise I felt all three emotions, in quite a short space of time' (James)

As identified by James, such use of the body made his experiences seem 'real' and genuine, creating some surprise at his own capacity to feel and know his emotions. A similar sentiment was shared by Chris who contrasted the rich experience of chairwork session to the emotional 'disconnect' of prior cognitive interventions. Such embodiment and focusing ultimately made each emotion more memorable and easier to recall. Kerry particularly described the exercise as a kind of sensory sampling, with her felt experience resonating in her memory (as opposed to lexical or imaginal recall):

'Remembering how it felt rather that what it looked like, it is almost like if you go into a shop and smell all the different scented candles, it was like a sensory experience rather than picturing myself' (Kerry)

The body was also deliberately used to break connection between emotional selves. Participants valued palate-cleansing prompts to '*get rid of all the remnants'* (*Charlie*) when moving between chairs, by slowing the breath and 'shaking it off' via physical gestures. Importance was also given to the use of the body to access the compassionate self, such as making intentional changes to posture, breathing and facial expressions (a 'smile').

Standing up, looking back: the benefit of moving chairs

In addition to the role of embodiment, participants emphasised how the physical act of moving between chairs supported shifts in emotion and mentality. When standing up from a chair, participants reported a symbolic sense of stepping out of their emotional selves and leaving them still 'parked' behind. Similarly, walking towards a new chair was experienced as an active, intentional means to take on new aspect of self *('to step into that shoes, be that person'*, *James*).

This phenomenon was particularly beneficial for participants who felt fused to a specific emotion.

'I don't think anyone would be able to do this exercise if they were just sat in one chair, it would be much harder to jump into a new mind-frame or a new self, I think you do need to have the three chairs' (Anya)

The importance of physical movement to change mindset is captured in Anya's use of language: 'to jump' into a different aspect of self. A similar sentiment was shared by Amy, who felt energised by the enactive elements of the session, providing her with a sense of agency and flow in contrast to the 'stagnant' nature of her habitual responding:

'It is really easy to just get stagnant when you are in one position and you are in one mindset…the fact that we moved through the room it didn't feel static at all, I think that was the key to keeping the blood flowing and making sure your brain is switched on constantly' (Amy)

For Amy and others, the physical energy created by the session's active methods contrasted with the lethargy associated with depression; the literal movement and active decision-making within the session appeared to raise the potential for broader movement and agency in dealing with participants' 'static' mental states.

The externalisation and concretisation of emotions onto set chairs, in set positions, not only created the potential to move between emotions at will, but also allowed for new, de-centred, perspectives. Participants were able to look back on their emotional selves with the benefit of physical and psychological distance and separation: the chance to explore the inside '*from the outside'* (*Charlie*). For Kerry, such distance provided an overview of her emotions from a new reflective position, at a remove from the usual intensity of her bodily reactions:

'It was almost like looking into a CCTV screen and they have all the different screens of all the different images… looking out of body, where you look at the scene and pick apart the emotions that are contributing' (Kerry)

As in Kerry's example, relating back to empty chairs, where parts of the self had been enacted, generated significant levels of mental imagery. For Kerry the notion of seeing oneself captured in multiple screens created an 'out of body' experience: a distance that enhanced her analytic capacity to reflect back upon her body and emotions. Images of emotional selves were typically visual representations of the self at moments of high affect *('I could see my younger self', James*). Seeing oneself externally represented allowed participants to meet themselves 'face to face', as if interacting with another human being ('*not you but it is you', Tim*). This enabled participants to dialogue with themselves in new ways, applying social-relational skills to their own internal world:

'This image of what you would look like sitting there, it actually felt like I was giving myself something to talk to. It gave me something to feel real to talk to. It could be three people sat in those three chairs' (Emma)

For the self to be separated, othered, and re-experienced in this way created a greater capacity for self-compassion and self-understanding. As in Emma's example, this was experienced as a way of 'giving' oneself a focus, a face, and a body to relate to and ultimately care for. These figures were experienced as 'real' despite their imaginary origin. Again, the distance created by movement away from a part of the self created the space for new relationships to form.

Theme 3: Compassionate Integration

Empathy, acceptance, and integration

In contrast to the emotional selves, the compassionate self was experienced as slower, more reflective, rational, and reasoned. The compassionate self was also capable of empathy for the reactions and experiences of the other selves and was associated with a '*wiser mind and perspective' (Kerry)*. Such empathy was evident as participants reflected on broader contextual factors that explained the presence and intensity of their emotions. This included consideration of situational triggers, an understanding of the other person's experiences, and an acknowledgement of the impact of childhood relationships. Amy, for example, identified her anger had become so dominant throughout her life '*just to be able to survive'*. Other participants found relating their

emotions to their evolutionary origin and function helped to comprehend and predict their patterns of thinking and feeling:

'I knew what their role was and I could use that to go off what was going on in my head and it was honestly so helpful' (Alice)

Accompanying such insights was a global reduction in self-criticism and blame. Participants validated their emotions as 'normal' and expected human experiences, rather than as personal faults or problems:

'Anyone would feel the same way, and I realise if I had watched that scenario unfold with anyone else I would have instantly taken my side. So I was able to leave that feeling of anger with that person and say 'you know what, it was never my fault' (Kerry)

In their personified form, the emotional selves were treated with acceptance, care and support. The compassionate self was experienced as a 'parenting' role, with participants equating their care for themselves to their relationship with family or friends. Genuine affection was also felt as participants expressed a desire to 'hug', hold and sooth their emotional selves. Rather than criticising, avoiding, or attempting to suppress their emotions, participants suggested they *'formulate a stronger motivation' (Chris),* in their compassionate self, to accept and work with them in a '*constructive'* or '*healthy'* manner. Participants identified the compassionate self as an integrative force that links and connects their various emotions together. Such connection of multiple strands of internal experience created a sense of personal cohesion and integrity:

'It is just one, it is the whole self, all combined together' (Anya)

The compassionate self was emphasised as 'holistic' in orientation, and able to capture the unifying function and aims of the threat emotions:

'To acknowledge that it is three sides to the same coin, and how they interlock and relate with each other' (Amy)

For Amy, this involved seeing all of the self's multiple sides, its seemingly impossible opposites ('*three sides to the same coin'*), from the encompassing perspective of compassion. Participants stressed the importance of separating their emotions in order for the compassionate self to understand, reorganise and coordinate them into a coherent whole (*'put myself back together' Kerry*). This final sense of unity was ultimately not achieved by removing complexity or difference between the emotions, but rather by achieving a balance and equilibrium.

'For me it is about the last compassionate self acknowledging that all of that together makes up one individual…combine it all and make it so you are a fully functioning adult human that is capable of making decisions and living life the way you want to' (Amy).

For Amy and others, the capacity to respect and care for various part of the self was a sign of maturity (as a '*fully functioning adult'*) and enrichment. The various parts of the self could ultimately be recruited and guided by compassion in the service of a more authentic and intentional life.

Chapter summary

This chapter has presented three themes from the analysis of the second study: multiple-selves chairwork. The initial theme, appreciating emotional complexity, highlighted how each emotion was experienced as a distinct 'self' with a unique patterning of thinking, feeling, behavioural impulses, and related needs. Separating out emotions on chairs helped to break down indistinct and undifferentiated feelings of distress, creating a sense of clarity and discovery. Participants revealed idiosyncratic emotional profiles, whereby one emotion was dominant, entirely absent or avoided. Emotions were understood to interact, creating self-perpetuating cycles. The intervention provided a means to identify emotions at the root of such cycles of reactivity.

The second theme, the role of chairwork process, captured similar experiences and insights to the prior two chapters. Embodiment offered a means to amplify, explore and identify each emotion in a way that was distinguished chairwork from prior cognitive approaches. The physical movement between chairs helped participants both to leave and access their emotions which

created a sense of agency. The movement also generated new perspectives and the capacity to see an emotional self as if ‘from the outside’, allowing participants to apply interpersonal skills to their internal world.

The final theme articulated the role of compassion, and associated skills and qualities of compassion, in regulating threat-based emotions. Participants were able to relate to their emotions with empathy: understanding each emotion’s history, function, and contextual triggers. Self-compassion, in contrast to self-criticism, was shown to accept and integrate difficult emotions into a broader and more holistic conception of self.

The clinical and theoretical implications of these findings are discussed in the final chapter, chapter 10. The following chapter is an analysis of relational themes covering the entire data set from both interventions.

Chapter 9: Relationship Factors Analysis

Introduction

This chapter presents an analysis of participants across both studies, focusing on relational and therapist factors. The analysis is of the total data set, consisting of the transcribed interviews of 21 participants (12 from the first study and 9 from the second). The importance of relational factors, and their influence on participants' experience of the intervention, became clear when reviewing data from both studies. As per IPA standard practice, the analysis progressed on a case-by-case basis before generating superordinate themes at a group level. The themes are: being directed and coached (the therapist as director of tasks and as motivational coach); being seen: bringing the inside out and outside in (which provided a beneficial external perspective whilst also causing shame and concealment); and being in a caring relationship (establishing prior trust and safeness in the relationship, and offering soothing and compassion during the session). I am currently in the process of preparing this analysis for publication.

Results

Analysis of the full corpus of data highlighted the importance of relationship factors in facilitating, and hindering, the chairwork process. The analysis generated three super-ordinate themes.

Table 9.1. Summary of themes and occurrences for relationship factors analysis

Superordinate themes	Sub-themes	No. of participants for each theme
1. Being directed and coached	-The therapist as director and guide -The therapist as coach	15/21 18/21
2. Being seen: bringing the inside out and outside in	-Concealment and shame -An external perspective	12/21 13/21
3. Being in a caring relationship	-Trust and safeness in an established relationship	12/21

	-Soothing and care during the session	17/21

Theme 1. Being directed and coached

The therapist as director and guide

Participants ascribed multiple roles to their therapists during chairwork. One such role was that of directing and guiding the client through the procedural and practical tasks of the method. Given the novel enactive nature of chairwork (e.g., moving between chairs and addressing imaginal representations), the practical nature of the therapists' interactions was given particular emphasis. Whilst the therapists' frequent prompts and instructions provided structure to the method, they also created a degree of emotional containment for experiences that participants found overwhelming, confusing, and aversive. Helen, for example, spoke of the benefit of having a therapist 'leading' her with authority, whilst James required repeated instruction from the therapist to get him 'back on track' and manage his avoidance. Sarah also identified the importance of such task-based guidance:

'I think it was being guided in that process is definitely helps you connect, being told, not being told what to do and how to do it, that wasn't the case, but being told and supported in that process allowed you to feel safe doing it.' (Sarah)

Sarah, in her correction and counter-correction ('being told, not being told…being told…'), appeared to be searching for a way to language this change in relating with her therapist. For Sarah, as for other participants, the increased level of direction was experienced as authoritative but not dominant, allowing her to feel safe and supported rather than stripped of autonomy.

The therapist's capacity as director was also of importance when encouraging participants to immerse themselves in their various roles during chairwork. Participants particularly required repeated instruction to *talk to* the percept in the other chair, rather than *talking about* the experience in a rational/cognitive manner:

'Yeah, but again that was prompted, that was directed. So rather than speaking to friends, countryman, romans, it was speaking to speaking to the chair, speaking to the person in the chair.' (Michael)

Michael's allusion to Shakespeare and the speech from Julius Caesar captures the potential for chairwork to feel like a form of self-conscious acting, a play to the audience of the therapist. Yet for Michael, the therapist functioned like theatre director, prompting him to focus on the 'person in the chair' and enter the surplus reality of the dialogue. A similar phenomenon was evident in participants' accounts of their therapist re-setting the scene and re-activating the memory underpinning the exercise which functioned to re-vivify the stimulus and create immersion in the task. The therapists' physical direction (e.g., guiding participants from chair to chair) and repeated labelling of 'parts', helped to separate and distinguish between various aspects of experience and orientate participants to the roles they were enacting. Most participants referred to their therapist's task-based interjections as 'prompts', giving a sense of short, directive statements, that, as Jean stated, helped to get '*into the swing'* of the enactment. Participants also benefitted from having tasks broken down into smaller stages to foster engagement and focus:

'Like baby steps, you can know what it is in a general area but actually honing in on what specifically it is and how to apply it towards yourself is extremely difficult, so me and (therapist) are having to take baby steps…and break it down.' (Alice)

For Alice, the repetition of 'baby-steps' highlights the parental role of therapists in scaffolding the task in order to meet the participants needs and development. Participants valued their therapists' modification of the task (such as reducing the amount of time spent in each role) to meet their particular needs on the day of treatment.

In highlighting the importance of practical guidance, three participants voiced a need for increased levels of direction. Charlie, for example, felt lost during the exercise:

'She was guiding me and sometimes I wasn't really sure what she meant about what I was supposed to do. Is it this is it that? Sometimes I don't understand the question, I work in quite a

factual environment, either it is right or it is wrong, whereas this emotion thing is quite new to me.' (Charlie)

For Charlie, given the experiential and emotional nature of the intervention was inherently strange and unknown ('this emotion thing'), she required greater structure and specificity from the therapist. For Alice the exercise was similarly alien, lacking any previous reference points or personal templates. She suggested the therapist be more concrete in his direction, to provide certainty and reassurance:

'It is about knowing what I'm trying to do, not being prompted too much, but knowing what is expected and the as soon as I know and feel comfortable with what is expected then I am alright to do it, but if there is a bit too much ambiguity then that's when struggle and then I'm overwhelmed with frustration.' (Alice)

The perceived lack of guidance was experienced as frustrating and detrimental to the method's effectiveness. Whilst participants acknowledged such frustration might be part of a therapeutic process (whereby their need for certainty and order is challenged), the perceived lack of guidance reduced their ability to be feel safe and connected to the dialogue. This was evident in Charlie's account of how her therapist's anxiety and hesitancy disrupted her own process:

'I think because (therapist name) has only just started doing it, she was reading from her notes, so that didn't feel as interactive, and that's not being horrible to her or whatever the word is, but if someone was more experienced it might have felt a bit more natural, but I think she felt a bit reserved about it as well' (Charlie)

In voicing her awareness of the therapist's doubts and skill, Charlie appears to have been drawn away from her own experiences and frame of reference. The therapist's lack of spontaneity in direction appears to have reduced the 'natural' flow of dialogue both between client and therapist, and between the client's multiple selves.

The therapist as coach

In addition to directing tasks and procedures, therapists were also experienced, and referred to, as a 'coach'. This coaching role focused both on emotional encouragement, celebration, and reinforcement, as well as skill-building and assistance with the competencies required for the task. For James, the provision of positive feedback (*'to say you are doing very well'*) was all that was required to build his confidence and persistence. For other participants, therapists were valued for their persistence and resolution in coaching greater levels of disclosure and emotional expression.

'She, not pushes you to get an answer, but sort of picks away at the seams to get you to open up' (Sarah)

Whilst Sarah emphasised her therapist's firm and insistent style, she also highlights how the therapist called her to respond and act, emphasising her own role ('*pushes you to get an answer'*), rather than providing answers. The metaphor of picking at 'seams', also captures the therapist's role in persistently loosening their client's various strictures, allowing them a chance to be revealed and open. The therapist's active motivational stance created a sense of mutual commitment and willingness to take therapeutic risks. For David, '*to have the coach there'*, allowed him to connect to his emotions in a way he had never experienced alone. Similarly, for Sarah, the perseverance and encouragement of her therapist facilitated her own capacity for engagement:

'I knew (therapist name) was there, supporting me. I was able to connect, I was able to do to the extent that I needed to, whereas at home you stop yourself, that barrier comes up' (Sarah)

Again, Sarah emphasised how her own personal agency was encouraged by her therapist (e.g., in her repetition of '*I was able…*'). For Sarah, chairwork was experienced as an interpersonal act, with the connection between herself and the therapist fostering and mirroring her ability to connect to her own experiences. Similarly, for Elena, the presence of the therapist provided a shared 'drive' to move beyond her own limits:

'The other thing is that (therapist name) is the drive, she will get you to do the things, if you are on your own you won't do the thing. She does give opinion. She is very encouraging, let's put it that way, she's very encouraging. I don't think that it is beneficial for a therapy to just have the person talking and not have any input. Just the interaction actually helps better, more, and (therapist name) is really good at it.' (Elena)

Elena highlights the therapeutic value of her therapist's personal engagement in giving feedback and opinion, creating a sense of active teamwork with an emphasis on their 'interaction'. Other participants valued their therapists' verbal coaching in providing summaries and affirmations that demonstrated empathic tracking of their experience:

'I like the aspect of the affirmative side of it, so for (therapist name) to go over, like repeat what I've said, help me answer the question in a way, so by repeating my answer it made it a lot clearer in my head.' (Jenny)

Jenny highlighted how such close paraphrasing offered her a means to 'hear' back her own expression with greater clarity, and to generate her own connections and insights ('help *me* answer'). The 'affirmative side' also captures how therapists positively acknowledged their participant's experience, validating their answers to facilitate further elaboration.

Participants also identified how their therapists repeatedly returned their attention to the body to coach emotional connection and expression. This included training participants to adopt specific body postures and facial expressions to fully inhabit each role. For David, '*to have the coach there*' encouraging him to try out new physical changes, helped him *'instantly'* embody his various roles. Participants were also supported to focus, in detail, on changes in feeling tone and sensory experience:

'…and was asking me how I physically felt in each of them so it wasn't just like what are you saying, what are you thinking, it was how do you feel, how does that physically make you feel, which part of your body do you physically feel it in yourself.' (James)

James highlights the micro-levels of detail asked for by his therapist to help him connect to his feelings, shifting him away from '*what are you thinking'* to specific parts of the body. Whilst there was an emphasis on supporting clients to acknowledge and express their present-moment experience, therapists were also recognised as coaching new compassionate ways of relating to such experience. This frequently required increased involvement from the therapist in preparing and shaping novel means of responding to difficulty and distress:

'I think it is because you can't get rid of it, (therapist name) mentioned that. If I said then get rid of it, she would of said we are not trying to get rid of it, because you can't get rid of it, so the only way to stop it having an effect is understand it.' (Claire)

Rather than finding her therapist's input prescriptive, Claire appeared to utilise his approach and feedback to explore and develop her own perspective. Again, the therapist was valued as an active agent in facilitating new discoveries for participants. Sarah shared a similar process:

'Me and (therapist name) talked about it, and reflected, and we came, I came, to the conclusion that the only way to be compassionate to the self-critic is to be understanding' (Sarah)

For Sarah, this sense of sharing and negotiating meaning with her therapist, allowed her to find her own compassionate voice in a way that she would not have achieved alone. The linguistic shift from 'we came' to 'I came' captures this process and dynamic, and how ultimately the support allowed Sarah to claim the insights for her own.

Theme 2. Being seen: bringing the inside out and outside in

Concealment and shame

Despite the relational benefits outlined above, the interpersonal nature of the exercise initially triggered intense self-consciousness, embarrassment, and shame in some participants. The methods of chairwork, in externalising and concretising aspects of participants' inner world, were experienced as exposing.

'It was embarrassing at first because I usually only say these things in my head' (Jean)

For Jean, her private thoughts and feelings were, when externalised, ‘heard’ and ‘seen’ by her therapist and re-experienced in a new way: the mundane and habitual suddenly charged with emotion when shared so openly with another. For Jean, as for others, such intensity of feeling occurred only ‘*at first’* and abated during the session. This aversion, however, was acutely felt. Jenny experienced such exposure as a form of disgust- reporting visceral reactions she expressed as *‘urghh, on edge, and not comfortable’*. Others described feeling ‘weird’ and momentarily disconnected from themselves and their therapist when encountering shame. For Elena, the sense of comfortable familiarity with her therapist appeared to vanish, replaced with an experience of being observed and scrutinised:

‘…you’ve got that random person observing you.’ (Elena)

In contrast to experiencing the therapist as a ‘guide’ or ‘coach’, Elena referred to her as a ‘random person’ as if the experience of shame had suddenly made her a stranger. For other participants, the experience of shame triggered memories of being similarly exposed.

‘I suppose it goes back to the days at school when you try to do a play at school and your classmates have got your shoulder shaking, laughing at you because you made a mess up or something, so it was just embarrassment…because it was a personal thing.’ (Jean)

Jean identified a specific shame-based memory and appeared to expect her therapist to react in same critical way as her classmates. Her association of chairwork with being on stage, as if pressured to perform or entertain, was also shared with others. Participants reported ‘acting’ to mitigate exposure and manage perceived external expectations. For Diana, this involved an intentional choice to ‘fake’ her experiences to meet the perceived demands of her therapist:

‘I thought I would fake it, do you know what I mean? So I thought I was going to have to fake it, I thought that was the way I was going to do it. It was just saying what I think he wants me to say.’ (Diana)

Diana's concern about her performance focused her attention away from her own process and into the mind of her therapist, pre-planning her answers to meet his needs as opposed to her own. Similarly, Simon reported to shape his answers to please the therapist:

'I was quite conscious, because of all the work that I'd done with (therapist name) that her, there were certain things that she might be hoping I say, and, so there was a right or a wrong answer' (Simon)

Like Diana, Simon's concern about failing to meet the standards of the task and therapist restricted his access to authentic experience and expression. The difficulty in being 'honest' in sharing internal experiences was echoed by other participants, most commonly in the context of demonstrating the extent of their self-critical anger. Participants reported an anxiety in acknowledging their own anger and a fear at how such anger might be perceived and received when outwardly displayed. For some participants, this was expressed as a concern for their therapist's sensibilities and a fear of causing offence:

'I don't like to swear in front of (therapist)…I do feel very bad sometimes when I do swear in front of him, so I mean that was difficult and I know a lot of therapists don't like it, but language is one of my coping things….' (Jean)

In her response, Jean appeared to expect disapproval from her therapist, making it 'difficult' to give voice to the true nature of her criticism (which was *'not as brutal as I was by myself, at home'*). She also notes how her swearing and anger differentiates her from her therapist, creating a sense of separateness from '*therapists'* who '*don't like*' the kind of way she reacts. Similarly, Jenny reported shielding her therapist from the harshest aspect of her self-relating, noting the split between her internal and external expression:

'…not to the level or extent that's in my head. It would probably be a lot harsher in my head and by myself rather than with my therapist.' (Jenny)

For Jenny, as for other participants, the experience of holding back, holding in, and toning down their experiences, appeared to create distance in the therapeutic relationship, leaving them carrying their 'harsher' experiences alone. Kerry also voiced concerns about overwhelming her therapist:

'I think I was a bit reserved because I didn't want (therapist name) to be scared of me. Because I get a bit scary when I'm really angry.' (Kerry)

Kerry's example suggests a concern for her therapist's capacity to manage the strength of her feeling, but also perhaps an acknowledgement of her own fears of its force: a shared concern at being both uncontained and uncontainable. The experience of trust in both oneself and the therapist did appear to develop mutually during the exercise, with an increased faith that what was being shared could be accepted and tolerated. For Elena, working through her initial shame-based reaction to allow another person into her internal world was integral to the therapeutic benefits of the method:

'It does feel a bit funny being observed, it does but it always will and that is probably the part of therapy, you are not alone, there is that person there' (Elena)

For Elena, there was the acknowledgement that there '*always will*' be onlookers and a discomfort at being seen, but also an insight that only by sharing herself in this way can she feel '*not alone'*. The benefits of having one's inner experience 'observed' in this way are described below.

An external perspective

In direct contrast to the shame-based experiences detailed above, participants felt the exercise allowed them to be truly seen and accepted by their therapist. Externalising and sharing aspects of oneself that participants found unacceptable when alone was found to be validating and comforting. Rather than eliciting criticism or re-creating shaming reactions (as per Jean's concerns above) participants were surprised to have their experiences recognised and normalised.

'For these different selves to be going on and there is this professional sitting infront of you who recognises, recognises that it kind of makes it okay, so you don't feel crazy. So for that to be recognised from a professional, that you do have these different selves and it is normal, I think that is helpful.' (Claire)

For Claire, her therapist's perspective provided a degree of professional acceptance and legitimisation, countering her fears of serious mental illness and the threat of having '*different selves'*. Whilst the caring qualities of the 'professional' involved were valued (and are outlined in theme 3), participants also benefitted from experiencing their therapist as a neutral, and somewhat distant, observer. This was particularly evident in the account of Kerry, who had initially feared her therapist's emotional reaction:

'It was just relief, being able to say it and say it to someone who didn't have any personal identification, who has absolutely no ability to judge because they can't, and to know there is going to be no repercussions to saying those things in that way, she is never going to find out, it wont get back to work, it will just stay in the room and never leave, it was nice to get it out.' (Kerry)

For Kerry, the cathartic urge to 'say it' and 'get it out' of her own mind was only possible with someone without personal 'identification' or investment, and where the experience could be witnessed and heard without repercussion. The presence of the therapist was also helpful in offering participants an external perspective when immersed in the subjective-processing of the chairwork task. Being externally witnessed and tracked during the session allowed therapists to offer a separate view-point from which participants could reflect back upon their own experience. The therapist's input was felt to come from the 'outside' which, as articulated by Claire, '*wakes you up*' and draws you out from your usual mode of emoting:

'because it is a lot easier if you are in frame of mind to, it is a lot easier to get out of it if someone from the outside intervenes so say (therapist name) and she talks about it from the outside or if something wakes you up a little bit, so I think because you need that outside thing,

by doing the exercise chair, it makes you look at it objectively which is how I found that outside person. So normally you are in your head' (Claire)

For Claire, having someone enter her 'frame' of mind offered a means to get outside of it. Again, there is less emphasis on the specific personal qualities of the therapist, and greater reference to the therapist as '*outside person'* or '*outside thing'*. This external perspective was also valued as means to recognise and reflect on participants' unconscious or unacknowledged experiences. This typically involved therapist feedback on participants' relational stance between parts of the self, clarifying 'latent' material as Simon explained:

'Well, as (my therapist) pointed out I wasn't being judgemental towards the critical self. I did feel that frustration that I had it, so in talking with (therapist name), you know, in the exercise, she picked up on that, it was kind of latent because I was trying to reassure it in a sense.' (Simon)

Simon's therapist noted the underlying anger he directed towards the critic from the compassionate self, despite his intention to do the contrary. Therapists also made observations on participants' non-verbal signs, such as posture, voice tone, facial expression. This external feedback frequently surprised participants who were unaware of changes in their body and affect. Amy, for example, was only able to recognise and clarify the changes in her emotions via her therapist's perspective.

'And as well having the facilitator there to be able to recognise there as well, because of the several times where I was either anxious or sad and anger would turn up again and (therapist name) was quick to be like 'that is a bit more angry than sad' and to be able to centre that back and have that in check.' (Amy)

For Amy, such observations helped her remain centred and focused, managing avoidance and confusion. There was a sense that in having her experiences reflected back to her via another, ultimately allowed her to become more knowable to herself.

Theme 3. Being in a caring relationship

Trust and safeness in an established relationship

Participants identified the chairwork intervention took place within a broader relational context. There was an emphasis on the established relationship between client and therapist, and the way in which this textured the participant's experience of the session. The quality of trust was repeatedly stated as essential for engagement in the chairwork task.

'I wouldn't have done this if I didn't have 100% trust in (therapist name) and all the things we have done, and I think that is really important for an exercise like this it is all about trust and feeling able to be safe in that space, because you are going into stuff that isn't natural to analyse yourself in this way…I think it is something that needs to be done after an established relationship develops.' (Amy)

Amy was unequivocal in the '100%' level of trust required within the relationship to engage in the exercise ('*it is all about trust'*). Such trust created a relational safeness that reversed her '*natural'* aversion to facing distress, increasing her willingness for internal analysis and exploration ('*going into'*). This phenomenon was shared by other participants who identified the therapy relationship as a salient factor in overcoming their fears relating to the process and content of the exercise. For Michael, a lack of trust in the relationship would have been a '*risk to the value gained from the session'*; he further reflected the relationship allowed him to '*let go*' and '*go into it more'* (mirroring the language used by Amy above). Similarly, for Helen and James such relational safeness was '*crucial'* to the method's success and deeper '*impact'*. For Emma, the chairwork task appeared absurd without the context of established rapport:

'If it was yourself that just said to me 'sit in a chair, smile to yourself, and breathe' then I would be like (laughs) …but it helps a lot to have (therapist) there who I know. She was a great support' (Emma)

Emma drew a direct contrast between the interviewer and her therapist to highlight the need for a shared history before engaging in experiential activities. The strength of bond within the

relationship was deemed to have evolved over time, facilitated by multiple meetings and interactions. Willingness to engage in the chairwork task was founded on confidence in the therapist, their skills and competence, and an acknowledgement of what has already been achieved together:

'I've been through too much in that room to have that much scepticism about the process, I trust the process and the therapist very strongly…In terms of the relationship in the room just then I just knew I could connect with that quite easily because I've done it several times in the past, I imagine that wasn't a concern for her.' (Michael).

Michael emphasised how repeated past experiences of accessing compassion and regulating distress within the relationship had assured him that such compassion could be accessed again. The quote captures a sense of mutual faith and trust, with Michael secure in his belief that the therapist shared his confidence. Other participants highlighted different qualities in their relationship that had grown over time. This included a shared sense of humour and playfulness and increased levels of intimacy and honesty. Such qualities helped participants overcome the self-consciousness discussed in theme 2:

'Yes she was helpful definitely. I don't know how it would feel if it was someone that I didn't know, like I said I have been with (therapist) quite a few months so if it was someone maybe, if say for example it was yourself and it was the first time I'm meeting you and you said 'nice to meet you the first time, what we are going to do we are going to get you to talk to yourself', that is more of an awkward situation, while as with (therapist) we could laugh it off to begin with and take it seriously' (Emma)

This earned sense of intimacy was also accompanied with a deeper knowledge of the participant and their history. In continuing to discuss the role of the relationship, Emma stressed the importance of having someone who 'knows' her and holds her whole life experience in mind during the chairwork task. Such knowledge was also identified as a factor in allowing therapists to attune to their client's distress in the session, to know their preferences and make adaptations based on their capacity and processing style:

'I've been seeing (therapist) for a while, so I've got that kind of relationship with him where he knows when I'm getting stressed…As soon as I was getting frustrated, I told him about it, and he changed the direction to accommodate it.' (Alice)

Alice's response suggests an expectation that that the therapist would be receptive to both her distress and her feedback, which deepened the sense of collaborative endeavour, perhaps instilling a sense of agency over the task. To be willing to attempt a task as emotive as chairwork, participants required lived experiences of their therapist as empathic, knowledgeable, and responsive.

Soothing and compassion during the session

These relational factors, developed across the course of therapy, had a significant influence on participants during the chairwork task. Participants particularly highlighted the role of the therapist in providing emotional soothing and regulation during the session. For some participants, the emphasis was placed on the skill of the therapist in delivering soothing-related exercises, focusing on the breath and body:

'(Therapist name) helps me a lot with my breathing and a lot she just stops me feeling silly about myself, even down to the breathing techniques it is like sit in a chair, smile to yourself and breathe…she just makes me, there is a good sense of security with (therapist).' (Emma)

'…after you are really, really, upset, it's bad. But then (therapist name) calmed me down and we did soothing breathing, so, so yeah it was okay, it was okay.' (Anita)

As in the examples above, significance was given both to the regulation practices and the way in which they were delivered by the therapist. For Emma, her therapist provided a sense of relational security to overcome her initial self-consciousness, whilst Anita emphasised the 'we' practicing together. Participants stressed the importance of external regulation during the session, which they related to their therapist's capacity to accept and manage their distress. The therapy room was notably referred to as a '*safe place'* (Helen), '*safe space'* (Amy), and '*comfortable*

ground' (Michael), as if the relationship provided a degree of physical grounding and containment.

An interaction was evident between participant's confidence to engage in difficult material and feeling soothed by the therapist during the session. In feeling cared for within the therapy relationship, participants were more receptive to their therapist taking a more active 'coaching' and 'directing' role during the session (see above). Chris, for example, identified how the therapists' soothing qualities helped to '*settle you, then you can look at the anger*'. For Sarah, such relational soothing and safeness was important during the chairwork task in order to engage '*to the extent that I needed to*':

'…being told and supported in that process allowed you to feel safe doing it, whereas when you are doing it yourself at home or in your day-to-day life, I know I don't feel safe feeling compassionate so I was allowed to feel safe in that position because I knew (therapist name) was there, supporting me. I was able to connect, I was able to do to the extent that I needed to, whereas at home you stop yourself, that barrier comes up.' (Sarah)

Sarah stressed that the relationship 'allowed' her to address what she was unable to face alone, as if providing both permission and capacity to adopt a new 'position' of compassion. The safeness within the therapy relationship was contrasted with 'home' and 'day-to-day life', suggesting the relationship has a unique quality not accessible elsewhere. Soothing and safeness within the relationship provided the opportunity for true self-compassion in participants: not functioning as an avoidance of distress, but rather providing a means to face it. In this way, participant self-compassion during the task appeared to be interpersonally fostered and supported by the participant's ability to receive care from the therapist. This was evident in Amy's use of her therapist to avoid dissociation and engage with the task, allowing her to modulate between feeling safe and facing threat:

'…something that keeps me in the session so I think maintaining eye contact with the facilitator or something like that .' (Amy)

The therapists' compassion towards participants during the session also provided a model for participants' own self-to-self relating. The therapists' understanding, validation, and acceptance of participants' painful experiences- such as unwanted sadness- influenced the participants' own capacity to adopt the same qualities and perspective ('*I could see it from a compassionate side of things*' Kerry). Participants also commented on the therapists' self-compassion and its importance in reinforcing the core tenets of the modality

(Therapist name) is really good at it, she has compassion in herself that makes her probably the perfect for this kind of therapy…She comes across as a very caring person and it really is important, it really is important' (Elena)

Elena highlights the importance of authenticity in her therapist's advocation of compassion, which she experienced as a '*perfect'* match between practitioner and practice. Compassion was ultimately experienced as a reciprocal flow between receiving compassion from the therapist and generating it for oneself. As Sarah identified, a balance was required between opening to care from another and offering it to oneself:

'It is important to feel safe and supported, not just by yourself but by the other person as well'(Sarah)

The relational qualities experienced during the chairwork process demonstrated that self-compassion and compassion from others are not mutually exclusive, but mutually reinforcing and interconnected.

Chapter summary

This chapter has presented three superordinate themes generated from all participants from both studies. The initial theme, being directed and coached, captures two key roles attributed to the therapist during chairwork. The therapist was initially experienced as a stage director, managing procedural tasks with a benign authority. In this role, the therapists provided a containing structure to the session, helping participants to approach aversive material. For some participants, greater levels of practical guidance and support were required for full immersion in

the intervention. The therapists were also experienced as emotional and psychological coaches, valued for their encouragement and affirmations. The way in which the therapists were actively involved in drawing forth emotional expression, via verbal paraphrasing or attunement to participants' bodies, was also noted. The chairwork process was ultimately deemed to be a joint venture, taking clients further than they would be able to reach alone.

The second theme, being seen, captures the benefits and drawbacks of having an observer when externalising and concretising very private experiences. Drawbacks included intense experiences of shame at being 'seen' by the therapist. Such exposure triggered shame-based memories and created a sense of interpersonal distance in the relationship. Participants coped by various acts of concealment and disguise to meet the expectations of the therapist or protect them from the critic's anger. In contrast, other participants experienced the external observer as a validating witness that normalised and legitimised their internal processes. Participants were able to see themselves through the perspective of their therapists, using them as an objective viewpoint to gain distance from their inner experiences.

The final theme, being in a caring relationship, initially focused on the importance of establishing a strong relational bond before attempting chairwork. The prior relationship influenced the way in which participants experienced the intervention, with the quality of trust being repeatedly emphasised. Participants stressed the importance of inter-personal safeness and the role it had in facilitating disclosure, The therapist was recognised as a source of soothing and regulation during the intervention, which facilitated engagement in its multiple tasks. The compassion shown by therapists during the session also acted as a model for the participants' own self-to-self relating.

A discussion of these findings, and those of the previous three chapters, is covered in the next and final chapter.

Chapter 10: Discussion

Introduction

This final chapter is a discussion of the research findings which have been presented in the prior four chapters. This chapter begins with a re-statement of the research questions and aims followed by a brief overview of the research analysis. The findings are then interpreted in the context of existing literature as expounded in chapters two and three. The implications of the research are then discussed in relation to the conceptualisation and treatment of depression, shame, and self-criticism. The chapter also explores the significance of the results for the understanding and application of CFT chairwork. The direct clinical implications of the research are summarised in clinical guidelines and practitioner points to increase the accessibility and utility of the project. Finally, the limitations of the study are discussed, with suggestions made for future research of CFT chairwork.

Research summary

The research question for the thesis was: 'how do clients with depression, self-criticism, and shame experience chairwork interventions in CFT?'. The primary aim of the project was to produce an interpretative phenomenological account of clients' experiences of CFT chairwork to understand what was learnt and valued from the interventions. Secondary aims related to identifying elements of CFT chairwork that were helpful or important for clients with depression, problematic self-criticism, and shame, and to improve the delivery and training of the approach.

Summarising the methodology, the project focused on two forms of CFT chairwork: chairwork for self-criticism and the multiple-selves method. The interventions were delivered to separate groups of clients by their therapists as part of a planned course of CFT treatment. The interventions took place during a single session and a total of 21 clients took part (12 for the self-critic intervention, 9 for the multiple-selves procedure due to Covid restrictions). Immediately following the intervention, the clients were interviewed about their experiences and the resultant data was transcribed and analysed using IPA.

The themes produced by the analysis were presented in four chapters (chapters six to nine) and three published papers (appendices one to three). In analyzing the total corpus of themes, six project-level super-ordinate themes were generated (see table 10.1). These interactive overarching themes were produced via further analytic engagement and interpretation, including the processes of subsumption and abstraction (mirroring earlier analytic stages that produced the initial superordinate themes). The aim of this additional level of analysis was to clarify the salient elements of client experience and to organise and focus the discussion.

Table 10.1. Project super-ordinate themes (across all studies)

No.	Project super-ordinate themes
1	Self-multiplicity
2	Externalisation and personification
3	Using the body: embodiment, enactment, and movement
4	Emotional activation and complexity
5	Integrating and transforming with compassion
6	Relational factors and the therapist's multiple roles

1. Self-multiplicity

As introduced in chapter 3, self-multiplicity is identified as a core principle in chairwork (Pugh & Bell, 2021). The notion of self-multiplicity is present in a multitude of psychotherapeutic modalities and its conceptualisation is shaped by various theories of self-hood and psychological disturbance. Aspects of the self are multifariously referred to as 'voices', 'parts', 'modes', 'ego-states', 'mentalities', 'subpersonalities', 'and 'I-positions' (e.g., Rowan, 1989; Watkins & Watkins, 1997; Hermans, 2004; Schwartz & Sweezy, 2019). Such parts might be linked to inner archetypes and collective potentials (Jung, 1963), schemata that organise information (Young et al., 2006), internalised experiences of 'self with others' ('self-objects') (Greenberg & Mitchell, 1983), or reciprocal roles (Ryle & Kerr, 2020). The relationships or interactions between such units of self are deemed to pattern a client's overall sense of self and play a role in creating and maintaining psychological distress (Gilbert & Irons, 2005). Jacob Moreno, the founder of

psychodrama, suggested the smallest unit of treatment is two, highlighting that we are always 'in relation' to another (Moreno, 1953; Lawrence, 2015).

In CFT, Gilbert (2010) refers to the 'multi-mind' to capture the complex, modular nature of the evolved human mind. Gilbert (2000) asserts that different motives and emotional systems organise the mind in different ways, for different ends, giving rise to various brain-states or mentalities. Affective patterns are, for example, deemed to function like 'mini-selves' with distinct characteristics, mind-sets, somatic signatures, and behaviours (Gilbert, 2020). Social mentality theory (see chapter 3) also elaborates a conception of the 'self' as fluid, relational, and contextual. The theory describes how evolved processing systems are responsive to signal-sensitive processing in others, creating interactional 'dances' between self and other in pursuit of biosocial goals (Gilbert & Irons, 2005; Gilbert 2017). This dance is reciprocally role-forming, creating self-to-other patterns for care-giving and care-receiving, competition and rank formation, mutual co-operation, or sexual arousal. Whilst social mentalities are understood to have originated to create and regulate interpersonal relationships, Gilbert (2000) suggests that these same mechanisms are recruited for internal, self-to-self relating. As humans, we can generate internal stimulus signals that we, ourselves, respond to, setting up the potential to create internal relationships based on the care-giving and receiving or dominance and subordination.

Social mentality theory is relevant to both of the chairwork exercises in the project. Both exercises contain the intentional switching from competitive or threat-based exchanges to care-based interactions and both are based on the conception of the self as made of multiple interactive patterns or potentials. The self-critic exercise involves participants enacting both the critic and criticised roles of the competitive 'inner social relationship' (Gilbert & Irons, 2015, p. 265), before shifting to the compassionate self and relating back to both parts of the self caught in the conflict. The multiple-selves exercise comprises both inter- and intra-personal relating, with a large number of different 'selves' involved. The angry self, anxious self, sad self, and compassionate self are all explored for their experience of an interpersonal difficulty before their inter-relationships are explored. This requires at least four chairs for the client: a room full of different selves! Despite the importance of self-multiplicity in CFT and multiple other

modalities, there is minimal research on how clients experience this conceptualisation of the self and whether chairwork interventions do create a broader appreciation of self-multiplicity.

Both sets of participants reported minimal difficulty in accepting the notion of the self as formed of multiple constituent elements. Participants were surprised at the speed by which they could acknowledge various patterns of experience as agentic 'parts' which participants could clarify, label, and distinguish with relative ease. The chairwork process (discussed below) allowed participants to access, inhabit, and articulate distinct subjective realities, referred to as a collection of different '*voices'*, '*separate entities*' or '*characters'*. Participants notably framed this sense of multiplicity as a contrast to their 'everyday' or 'daily' notion of themselves, as fixed, singular, and totalised. In contrast, self-multiplicity, was experienced as 'strange' and 'weird'- as a break from the normal- but not as aversive. Participants also remarked that to achieve such multiplicity, they required an active 'separation' or 'splitting' of their habitual singular self, which was facilitated by the use of multiple chairs. It is of note that 'separation' is a core process of chairwork's underpinning trans-theoretical foundations as proposed by Pugh (2020).

In breaking from their everyday sense of self, participants experienced a sense of expansion and possibility. This was beneficial in allowing participants to experience specific parts as not the 'whole', thereby broadening their repertoire of being and responding. Another was the possibility of examining component parts with greater clarity and specificity, a process captured by various metaphors: the untying of prior conceptions bound within a singular self, or the unpacking of boxes that can be picked through and reorganised. Participants experienced the potential to change 'self' or 'mode', realising a degree of personal 'choice' and agency in which parts of the self are cultivated, comparable to the choosing and changing of clothes. Experiencing a sense of possibility, agency, and flexibility is particularly important when considering depression is associated with inflexibility and the presence of a singular, monolithic voice that 'de-presses' variation and multivocality (Gilbert, 1992; Greenberg & Watson, 2005). Participants even reported curiosity and playfulness *('it is quite fun'*) when exploring different aspects of themselves, which is remarkable for a client group with high levels of shame, self-criticism, and low mood.

These findings echo prior research by Chadwick (2003) who found a two-chair intervention for clients with psychosis led to a broadened model of self. His thematic analysis identified an 'appreciation of complex, multi-faceted and changing nature of self' (p.448), with illustrative quotes such as: '*I had always thought there was just that one part of me, a negative one. I thought this all my life. It's nice to find this isn't true.*' (Chadwick, 2003, p.448). A thematic analysis of client experience of EFT chairwork for self-criticism also produced a similar finding: that participants experienced a helpful 'realisation' of agency over their internal processes, with an insight that one part of the self was 'doing' something to another and that this could be changed (Steigler et al., 2018). There appears to be growing evidence that chairwork creates experiences of self-multiplicity that are both accessible and beneficial. The current results suggest that a relatively brief (hour long) CFT chairwork intervention can influence and elaborate a client's self-concept, yet it remains unclear whether such changes are lasting or clinically beneficial in terms of managing depression.

Separating multiple aspects of the self onto various chairs also allowed participants to explore the relationships that exists between them. In turn, this highlighted the essentially dialogical nature of various internal processes, such as self-criticism, and encouraged participants to explore the character of these internal relationships (e.g., witnessing and experiencing the dominant attack of the self-critic). It also allowed for participants to contact previously inaccessible or unknown parts of the self (e.g., the criticised self's defeat) or internalisations of others (e.g., in associating the critic with figures from the past). Explorations of self-multiplicity via chairwork can also change the internal nexus of relationships by introducing new voices (i.e., the compassionate self). Within chairwork literature, Pugh and Broome (2020) provide a helpful framework to conceptualise the 'dialogical dysfunctions' between parts of the self (see chapter three). According to this conception, pathological consequences can be created when parts of the self are dominant, restricted, absent, or undifferentiated, or when dialogues between parts of the self are impoverished or stereotyped (Dimaggio et al., 2004). As suggested by Elliott in Stiles et al., (1997), treatment therefore 'requires evocation and explication of the implicit self-aspects, as well as facilitation of psychological contact, especially tolerant or even friendly contact, among the self-aspects.' (p.245). CFT chairwork appears to fit this criterion well.

Participants also found the concept of self-multiplicity and self-conflict to be validating of their lived experience. The chairwork exercises proved an experiential means to socialise participants to CFT's concept of the human 'multi-mind' as comprised of various, contrary motives, emotions, and competencies derived from different stages of evolution, for very different evolved goals (Gilbert, 2010). This appeared to normalise, and explain, participant's experiences of internal inconsistency and contradiction. As one core aim of CFT is to de-shame client's experiences of internal conflict and to develop empathy and explanations for such extreme modularity of mind, it is notable that this was evident in participant's subjective reports. Various chairwork approaches stress that self-multiplicity is 'an essential part of being human' as well as being 'a therapeutic resource, to be nurtured and valued' (Elliott & Greenberg, 1997, p. 225). It appears that CFT chairwork helps to create a healthy view of the self as suitably complex, rich, and dynamic.

A minority of participants described the experience of multiplicity as a process of channeling or marshalling forces larger than themselves: with the self a conduit for something unknowable or numinous. These experiences could provide fertile therapeutic material to explore existential or spiritual issues with clients. The transpersonal approach of Rowan (2010) or mysticism of Deikman (1982), provide examples of how multiplicity and spirituality might be discussed. It also highlights that some clients might need additional support to integrate these new experiences given their prior belief systems. A limitation of the current study is the lack of negative experiences that participants reported in terms of self-multiplicity. Future research might actively ask for such experiences. Chairwork literature has also cautioned about embodying multiple selves for clients with symptoms of dissociation or psychosis as they may 'lack the ability to integrate their experience' (Stiles et al., 1997, p.245). Whilst this assumption has been challenged by various authors (e.g., Corstens et al., 2018), further research might explore CFT chairwork for clients with these presentations.

2. Externalisation and personification

Throughout chairwork's history, importance has been placed on concretising and physicalising inner experience. Dayton (2005), for example, regards externalisation as the necessary initial

stage of enactment, whereby ‘the protagonist’s object relational world is concretised’ and their ‘transferences and projections will reveal themselves on the stage where they can be explored’ (p.24). Participants found that giving parts of the self a physical form offered a novel means to differentiate, symbolise, and relate to their inner experiences. The beneficial processes created by such externalisation are now discussed below.

Externalising parts of the self on the set form of a chair, and giving the chair a set space in the room, allowed participants to modulate their connection and contact with different aspects of their experience. Parts of the self could be ‘literally’ sat in and then left. Participants identified the physical procedure of standing up and away from the chair created a symbolic and psychological shift of being, an intentional stepping out of one role and into a next. Phenomenologically, participants still experienced the previous self as firmly ‘parked’ in the prior chair, which led to a reduction in affective intensity. The movement between chairs was particularly helpful for participants who felt ‘*stagnant’* and stuck to a single ‘position’. The movement therefore provided a sense of agency, choice, and possibility. There appeared to be a relationship between physical movement between chairs and the subjective experience of psychological expansion and space. Such findings are of potential importance given the experiences of restriction, demobilisation, and exhaustion that are associated with depression (Gilbert, 1992; Kendler, 2016). More generally, these findings suggest that such externalisation and movement could be used in a targeted way with clients who over-identify with a particular self or social mentality.

The literature on self-immersion and self-distancing (e.g., Barbosa et al., 2017) provides helpful insights to understand the benefits of externalisation and movement between chairs. Transitioning to a self-distanced, observer perspective, from an ego-centric, self-immersed perspective, has many benefits including decreased rumination and distress, improved performance, and consideration of other’s viewpoints (Ayduk & Kross, 2008; Kross & Ayduk, 2008; Kross et al., 2012; Grossmann et al., 2016). In terms of depression, Barbosa et al., (2020) found that greater flexibility between immersion and distancing, ‘characterised by frequent and fast transitions between the two perspectives, may be an adaptive pattern’ in the treatment of the disorder (p.493). Prior EFT research found a progressive shift from high immersion during the

initial stage of therapy to high distancing in the final phase of therapy was helpful in experiential treatments for depression (Barbosa et al. 2017).

For participants in the current project, chairwork can provide such flexibility and oscillation between perspectives. Psychodramatists have long argued that new learning is generated by both experiential *involvement* and *detachment*. Kellerman (1992), for example, suggests that embodiment (taking the seat of a given 'self') creates *involvement* by 'activating the experiential self-as-subject ('I am')', whilst detachment is created by changing roles and experiencing 'the observational self-as-object ('looking at myself from the outside')' (p.90). Participants undertaking CFT chairwork reported such a decentered, reflective, observational state, whereby they witnessed themselves as if behind CCTV screens. The movement between chairs created both physical and psychological 'space', in a way that literally created new perspectives. Such findings are consistent with prior chairwork studies whereby participants experienced 'metacognitive' distancing during their sessions (Chadwick, 2003). In many ways, this experience of de-centered observation captures the qualities of mindfulness which are crucial in CFT (Gilbert & Choden, 2013). It is also perhaps such distancing that facilitates the tolerance of high affect (described below), which Lawrence (2015) eloquently suggests is akin to 'placing the grounding feet of wisdom into the swirling intensity of strong affect' (p.65).

In a review of methods that strengthen the client's 'observing ego', Glickauf-Hughes et al., (1996) suggest that chairwork can be used as a 'distancing technique' alongside other approaches such as journaling, use of metaphor, perspective taking, and use of stories/narratives. This raises the potential that other distancing techniques might be used to supplement chairwork, particularly as a homework task to strengthen and continue the gains from a chairwork session. Further research might also evaluate whether the physical movement of chairwork creates greater self-separation when compared to the verbal or imaginal methods used within other therapies that emphasise self-multiplicity (e.g., Internal Family Systems; Schwartz & Sweezy, 2019).

Giving each self as specific chair and position within the room created a new reflective overview of the participant's problem, mapping out complex internal relationships in external space. Given participants' emphasis on 'space', 'position' and 'distance', an innovation to CFT chairwork

might include adaptations of psychodrama's sociometric methods (Cruz et al., 2018) whereby relationships between self-parts can be represented and explored by altering the proximity, arrangement, and order of chairs. Clients might also be given more ownership to move the chairs as they find helpful, and more freedom to inhabit and move about the space of the room (checking for any changes this creates in internal experiences and mental 'perspective'). Such concretisation and physical mapping might function as a formulation or material marker to measure psychological processes: 'a conceptual and later experiential road map for therapeutic work' (Roediger et al., 2018, p.180)

Participants also found the externalisation of internal relationships between chairs encouraged parallels to be drawn between participants' intra and inter-relating. For example, participants were shocked to hear the contempt and hostility of their self-criticism expressed outwards as if to another human being, which helped to demonstrate the power and relational aspects of the exchange (dominant to subordinate). The phenomenon of experiencing the self as 'other' also facilitated self-compassion in participants who had previously only been able to express compassion externally. Again, the literature on self-distancing provides a helpful framework, with Leitner et al., (2017) stating: because 'a self-distanced perspective psychologically transforms the part of the self being observed into an 'other', it may attenuate processes typically involved in self-referential thought' (p.535). In this instance, chairwork appeared to attenuate self-focused criticism and blocks/resistances to self-compassion, whilst also boosting social-relational competencies such as the ability to mentalise and empathise. The evidence from these findings supports Pugh's (2020) assertion that externalisation in chairwork allows clients 'to apply skills from the external world to their interpersonal experiences' (p.24). Such conflation and comparison between self- and other-relating is pertinent given CFT's express aims of unblocking both inner and outer flows of compassion: from self-to-other, other-to-self, and self-to-self (Gilbert, 2010). The findings from this project suggest that chairwork offers CFT a unique means to side-step typical blocks to self-compassion by recruiting a client's ability to focus compassion externally.

The experience of the self as other was enhanced by the presence and use of mental imagery.

For participants, the experience of seeing and hearing personified parts of the self- their facial features and expressions, bodily gestures, and voice tones- heightened their emotional reactions and ability to apply compassion. Gilbert and Irons (2005) have previously stated that in 'social mentality theory we use relational imagery' as 'patients find it easier to engage with affect it is in a social relational format' (p.278). This was evident for participants in the study who reported feelings of sympathetic connection and an urge to regulate each self with physical touch. The imagery appeared to heighten the power of social signaling: the sniggering of the critic or the emotional distress pictured in the emotional selves. The presence of imagery also augmented the experience of authentic dialogical encounter, creating a 'face to face' focus for the relational exchange. As Emma explained: '*it actually felt like I was giving myself something to talk to. It gave me something to feel real to talk to'*.

Encouraging clients to visualise self-parts or other people in chairs is a core part of chairwork practice (Kellogg, 2015). Reasons for using imagery include its links to symbolic representations and implicit modes of processing and its role in increasing cognitive-affective immersion (Holmes & Mathews, 2005). As observed by Pugh (2020), imagery enhances how clients engage with 'representations of the self and others as real percepts during chairwork' (p.45). In EFT chairwork, imagery is a key part of making psychological 'contact' with the self/other-construct the chair and evoking affective reactions (Elliott et al., 2004). The current research supports the relevance of such factors, whilst also highlighting how imagery might be used to increase clients' capacities to differentiate between self-parts by giving them distinctive form. Imagery is not an explicit process-task in the multiple-selves exercise, but clinicians may benefit from encouraging imaginal representations of each emotion to aid differentiation. The current research is also notable in demonstrating how clients independently utilised imagery (of various sensory modalities) to deepen their connection to various selves. This included personifying the compassionate self in visual form before 'stepping into' and embodying the image to adopt a new perspective. Such experiences suggest ways in which chairwork and imagery can be combined to access the compassionate self in CFT.

The research findings also highlight the phenomenon of fluctuating spontaneous imagery, which acted as marker and measure for psychological change during the intervention. This was most

striking during the self-critic exercise when shifting social mentalities. When related to with compassion, the self-critic transformed from an evil creature, cave man, or bully into the image of a frightened child. The imagery often switched between different 'versions' of the self (at different ages or in specific contexts) or took on archetypal forms, such as the compassionate self personified as a caring and wise elder. Again, this highlights how changes in imagery might be actively asked for by clinicians to express, explore, and extend shifts in meaning and mentality. As previously identified by Hales et al. (2014), spontaneous imagery is rarely volunteered by clients which, as these findings attest, could prevent reflection on rich internal material and new representations of the self.

A large proportion of participants linked their imagery to specific past events, relationships, or amalgamations of memories. The association between episodic, autobiographical memory and imagery is well established (Conway & Pleydell-Pearce, 2000), with imagery deemed to be the 'preferred form in which highly affective experiences are recalled' due to its links with sensory-perceptual information (Hackmann et al., 2011, p.35). During the exercise, participants reported 'seeing' past versions of themselves and others, which highlighted the time-scale and interpersonal context in which the 'critic' originated. This was helpful for clients to connect current reactivity to past vulnerability, whilst also highlighting the adaptive nature of their protective action (e.g., submissiveness). The identification of specific memories via spontaneous imagery during chairwork could provide potential targets for therapeutic interventions. Such interventions might include imagery re-scripting (which has been found to be effective as a stand-alone treatment for depression, Brewin et al., 2009) or alternative chairwork interventions whereby the 'critic' is identified as an internalisation of an abusive other and is externalised from the self (Bell, 2022). Given the role of shame-based memories and intrusive imagery in maintaining depression (Matos et al., 2014; Patel et al., 2007), standard CFT chairwork could be particularly useful for assessing for, and accessing, distressing memories in depression.

3. Using the body: embodiment and enactment

Embodiment is deemed to be a central principle within chairwork (Pugh & Bell, 2020). Whilst the term is used differently within mutiple fields of research- such has philosophy, psychology, and artificial intelligence (Wilson, 2002)- within chairwork, embodiment is part of the animation

process and requires the client to change chairs and *become* a specific self-part. The client is then encouraged to immerse themselves in the psychological, emotional, and physiological 'surplus reality' of the part (Kipper, 2000). This typically requires the client to enact or bring to life the self-part by using the body to express its character via posture, facial expression, gestures, and voice-tone (Pugh, 2020).

The importance of the body and bodily expression was emphasised by the participants in both studies. Such tangible physical expressions were used to differentiate and identify different aspects of the self, with each self-part anchored to specific somatic markers (e.g., the criticised self's immobility, collapse in posture, and lowered gaze). Embodying parts of the self, and attending to proprioceptive cues, offered novel access to implicit sources of information and insights into the nature and function of each self. For example, participants could literally 'hear' the character of the emotional self in the tone and volume of each voice, or 'feel' the protective function of the angry self in its clenched fist, aggressive gestures, and urge to 'smash' and attack. As one client eloquently explained, the selves were sensually sampled as if smelling different scented candles. This raises the potential that such embodiment and body-focusing can increase a client's capacity to discern the presence and influence of these patterns, much in the way that mindfulness-based therapies for depression are deemed to facilitate early detection of escalating emotional patterns (Segal et al., 2018).

Participants also instinctively used their bodies both to access and deepen their connection to various 'selves'. Automatic reactions were extended, elaborated, and amplified by an intentional physical inhabitation and enactment of each self. Examples included changing or holding a physical posture or altering breathing rhythm. In this way, the body was intentionally used to influence the mind and the resultant changes in mind were most vividly articulated in the body, creating an interactive cycle by which each self was accessed, expressed, and understood. Notably, participants frequently changed their posture and gestures during the research interview to aid their recall of particular 'selves' which has wider clinical implications for how clients might be taught to use their body to re-access particular insights and states of mind away from the session. Participants also frequently used body and action-based metaphors to illustrate

subjective experience ('to step into that shoes' or to 'jump' into a different self) which perhaps highlights the influence and role of the body in chairwork.

Whilst the body was utilised to contact and explore different roles, participants also intentionally used the dynamic interaction between body and mind to leave such roles. As mentioned above, the physical movement between seats supported the process of self-separation, but participants also benefitted from 'shaking off' each role between chairs (e.g., rapid motor movements in the arms and upper-body). Dayton (2005) has previously noted that 'some role-players also like to 'brush off the role' physically so they can concretise letting it go' (p.25). A similar process of 'shaking' is utilised in somatic experiencing to process and release traumatic experiences (Levine, 2010). Such physical gestures of separation, in addition to the movement required between chairs, might be emphasised more by CFT therapists to support shifts between motives, emotions and patterns of experience. As Greenberg and Watson (2006) have highlighted, the body provides a key means to regulate and modulate our affective experiences: 'motor expression may intensity congruent emotion, but also dampen other emotions' (p88).

Various theories have been posited to explain the mechanisms and benefits associated with embodiment and enactment in chairwork. Pugh (2020), for example, has employed multi-level cognitive theories when discussing chairwork in CBT: e.g., interacting cognitive systems (Teasdale & Barnard, 1993), and cognitive-experiential theory (Epstein, 2014). Both of these theories emphasise the need to modify affect-laden schematic models associated with non-verbal encoding and implicit 'felt sense' or 'heart-level' meaning. Achieving such modification 'relies upon experiential modes of information processing, characterised by higher levels of emotional arousal and multi-sensory inputs including sights (imagery), sounds (voice tone), and bodily feedback (posture)' (Pugh, 2020, p.4). This is in direct contrast to intellectual, 'head-level' meaning and encoding, and analytic, language-based interventions. Participants in the current project experienced chairwork as a shift away from cerebral processing towards engagement with the body and feelings, contrasting the experience of chairwork with their emotional 'disconnect' during prior cognitive methods. As James stated: *'it wasn't just hypothetically, it was something that was real*'. The rich sensory nature of embodiment appeared to create changes

that felt authentic and 'real', giving credence to the exercise despite its sometimes novel, strange, and fantastical elements.

Another associated theory is embodied cognition and the notion of bi-directionality. Whilst embodied cognition is a broad subject within itself, relevant theories suggest a bi-directional influence between the body (and its interactions to the environment) and the way in which we think (Varela et al., 2017). A two-way street is proposed between physiological state and psychological process: cognitions are deemed to influence emotion and body via 'top-down' processing, but body-states can also influence cognition and affect via 'bottom-up' processing (Pugh, 2020). Experimental research supports the theory of bi-directionality with manipulations of body-states (e.g., facial expression, posture, and gait) influencing emotion, cognition, and behaviour (Riskind, 1983; 1984; Strack et al., 1988). Physiological changes are also deemed to influence memory retrieval (Michalak et al., 2015). The exploitation of this link (typically involving a greater focus on the body and senses), is deemed to be a common factor in successful psychotherapeutic change (Tschacher & Pfammatter, 2016). Participants in the current study appeared to profit from such bi-direction influences in their use of the bodily changes to access and discover changes in mindset and motivation.

The concept of 'top-down' and bottom-up' processing has also been utilised by Yaniv (2014, 2018) to explore the benefits of embodiment and enactment in psychodrama. Yaniv suggests that psychodramatic methods- in their bottom-up focus on the body, affect, and implicit non-verbal meaning- offer a helpful challenge to restrictive top-down cognitive influences. Such top-down cognitive control is often 'conserved' and rule-bound, based on preconceptions, habits, and preexisting formulas and theories. Bottom-up processing (e.g., utilising the body and its senses) is, by contrast, based on here-and-now stimulus dependent spontaneity and open responsiveness. For psychodramatists such as Moreno (1946) and Blattner (2000), spontaneity is a central tenet of the approach and offers the potential to bypass linguistic, rational defences by means of child-like curiosity, creativity, and play. Kellerman (1992) also highlights how certain insight can be 'achieved only in action, while moving about, standing still, pushing and pulling, making sounds or gestures or pronouncing words; in other words, while communicating through action-language (p.86-7). Participants in the current study, such as Charlie and Alice, identified how chairwork

challenged their typically 'factual' and verbal approach to problems. The same participants found the 'ambiguity' of the enactive method to be frustrating but also therapeutic in creating new ways of being with their difficulties. Further research might focus on the benefits of chairwork for clients with problems of over-control (following the example of 'radically open' adaptations of third wave CBT (Lynch, 2018)), and how such clients can be supported to overcome their initial aversion.

The use of enactive and embodied methods in chairwork also matches CFT's emphasis on body awareness, body cultivation and the stimulation of physiological and affective states associated with care (Gilbert, 2010). Within CFT, clients are supported 'to train/use the body to support the mind' (Gilbert, 2020, p. 26). As introduced in chapter three, this might involve, for example, breathing exercises to ground and stabilise the body and mind, influence the vagus nerve, and support cognitive and affective competencies related to compassion. Participants' experiences of chairwork suggest the method is well suited to CFT's focus on holistic, whole-system change. Embodiment and role-taking in chairwork complements Gilbert and Choden's (2013) suggestion that to cultivate the compassionate self you need to 'become that character- living it from the inside' and 'feel into' the identity (p.234). Participants in the study identified that chairwork offered a new embodied way to experience this version of themselves with the additional benefit of procedural skills practice in the dialogic exchanges. Matos et al, (2018) found that the embodiment and enactment of the compassionate self in daily life were key factors in the perceived helpfulness of compassionate mind training and were associated with improved levels of compassion across its multiple flows. Additional research might explore whether embodying the compassionate self in chairwork translates into increased levels of out-of-session embodiment, particularly if compared to imagery training which contains less procedural/enactive elements.

Considerations of embodiment and action-methods are pertinent to the treatment of depression, given the disorder's impact on energy, motor movements, and activity levels. One of the most successful treatments in depression is behavioural activation which includes the integration of behaviours that increase positive reinforcement, creating experiences of mastery and pleasure (Martell et al., 2001). The chairwork methods described in this project could be conceptualised

within a behavioural framework as containing aspects of behavioural rehearsal (given its active broadening of behavioural repertoires when faced with threating experiences) whilst also providing a reinforcing experience of mastery. Participants reported a sense of '*pride'* at overcoming their initial apprehension and aversion, and even noted the '*fun'*, playful, and energising nature of the session. Treatments targeting movement in depression demonstrate a positive impact after a single-session (Koch et al., 2007). The role of movement within chairwork for depression requires further research and elaboration. Based on clinical utility, Kellogg (2015) reports that when 'working with patients who are depressed or a bit disconnected, I often invite them to stand as it tends to increase their energy level' (p.182). Clients receiving CFT chairwork for depression might similarly be invited to move about the room as their compassionate self before standing behind the compassionate seat to embody the agency, authority, and 'overview' perspective of the compassionate self.

The literature on mindfulness-based approaches to depression also offers insights into the potential benefit of focusing on the body during chairwork. Mindfulness-based cognitive therapy for depression (Segal et al., 2018) incorporates various body-based exercises whereby attention is intentionally focused on sensations of the body. One rationale for this shift towards the body is that it moves clients away from cognitive processing and rumination, providing attentional stability to engage in core affective material without iterative cognitive elaboration (Williams & Penman, 2011). Similarly, in chairwork, clients are asked not to verbally elaborate their stories and thoughts about an event, but to bring them alive via the body, to contact and express their felt experiences, and to heighten their focus on present-moment experiencing (Perls, 1973). In their review, Michalak et al. (2012) suggests that mindful awareness of the body has multiple functions and benefits: it enhances body awareness as an antidote to emotional avoidance; provides insight into the interplay between emotional and body processes; increases awareness of organismic needs and limits; and creates 'embodied compassion'. As CFT incorporates mindfulness as an integral component, further research might explore how mindfulness and chairwork might be optimally combined or sequenced, and whether CFT chairwork does share similar mechanisms of action with mindfulness-based approaches.

4. Emotional activation and complexity

Both exercises were notable for activating a variety of strong emotional experiences. This was most apparent during the multiple-selves approach where, supported by the method's sequential structure, participants were able to experience, express, and label distinct affective patterns in each separate seat. Echoing previous literature on emotion in depression (Greenberg & Watson, 2006), participants initially described their emotional reaction to their chosen memory as undifferentiated, indistinct, or globally 'bad', experiencing them as a 'jumble' or 'mish-mash' of feeling. Separating each emotion on specific chairs helped participants to break-down their undefined reactions into 'facets' or 'building blocks' of feeling. By clarifying their overall reactions into constituent parts, participants were able to focus on their emotions in greater detail, facilitating further insight and analysis. Echoing the experiences discussed in the context of self-multiplicity, participants found that separating their emotions provided a degree of organisation, clarity, and containment, whilst simultaneously providing a sense of possibility and expansion as a greater repertoire of emotion was actualised, tolerated, and explored.

As introduced in chapter 2, depression is associated with restricted emotional tonality, fear of emotions, and a shutting down, or 'de-pression' of an individual's core-affects (Greenberg & Watson, 2006; Licht et al., 2008; Yoon et al., 2018). As emotions are deemed to provide implicit information about both self and the world in relation to core motives and needs, depression of these emotions can cut clients off from adaptive information (Gilbert, 2015b). Given this profile of emotional constriction or collapse, it is no surprise that depression is also associated with a reduced ability to differentiate negative emotions (Demiralp et al., 2012) which, in turn, is correlated with a reduced ability to regulate negative emotions (Barrett et al., 2001). The experiences outlined in the prior paragraph are therefore particularly promising in clients with depression. The exercise appears to generate an appreciation of emotional granularity, an opportunity to switch emotions in quick succession, and a means by which to approach avoided feelings and inner experience. As increased emotional awareness has been shown to predict recovery of mood after receiving distressing stimuli (Salovey et al, 1995), the multiple-selves exercise may well offer practically helpful support for clients with depression.

The multiple-selves exercise was also notable for highlighting the idiosyncratic and emotionally complex nature of depression beneath the global flattening of affect. Participants presented with

individually distinctive profiles of emotion, with specific emotions experienced as dominant or 'default'. Anxiety was the strongest and most prominent emotion in participants, whilst sadness and anger were most frequently avoided, absent, or 'controlled'. Such findings support the assertion that depression is not a single emotion, but rather is 'a syndrome, and often avoidance of core emotion is an aspect of this syndrome' (Greenberg & Watson, 2006, p.55). As outlined in chapter two, depressive affect (and associated experiences, such as hopeless, submission, defeat) can be conceptualised as a secondary emotional response to underlying primary emotions, which inhibits important needs and motives (Greenberg & Safran, 1987; Gilbert 1992). This conception of depression was evident in how participants experienced their emotions as interactive and in conflict, with the primary 'root' (as described by participants) being restricted by secondary reactions or emotional co-conditioning. Examples of such emotional conflict include fear and avoidance of sadness related to grief and bereavement. Another was the internally focused anger at one's own anxiety and vulnerability. Clients dynamically shifted the focus of their emotions, between internal and external foci, responding to a variety of internal and external threats. This was most evident in the dynamic way external anger was blocked and internalised as self-criticism (see discussion below). The multiple-selves approach might well be used to identify particular idiosyncratic patterns in clients' depression to allow treatment to be accordingly tailored and targeted.

The emotional conflicts and interactions described above were encountered during the chairwork process as difficulties in accessing, leaving, separating, or tolerating particular emotions. Whilst such difficulties might be deemed problematic (if the intention was to follow a set script of procedural steps) they might also be embraced as a 'live' means to identify and assess for an individual's characteristic emotional profile. Therapists might therefore view the multiple-selves method as both intervention and assessment, valuing any blocks or obstacles that are encountered for the therapeutic insights they provide into the client's internal world and learning history. Difficulties within the process of multiple-selves chairwork can therefore be approached in the same spirit that Gilbert (2020) suggests CFT clinicians approach blocks, fears, and resistances to compassion: as an 'intuitive wisdom' that reveals areas of personal threat and need. Process observations might therefore be used during the session to highlight problems in accessing or clarifying different emotions (e.g., noting that the client becomes tearful when expressing anger).

Additional questions that might aid the assessment of a client's emotional profile include: 'which emotion is the most and least accessible?'; 'are there sequences of emotional activation (e.g., does anxiety follow sadness)?'; 'do some emotions naturally focus inwards rather than outward?'; and 'do any emotions naturally arise together or appear fused?'.

In supporting participants to access and express a variety of threat-based emotions, the multiple-selves exercise facilitated the expression of a variety of adaptive protective strategies and behavioural impulses. As previously discussed, depression and shame are associated with arrested defences: submission, immobilisation, learned helplessness, avoidance and inhibited external anger (Miller & Seligman 1975; Gilbert, 1992; Gilbert, 2013; Gilbert et al. 2004). The multiple-selves method appears to provide a safe experiential means by which clients can experiment with enacting a range of healthy innate defences. This includes the 'fight' of anger and the capacity for healthy protest, assertive responses, and protective personal boundaries. Participants were also encouraged to explore the 'flight' of anxiety and the agency to remove oneself from danger. Sadness, which was highly avoided by participants, was also explored for the healthy expression of distress and help-seeking as well as the adaptive processing of loss (e.g., grieving). Activating the protective responses in this way provides participants with a broadening of their coping and role-repertoires, reversing the pattern of defeat and entrapment that are associated with depression (Gilbert & Allen, 1998). Further research might explore whether such activation is carried into the client's life and interactions, and clinically what might be required to support this transition.

The discussion of emotional multiplicity is also relevant for the self-critic exercise. For example, some participants were surprised to experience sadness and anxiety during the self-critical process, having previously only identified with the anger of the critic. In contrast, other participants were shocked at the presence and strength of their anger, which was previously unacknowledged in their identification with feelings of anxiety. During the process of role-reversal, the participants' emotions offered the primary means to acknowledge the full impact, power, and nature of the internal competitive mentality. Discovering the variety of emotions underpinning criticism also allowed participants to consider novel ways in which they could be addressed or directed. As an example, participants discussed their anger as a new source of

potential ‘energy’ (Elena) or ‘power’ (Anita) that could be redirected externally for assertive purposes. Such a suggestion is in keeping with theories that self-criticism in depression is related to problems with externalising anger and dealing with conflict (echoing the discussion of blocked defences above) (Forrest & Hokanson, 1975; Gilbert et al., 2014). Overall, these findings support the clinical guidance that a variety of emotions should be assessed for, and targeted in self-criticism (Gilbert, 1992; Greenberg, & Watson, 2006).

Emotions during the self-critic exercise were also helpful in distinguishing compassionate and critical forms of relating, contrasting the feelings of safeness and soothing created by the compassionate self and critic’s anger and disgust. Self-criticism and shame are deemed to create their pathogenic effects not only by self-focused hostility and loathing but also by its blocking of self-directed warmth and reassurance (Gilbert, 2000; Gilbert et al., 2004). Gilbert therefore suggests that CFT treatments for self-criticism should not solely aim to reduce self-criticism and shame, but also generate experiences of self-focused care and soothing as an antidote to threat (Gilbert & Irons, 2005; Gilbert & Proctor 2006). This was evident in the participants’ experiences of warmth and sympathetic sadness when feeling ‘moved’ by their own distress. Prior chairwork research has highlighted the importance of accessing new feeling-states when building ‘positive’ self-representations: Chadwick (2003), for example, aimed to give new self-schemas an emotional (“lived”) quality, with participants reporting this allowed such schemas to *‘soak right through me and permeate my thinking’* (p.448). For participants in this current study, emotionally connecting to the compassionate self provided a ‘deeper knowing’ of this mentality, helping to build conviction in the benefit of compassion and its cultivation.

Participants reported a heightened and ‘extreme’ intensity of emotion during both exercises. Initially, such intensity was experienced as aversive in a large proportion of participants which echoes prior findings that participants feel ‘scared’ and in ‘shock’ when commencing chair-work (Robinson et al., 2014). However, after initial fears relating to relapse and becoming overwhelmed, participants experienced the intensity of feeling and expression to be cathartic and therapeutic. Again, these findings are in keeping with prior qualitative studies of chairwork which contained descriptions of the approach as ‘intense and demanding, but also meaningful’ (Steigler et al., 2018, p.139). For some participants it was the very experience of such high affect

that enhanced the perception of increased emotional tolerance, mastery, and understanding. Such capacities are suggestive of emotional self-efficacy which, in turn, are associated with emotional self-regulation (Allessandri et al., 2015). The participants' experience of shifting in and out of extremes of emotion when moving between chairs also supports prior suggestions that the multiple-selves method is a potent means to teach emotional resilience (Kolts, 2016). Emotional activation during treatment is also associated with modifications in in 'heart-level', implicit meaning (see discussion above). Participants positively compared CFT chairwork to prior cognitive treatment when contrasting chairwork's 'feel-it' moment to the rational focus of verbal or written interventions.

Emotional arousal and expression are hallmarks of chairwork and are deemed to be key mechanisms of change within experiential therapies (e.g., Greenberg et al., 1993). However, it is not simply the level of arousal but also the capacity to remain with and deepen the experience of emotion that predicts outcome in treating depression, including in therapies using chairwork (Watson & Greenberg, 1996; Goldman et al., 2005). The utility of emotional arousal in therapy therefore depends on the under or over-regulation of emotion and whether adaptive emotional processing occurs (Pos et al., 2003). Pugh (2020) has previously suggested chairwork facilitates the two conditions required for emotional processing to occur: the activation of emotional structures (emotional arousal) plus the incorporation of disconfirmatory information into existing knowledge (new learning) (Foa et al., 2006). The findings of the current project demonstrate the presence of both these conditions- increased levels of emotional arousal (at an intensity which can be tolerated and fosters experiential connection) plus the integration of new information in the form of compassionate relating. Prior research suggests the optimum levels of emotional arousal in experiential treatments for depression are higher arousal during mid-treatment coupled with reflection on the emotion and deeper emotional processing later in a course of therapy (Warwar & Greenberg, 2000; Pos et al., 2003). As Greenberg and Pascual Leone (2006) have suggested: 'it is not only arousal of emotion but also reflection on aroused emotion that produces change' (p.615). CFT chairwork appears to be the ideal vehicle to achieve these twin aims by offering a concrete means to modulate between emotional arousal and reflection.

5. Integrating and transforming with compassion

During the initial stages of both exercises (when recalling memories of disappointment or conflict), participants experienced their internal (self-to-self) and external (self-with-others) worlds turning hostile, switching off both inter- and intra-personal sources of reassurance and safeness. Such experiences are in line with prior findings that shame increases depressive symptoms via a reduced capacity to feel both socially safe and self-reassured (Marta-Simoes et al., 2017). In similar findings, people with higher trait self-criticism not only experience elevated negative feelings towards the self but also have difficulties creating self-directed warmth and reassurance (Gilbert et al., 2006; Gilbert et al., 2004). As Gilbert & Irons (2005) have previously asserted, the focus of CFT treatments for self-criticism and shame is not to challenge and dispute threat-based perceptions and reactions but rather to increase the client's access to care and soothing (from both self and others) as an antidote. As discussed above, CFT chairwork offers a means to embody and enact these changes in social mentality- switching from rank-based, competitive relating to care-based giving and receiving.

As experienced by participants, the compassionate self was initially accessed via a process of separation and embodiment: a stepping back from threat-based experiences and internal conflict with the aim of re-engaging them from an entirely different mentality. This initial movement away from threat-based processing was therefore not an end in itself but rather a precedent step for compassionate relating. As Gilbert (2015a) has repeatedly emphasised, compassion in CFT is not presented as an 'ascent' away from suffering and the darker aspect of the mind but is rather a motivation 'to move down (descend) into the real pain and tragedies of life' (p.251). To create the optimal conditions from which to connect to such suffering, CFT chairwork uniquely utilises an additional 'compassionate chair' in which clients are encouraged to access their compassionate self via body-based soothing practices and compassionate mind focusing (see chapter three). Participants emphasised the importance of such physical and mental preparation to break from prior threat-based responding, creating the space to realise the various skills and attributes of the compassionate self.

The compassionate self was frequently defined in contrast to threat-based processing. Participants associated the compassionate self with a sense of slowing down, and the capacity to be reasoned and intentional, as opposed to being defensive, stereotyped, and reactive. The

compassionate self, supported by the induction practices mentioned above, created a degree of mindful observation or witnessing. This reflective capacity was also associated with balanced objectivity and the opportunity to gain a deliberative overview before intervening. Participants drew analogies to judges and wise kings ('King Solomon') to capture these characteristics of the compassionate self. Such characteristics were evident in the way the compassionate self considered broader contextual and historical factors in both exercises, in contrast to apportioning personal blame and fault. Participants also emphasised the importance of empathic understanding and sympathetic emotional connection, which Gilbert (2010) lists as key compassionate attributes. In CFT, such compassionate attributes, skills, and qualities are linked to care-giving competencies (emotional, cognitive, and behavioural) that evolved within parent-offspring dynamics (Gilbert, 2005).

The participants' compassionate skills and attributes were ultimately discovered and potentiated in the application of the compassionate self. In terms of the self-critical relationship, participants described the power of generating empathy and non-judgmental sensitivity towards the self-critic. Compassion for the personified critic identified its underpinning fears and related protective functions. As introduced in chapter two, self-criticism is not a singular process, and its functions can be manifold. Participants identified many of the functions found in prior literature, such as threat-based monitoring of errors to avoid performance failure, the inhibition of external anger (e.g., when the expression of such anger could be dangerous), and the pleasing or placating of others to avoid rejection (Gilbert et al., 2004; Gilbert & Irons, 2005). In clarifying the role of the critic as a safety strategy (rather than viewing self-criticism as a cognitive distortion or maladaptive schema) participants were able to focus on the vulnerability driving it. In doing so, compassion transfigured the critic from an attacking monster to an injured child (as discussed in the context of imagery above). Self-criticism was ultimately transformed from a source of fear and further self-recrimination to a signal of distress requiring care and reassurance, demonstrating the shift in social mentality. In identifying the self-critic's function, the compassionate self also gained insights into its adaptive origins of self-criticism which provided a further focus for compassion.

Similar processes were evident when applying compassion to threat-emotions within the multiple-selves exercise. A new relationship was developed with multiple threat emotions when generating empathy, sensitivity, and non-judgmental interest towards them in their personified forms. This again involved clarifying the emotion's protective function, their associated needs, and their idiosyncratic history within the individual. Similar too was the way in which compassionate attributes and skills were key in generating insights into their evolved roles and functions, but also how such insights increased participant's compassion towards them: e.g., viewing threat emotions as non-pathological, evolved reactions, that have been potentiated or punished within a lifetime. Reflecting on the evolutionary and developmental origins of their emotional reactions helped participants to de-personalise and de-shame their intensity and occurrence, whilst also providing an explanatory frame to accept, predict, and understand patterns of motivation, feeling, and thinking. Given the benefit of this orientation, there is the potential to focus more explicitly on the function of depression and its evolved, adaptive role in blocking and collapsing motives and emotions (as discussed). This approach might feasibly encourage clients to foster compassion and curiosity towards their own depressed mood states, and an interest in the specific 'underlying determinants' driving their presenting symptoms (Greenberg & Watson, 1996, p. 263).

In relating to threat-based patterns with the care-based attributes and skills, the compassionate self offered a means to integrate disparate and conflicting parts of self. As identified above, the chairwork processes of separation, animation, and dialogue highlighted a complex concatenation of intrapersonal conflict, frequently shaped by internal competitive social-relating. Experiencing such high levels of threat can result in segregated stereotypic reactions, shifting clients between encapsulated forms of defence (e.g., from anxious self's flight to angry self's fight) which causes, 'in extreme cases, disintegration and dissociation' (Gilbert, 2017, p.35). Generating care for all aspects of the self reduced the cascade of threat-based reactivity, separation, and conflict, and instead created a degree of self-cohesion and inclusivity: a 'shift from the stab of self-blame to the embrace of self-compassion'' (Badenoch, 2008, p. 184). As Gilbert (2017) has suggested, the compassionate self is by nature a 'relation-forming aspect of mind' (p.62), and in seeking to build connection, care and internal safeness, compassion can provide the 'integration of inherently disparate and segregated systems' (Gilbert, 2017, p.35). This capacity for integration

is supported by the neurobiological processes associated with care that are conducive to social engagement, cognitive flexibility, and psychological integration (Liotti & Gilbert, 2011; Porges, 2011; Stellar & Keltner, 2017; Gilbert, 2014).

Having differentiated depressogenic experiences into their composite 'building blocks' during earlier stages of the intervention, the compassionate self acted to co-ordinate and re-organise self-parts into a new synthesised whole. Prior literature on contemplative practices has posited that such re-organisation is achieved by 'uncoupling' conditioned experiences of mind, whilst allowing differentiated elements to be linked together in novel combinations (Siegel, 2007). The compassionate self found new ways in which to find unity between disparate elements of self, even when such unity initially appeared impossible or paradoxical. This included conceptualising the multiple-selves emotions as 'three-sides to the same coin' (connected by their protective aims and nature). Similarly, the critical and criticised selves were deemed to be unified at a deeper level by the same underlying fears. The final sense of self-coherence was not achieved by removing difference and complexity, but rather by respecting and valuing the nature of each self-aspect and understanding their function within the broader system. Balancing and connecting parts of a complex system, whilst allowing parts of the systems to remain distinct, is deemed crucial for the stability and wellbeing of individuals, societies, and wider eco-systems (Siegel, 2019). For Gilbert (2020), compassion offers a key means to foster both internal and external integration and connection. Whilst not a finding in the current research, it would be of interest whether the multiple-selves exercise does generate greater feelings of connection to the 'other' in the conflict chosen for the intervention (e.g., in acknowledging common humanity in threat-based processing).

Participants described the compassionate self as adopting a 'parenting' role with distressed aspects of the self. Gilbert (2020) has suggested the role of the compassionate self/mind overlaps with that of a healthy attachment figure: as 'an inner sense of a secure base and safe haven' (p.13), that has both a regulating/containing function and also an encouraging/mediating capacity. These dual roles were evident in the participants' accounts of the compassionate self as a soothing figure (with a desire to 'hug' and sooth the selves' distress) and as a guiding force, encouraging them to engage with personally challenging and meaningful issues (such as

interpersonal conflict). Within the context of the multiple selves framework, Kolts (2016) also uses the metaphor of the compassionate self as 'captain of the ship', which has a superordinate role to tend to the alarmed emotion passengers whilst also steering a clear course through the storms of life. This metaphor found an echo in a participant's description of their anxiety as having taken the self's 'driving seat'. Both as 'captain' and 'parent', the compassionate self seeks not only to alleviate suffering but also to facilitate flourishing and purposive development (Gilbert, 2020). Again, participants identified that such growth (into a *'fully functioning human'*) could not be achieved by denying or rejecting problematic parts of the self, but by building a '*stronger motivation*' (a compassionate motivation) to work with all of them for a common goal.

The aim of psychological integration has been a common feature across modalities that utilise psychodramatic methods. From the conception of psychodrama, Moreno (1953) emphasised how the approach's expressive methods sought to achieve a 'catharsis of integration' rather than abreaction, not only offering emotional relief and release but also a 'realisation of the self' (p.546). As evident in the experiences of participants in this study, psychodramatists have focused on how chairwork methods allows for the externalisation of self-parts in order for them to re-integrated in new internal configurations. Moreno (1972) described this as a two-staged process: the first stage involves objectification and the second stage is to 'resubjectify, reorganise, and reintegrate that which has been objectified' (p.xxi). As eloquently described by Dayton (2005), this can create a new experience of self-consolidation and coherence, much like 'coming to your home country after a voyage away from it and seeing it as if for the first time' (p.24). The spontaneous, creative, and embodied elements of chairwork are deemed to be key in opening up rigid self-structures that are bound by 'top-down' cognitive predictions and rules (Yaniv, 2018). Creating embodied dialogues between self-parts is similarly deemed a means to build co-operation and partnership between aspects of the self that appear incompatible (Pugh, 2020). Whilst chairwork and psychodramatic methods appear to offer CFT an ideal medium by which to explore new forms of self-identify and organisation (an explicit aim of CFT, Gilbert, 2020), CFT also has the potential to support Moreno's second stage of reintegration by utilising compassion and the compassion self as the integrative force: as the part of the self that, by nature, seeks to care, help, and heal.

6. Relational factors and the therapist's multiple roles

An overview of the entire corpus of participant data highlighted the importance of relational factors to chairwork's acceptability and benefit (see chapter nine). There was a particular emphasis on the therapists' multiple roles in relation to the client and the task. In terms of the existing literature on the subject, Kellogg (2015) has notably distinguished between 'modifying' and 'facilitating' stances in terms of the therapist's role during chairwork. This distinction was originally made by Greenberg et al. (1989) in relation to how the therapeutic relationship can be used within experiential treatment. In a facilitating orientation, the therapist's role is to create the opportunity for different parts or voices to emerge and express themselves without a set agenda. Kellogg (2015) summarises this approach as: 'giving voice is the heart of the work; nothing else is needed' (p.172). This stance is evident in approaches such as voice dialogue (Stone & Stone, 1998) and in Perl's (1992) trust in the client's own emergent capacity for integration when dialoging between polarities of experience. In contrast, a modifying stance is goal-orientated and directive in nature. Examples include the goal-focused methods of CBT chairwork (Pugh, 2020) or the active challenging of specific voices in modalities such as schema therapy (Young et al., 2006) and re-decision therapy (Goulding & Goulding, 1997).

In relation to the findings presented in chapter nine, participants identified elements of both facilitating and modifying styles in their therapists. In terms of taking a facilitative stance, participants reported the benefits of their therapist acting as a witness to their distress which, in turn, created a new way of seeing their own experience from a 'distanced' position. In this instance, participants identified the importance of their therapists' presence and perspective rather than action, and the role perhaps has some similarities with the reflective 'auxiliary ego' in psychodrama (Glickauf-Hughes et al., 1996). Yet, whilst participants used their therapists as an 'objective' external reference-point from which to reflect, the caring qualities of the therapist appeared important in modelling and fostering new compassionate perspectives towards the self. Similarly, Kellogg (2015) has previously identified the role of the therapist as 'witness' during chairwork, yet he asserts that it is the therapist's 'caring presence' that is ultimately transformative, allowing clients to 'share the un-shareable' (p.173). Participants in the study emphasised this caring presence as a factor in creating a 'safe space' for the further disclosure of personal and emotional material. In opening themselves to their therapists, quite literally by

displaying their internal world upon chairs within the room, participants were inviting their therapists to see and hear them in a new and uniquely intimate way.

Kellogg (2015) also uses the metaphor of ‘midwife’ to capture the notion of the therapist as facilitator of natural processes (which might require assistance when blocked). Rather than midwife, the participants in the project identified their therapists as ‘coach’, with the attendant connotations of sporting or executive coaching for motivation, performance, and development. In the role of a coach, the therapist was experienced as emotionally encouraging and motivating, whilst also focused on enhancing skills and competencies in the task. This role could be considered facilitative in that the therapists sought to empower their clients to express their latent potential, elaborating and articulating motive-related emotion and cognition when the client stalled due to fears or lack of ability. There appeared to be a balance between positive encouragement and more focused, practical, support to build competencies such as present-moment awareness and introception, and the languaging of what was noticed. Examples of such therapist interventions included the mirroring, summarising, and affirming of participant expressions, both to validate their experiences and also to deepen their awareness of the material shared.

The therapists were shown to adopt both a facilitative and modifying role when fostering emotional expression, connection, and regulation. Heightened emotional expression and connection to threat-based emotions was often promoted by therapists’ close attunement to the body and their encouragement for participants to return their attention to somatic experiencing, often asking for micro-levels of detail in specific parts of the body. Emotional regulation was similarly facilitated by the therapist re-focusing attention to the body and coaching changes to breathing and posture. The therapists were also noted for their own embodiment of soothing qualities and modelling of compassion. Prior literature suggests the benefit of emotional arousal is mediated by the working alliance so that high emotional arousal within therapy is only beneficial in the presence of a strong alliance (Iwakabe et al., 2000; Beutler et al., 2000). For productive emotional processing to occur, Greenberg & Pascual-Leone (2006) have suggested the therapeutic relationship should function as a ‘“thermostat” for the “fire” of emotional arousal’ (p.619): adaptively regulating and soothing distressing emotion when the client is

overwhelmed, whilst also innervating and heightening arousal when arousal is unproductively low. The participants' experiences of the therapeutic relationship in the current study matches this description well, highlighting the therapists' dual role as both brake and accelerator of high affect. Participants emphasised the benefit of having an external regulator of their emotions which provided them the confidence and shared 'drive' to access and process greater levels of emotional intensity than they would have achieved alone.

The therapists' modifying stance was most evident in their role as 'director' or 'guide' through the procedural and practical tasks of the method. This role involved therapists providing 'leading' instructions that included requests to shift seats and position, guidance to access different mentalities, and prompts to move participants through the method's set structure (e.g., systematically asking each emotional self for their thoughts, feelings, action impulses, etc.). The notion of chairwork therapist as 'director' has links to chairwork's origins in psychodrama and its language of theatre. As a group approach, psychodrama requires a 'director' (Blatner 1988) who guides the named protagonist, enlists other group members in the drama, and organises the enactment on 'stage'. In one-to-one chairwork, the directorial dynamic has remained: for example, Goulding and Goulding (1997) suggest the 'therapist is the director of the drama, writer of some of the lines, and occasionally interpreter' (p.178). Given the considerable task demands of the approach- i.e., the requirement for physical movement and dramatic enactment, and the coordination of multiple-selves across as many as four chairs- it is perhaps no surprise that participants perceived their therapists as taking a more active and directive stance when compared to traditional, verbal-based sessions.

Participants notably valued the higher levels of instruction and authority from their therapists during the chairwork session. Such interactions were experienced as providing structure, certainty, and containment during an exercise that created high levels of arousal. The benefits also included the active management of avoidance, heightened immersion in the dialogue via repeated prompts, and support in maintaining separation between 'selves'. Within the literature of psychodrama, Kellerman (1992) warns of the potential for idealisation, regression, and enforced obedience in clients when therapists adopt the powerful role of 'director'. However, rather than enacting unhelpful dominance-subordination dynamics (which is perhaps a risk in

this client group), the therapists' active role was experienced as a form of supportive scaffolding, creating safeness and enhancing self-agency. Three participants explicitly stated the need for increased levels of direction, structure, and practical guidance and experienced the lack of authority in their therapist as undermining of their own confidence. Kellerman's (1992) own guidelines are perhaps helpful when considering how to mitigate against the drawbacks of directorial leadership in chairwork methods. He suggests that personality factors (e.g., demagogic skills) be balanced with professional competence, that power in the relationship be equalised, and that leaders be sensitive to their client's temporary needs to idealise and become dependent. Such guidelines could be considered in future CFT chairwork training and supervision. Therapists originally trained in non-directive therapy traditions may well benefit from additional support when navigating the new role-demands for facilitating chairwork.

In terms of empirical research on chairwork relationship factors, the literature is minimal and focused on EFT practice. A qualitative paper by Robinson et al., (2014) highlighted the benefit of participants observing and reflecting on other participants' chairwork during group-based EFT, whilst Munitgl et al.'s (2017) conversational analysis of the 'entry' stage to chairwork identified various interactive processes that supported client engagement. The detailed analysis of Muntigl et al., (2017) emphasised the therapist's role in shifting the client to a new 'setting' and 'frame' when starting chairwork whilst also supporting clients to navigate between 'speaker' (during enactment) and 'listener' (to their therapist's interjections). The paper also highlighted the therapists' balance between 'following' and 'guiding' orientations: *following* the client's own process and emotional experience, and then *guiding* them to achieve 'task alignment'. There are clear parallels with the terms, concepts, and experiences identified in the current project. Given the insights generated from a detailed focus on a specific stage of chairwork, there is the potential that conversational analysis might be fruitfully applied to phases of CFT chairwork (such as the application of the compassionate self) to explore how client and therapist navigate these changes in frame and focus.

Despite the benefits of relationship factors in facilitating the chairwork process, participants reported intense and visceral feelings of shame at being exposed to their therapists. Prior literature has found self-critical clients report embarrassment and awkwardness when engaging

in chairwork (Steigler et al., 2018) and can conceal the true extent of the self-criticism during experiential treatment (Nodtvedt et al., 2019). Given that participants were selected for CFT treatment due to the presence of shame it is perhaps no surprise that shame was experienced during the chairwork task; similarly, given that self-criticism and depression were pre-requisites for inclusion in the study, it is also predicable that participants adopted submissive or avoidant coping styles (such as pleasing and placating) to manage the interpersonal stress between themselves and their therapist. Whilst such aversive in-session experiences are distressing and potentially disruptive to the task, Nodtvedt et al., (2019) suggest that sharing distressing emotions live during experiential treatment can allow 'corrective' emotional experiences to be provided that model acceptance and compassion, mirroring the findings of the current papers. The expectations of negative judgement, pressure, criticism or lack of capacity for containment from the therapist could also be understood and explored in the context of transference (e.g., the therapist experienced as a school bully) and projection (e.g., projected fears about emotional containment). If identified and shared, shame-based experiences within CFT chairwork can therefore provide a therapeutic opportunity to gain insight into related past experiences and present-day coping, experiment with new ways of relating, and receive corrective care-based experiences.

One factor that appeared to mitigate the impact of shame, was the depth of the participant's relational history with their therapist. Participants stated that having '100% trust' in their therapist and feeling 'safe' in the relationship were 'crucial' requirements to engage in chairwork. Such qualities were born of the participants' lived experience of being cared for and supported during prior sessions and their therapist's appreciation of their history, needs, and preferences. For these reasons, chairwork is not typically used during the earlier stages of CFT treatment, and this is echoed in the clinical guidance of other modalities (e.g., Young et al., 2006). Utilising the language of Bordin (1979), an experiential 'task' is only proffered once the broader 'bond' has been established within the working alliance. Elliott and Greenberg (2021) are strikingly forthright on the matter:

'*The fact is, chair work simply won't work in the absence of a strong, genuine, caring, empathic counselling relationship. It should not be offered before session 3 or 4.'* (p.81)

In contrast, Pugh (2021) has pioneered the use of single-session chairwork whereby clients engage in experiential work within minutes of meeting their therapist. To support this process, Pugh suggests ‘warm up’ measures such as co-developing a ‘dialogical hypothesis’ before chairwork takes place and offering an opportunity to explore client fears and apprehension via an ‘interview’ procedure with the client’s ‘inner protector’. From a personal communication with Pugh, single-session clients have typically been health professionals or coaches and are self-selected in response to adverts. It may be that clinical subjects with depression and problematic shame and self-criticism require greater relational safety and history to engage in chairwork. It remains an important research question as to the optimal stage in therapy to conduct chairwork, what most beneficially proceeds chairwork in CFT, and what factors in the relationship or client’s presentation allow chairwork to be expedited.

The various roles attributed to the therapist during CFT chairwork can be understood through the lens of social mentality theory (see chapter 3). The therapist was positively experienced as both care-giver and collaborator, in addition to the higher-rank role of leader (i.e., as ‘director’ and ‘guide’). In dynamic reciprocation, participants could be formulated as adopting care-receiving and collaborative roles, as well as welcoming their therapists’ authority in leading and directing the task. Difficulties occurred when there was a lack of fluidity and flexibility between roles: for example, when a participant’s shame blocked care-receiving and they became encapsulated in rank-based relating, or when the therapist lacked the willingness or capacity to take on a leadership role. Within social mentality theory, the capacity for self-compassion is potentiated by receiving care from external others and utilises the same care-based mentalities (Hermanto & Zuroff, 2016). The findings from the current study suggest that receiving compassion from a therapist does indeed influence a client’s own capacity for self-compassion during CFT chairwork.

Many of the qualities experienced in the therapeutic relationship also overlap with the qualities and functions of a secure attachment relationship. This is particularly evident in the use of the therapist as a secure base from which to engage in new and difficult behaviours and as a safe haven to regulate distress. From participant feedback it appears that the therapeutic relationship

offers a model for the client's own compassionate self, which Gilbert (2020) suggests functions as an internal attachment figure that fosters self-generated encouragement and soothing. The way in which clients can utilise their therapist as a compassionate model, internalising them as a healthy 'internal working model' for care, has received minimal empirical attention within CFT literature. In the broader literature, Nissen-Lie et al. (2015) suggests that 'it is probable that therapists serve as a role model for their clients to internalise, which they take with them after the end of treatment, as an internal image to use in situations of distress' (p56). This chimes with how compassionate imagery (e.g., the compassionate self or other) is utilised within CFT (Lee, 2005). There is perhaps the potential within CFT for utilising the therapist more actively and intentionally as a model for care during chairwork, entering the enactment to speak directly to different parts of the self, particularly when the client requires support. This method of modelling a new care-based relationship within chairwork has precedence in the Schema therapy's 'limited reparenting' (Young et al., 2006) and could be adapted within a CFT frame. This might be achieved by increasing the focus on chairwork process skills such as 'doubling' or offering compassion-based 'feeding lines' (see chapter 3) (Kellogg, 2015).

The attachment function of the therapist can also be understood in terms of CFT's three-system model of emotional regulation. The therapy relationship can be conceptualised as providing feelings of soothing-safeness to modulate threat-based emotional reactions (safe haven), whilst also stimulating drive-based affects when 'coaching', reinforcing, and celebrating the client's engagement with the task (secure base). Difficulties in emotional reactions during the chairwork task could also be understood in terms of threat-based conditioning within the attachment system- e.g., feelings of anger, anxiety or shame when receiving care. The way in which the therapeutic relationship was utilised to modulate and balance the participants' emotions appeared particularly conducive to the chairwork method, with participants reporting how their confidence to face threat-based experiences was fostered by their felt sense of safeness within the relationship. Such safeness was not only created by interactions seeking to stimulate parasympathetic soothing, but also by the therapist's active and authoritative stance (mentioned above). Notably, when therapists were perceived as being too 'nice', and lacking such authority, participants were unable to bring the full force of their emotional expression. Given these findings, there is the potential for greater affect matching during CFT chairwork as part of the

‘coaching’ role discussed above. In terms of the range of emotions shared in the relationship, participants also reported the presence of ‘fun’ linked to experiences of play and creativity which are important aspects of a secure attachment relationship (e.g., Main, 1983). As playfulness is a core constituent of psychodramatic approaches (Blatner & Blatner, 1997), such methods provide an opportune means of helping clients to access and experiment with the kind of affective experiences associated with curiosity, exploration, and freedom.

Whilst beyond the scope of the current project, much has been written about the therapeutic relationship in psychotherapy. Research has consistently shown the therapeutic relationship to be the most significant factor in creating variance in psychotherapy outcomes (Norcross, 2002; Ardito & Rabellino, 2011; Horvath et al., 2011) and is a significant contributor to clinical outcomes in the treatment of depression (e.g., Zuroff & Blatt, 2006; Cameron et al., 2018). Given such findings it is not surprising that relationship factors are important in the delivery of chairwork for clients with depression. It is perhaps more surprising that relationship factors were so valued given that clients with higher levels of self-criticism have been found to experience reduced benefits from therapeutic core-conditions (Zuroff et al., 2016). There is considerable variation in how the therapeutic relationship is conceptualised in psychotherapy and how it is utilised either as a facilitator of treatment technologies or as a key agent of change (Gilbert & Leahy, 2007).). In CFT, Gilbert (2022) suggests that CFT’s psychoeducational frame, skills training, and the therapeutic alliance, ‘*all* contribute to outcome and are probably synergistic’ (p. 386). From participant accounts in this project, the therapeutic alliance was utilised both as agent of change (e.g., as model for compassion) and as facilitator of change (e.g., as ‘coach’ supporting the dialogical exchanges), but was an essential and inextricable factor in all aspects of the approach. The findings support Castonguay et al.’s (2006) assertion that the ‘therapeutic relationship cannot be viewed as a nonspecific variable that is merely auxiliary to other active components in treatment’ (p.277). As outlined in the discussion and analysis above, CFT chairwork is fundamentally grounded in relationships: between parts of the self, between client and therapist, and within multiple flows of compassion. The finding of the project highlight just how interconnected these internal and external relationships are during chairwork, and the unique opportunity it provides for the therapeutic alliance to influence a client’s intrapersonal world.

Clinical implications

The table below offers a summary of clinical guidelines based on the project's findings. The guidelines have been produced to give brief and concrete practitioner points for busy clinicians in the field.

Table 10.2 Clinical guidelines and practitioner points for CFT chairwork

No.	Clinical guidelines and practitioner points
1	The principle of self-multiplicity, facilitated by the process of separation, can be helpful in breaking down the inflexible, monolithic voice of depression into its constituent parts. This allows for greater options for therapeutic intervention and an enhanced awareness of the specific, idiosyncratic mechanisms maintaining a client's depression.
2	The notion of self-multiplicity appears to be acceptable to clients, helps to normalise and explain confusing internal experiences, can provide a sense of expanded possibility and flexibility, and offers the potential for re-organisation. Some clients may well benefit from additional support to help integrate the concept of self-multiplicity into their prior belief systems.
3	Separating and animating different parts of the self on different chairs can help clients to identify and explore the kind of relationships that exists between them. These processes allow clients to discover internal conflicts and acknowledge both 'giver' and 'receiver' of internal stimuli (e.g., a part of the self that attacks and a part of the self that is attacked).
4	When internal relationships are externalised and enacted between chairs it can be helpful to explore whether a client can recognise qualities of their self-to-self relationship in historic interpersonal relationships. This may provide insights into the external origin of internal relationships (e.g., self-criticism).
5	Self-criticism can be explained by social mentality theory as an internal rank-based dominant-subordinate relationship. During the CFT self-critic chairwork exercise, clients with depression typically experience submission and defeat in response to the self-critic's attack. In contrast, the compassionate self seeks to generate a care-giving

	to care-receiving reciprocation between itself and other aspects of self. Identifying the fear driving the critic can facilitate such care-based relating.
6	When the self is externalised and concretised in a separate chair it can be experienced as if it is a separate person. This experience of the self as 'other' allows clients to recruit the social-relational skills they use in their external relationships and apply them to their internal world. This phenomenon appears to facilitate self-compassion and related competencies, such as empathy. Having clients externalise their self-criticism (expressed as if to another) can also help clients to contrast how they relate to themselves and how they relate to others.
7	Externalising and concretising parts of the self on different chairs can be experienced as mapping out one's internal world in external space. This can provide a sense of inner-organisation and clarity. There is the potential to give clients more control over where and how they place their chairs as a means to represent the relationships between parts of the self. For example, during the multiple-selves exercise, clients could be encouraged to demonstrate which emotions are uppermost in their experience by placing one chair in front of another. Changing the seating arrangement could also allow clients to explore and represent new ways of responding (e.g., 'what would it be like to bring the angry self forward by moving its chair in front of anxious self? How does that feel?).
8	Moving from chair-to-chair, back-and-forth between parts of the self, can enhance a client's sense of self-efficacy and agency. The process of physically standing up to leave a part of the self on a set chair, and then walking towards a different self on a new chair, can foster new experiences of choice and power. This appears to be particularly helpful in clients with depression where a sense of agency and efficacy can be lacking.
9	The same process of stepping out of a chair and then looking back to the self in a concretised position provides a modulation between self-immersion and self-distancing. Seeing the self from a physical distance creates the phenomenon of psychological distance, allowing clients to observe their own experiences from a de-centered position. This position can enhance self-reflection whilst reducing affective arousal and can complement insights gained from mindfulness practices within CFT.

10	The multiple selves chairwork exercise offers a novel means to learn new skills in emotional regulation. The physical movement between chairs, and shift between self-distancing and immersion, allows clients to intensify emotional experiences and also to attenuate their intensity. This process may support emotional self-efficacy and distress tolerance. The framework of the multiple-selves exercise (different emotions in different chairs) provides a safe structure for clients to engage with threat-based emotions, allows compassion to be applied to each emotion in-turn, and may well increase the differentiation of negative emotions.
11	The multiple-selves intervention can help to generate insight into the client's threat-system and emotional profile: for example, identifying which emotion dominates or is most potentiated in a client's life, and which emotions are blocked or absent. This can provide helpful information about arrested defences and related unmet needs (e.g., the absence of anger and the reduced capacity for healthy protest and protection). Helpful questions include: *which emotion is the most and least accessible? Are there sequences of emotional activation (e.g., does anxiety follow sadness)? Do some emotions naturally focus inwards rather than outward? And do any emotions appear fused together or naturally arise together?* The multiple-selves chairwork provides a safe means for people with depression to explore the healthy expression of protective defences, broadening their role-repertoires.
12	Elaborating imagery in chairwork (i.e., imagining the person/being in the empty chair) can enhance the experience of 'authentic' social-relational exchange (i.e., a sense of talking to an 'other'). This can heighten the experience of sending and receiving social-signals, can aid differentiation, and can provide symbolic insight into the nature of self-parts and internal relationships.
13	It can be helpful to monitor for changes in spontaneous imagery during chairwork. Such changes can indicate and symbolise psychological changes, such as a shift in social mentality (e.g., the image of the self-critic shifting from 'monster' to 'frightened bully' when related to with compassion). Imagery of self-parts can also be assessed for their link to episodic memories, giving insight into their origins and adaptive nature.

14	The embodiment of self-parts (adopting the posture, facial expressions, gestures, and voice-tone of a particular self) can clarify their nature and function (e.g., noticing the clenched fists of the 'angry self'). Specific somatic markers can be used to anchor a client to each self-part and differentiate between them. The bi-directional influence between body and mind can be utilised to immerse clients into the internal world of each self (e.g., shaping the body to shape the mind). The body can also be used to de-role from each enactment by literally 'shaking off' each role.
15	Increasing embodiment and affective connection during chairwork can create 'heart-level' or 'felt-sense' changes in a client's belief system. Embodiment and affective connection can also encourage clients to 'feel' the impact and benefit of the exercises, creating insight into the impact of different forms of self-to-self relating (e.g., the feeling of being cared for).
16	CFT chairwork provides a means to demonstrate the integrative and relation-forming nature of compassion and care. The compassionate self can be used to understand, and care for, difficult aspects of the self and acknowledge their place within the broader self-system. Such care-based relating allows the compassionate self to take a containing or holding role (linking to the qualities of a secure attachment relationship). Utilising the compassionate self to identify the protective function, underpinning fears, and adaptive nature of different parts can facilitate this integrative process. When related to with compassion, parts of the self can be 'transformed' from hostile self-sabotaging voices (requiring suppression or avoidance) into aspects of the self that carry fear and vulnerability (requiring care) or into personal resources (requiring redirection for more helpful ends). The compassionate self can be experienced as a force that recruits multiple strands of internal experience to work for a common goal or value.
17	CFT chairwork allows for the procedural practice of core compassionate skills and attributes. In externalising and enacting self-compassion between chairs, therapists can highlight and coach specific care-related competencies, such as the capacity to empathise or mentalise. Having parts of the self separated, named, and concretised allows for compassion to be given in a focused and concentrated form.

18	During chairwork, the compassionate self can be utilised as a secure-base and safe-haven to support the engagement with threat-based material (i.e., moving to and from the compassionate chair). In CFT chairwork, the therapist can similarly function like a secure attachment figure for the client: celebrating and encouraging exploration and engagement with task as well as providing soothing and safeness. There is the potential that the therapy relationship can influence and model the way in which the client utilises and expresses the compassionate self.
19	The therapist is required to adopt multiple-roles during CFT chairwork. In addition to modelling compassionate qualities and relating (as above) this also includes witnessing and validating the client's experience and acting as a 'objective' reflective viewpoint. The therapist is also required to be an authoritative 'director' and 'guide' to help the client through the task, and to be a 'coach' in amplifying affective connection and immersion. Therapists are also valued as a source of soothing and emotional regulation and have a role in heightening their client's awareness of present-moment experiencing. The therapist's flexible movement between roles supports the client's own capacity to move between roles and mentalities (a process that can be explored and explained via social-mentality theory).
20	In CFT chairwork, the therapist can match the affect of the client to encourage the full expression of emotion. If the therapist models only 'soothing' (or is passive in managing the task) the client may not feel they have permission to share the extent of their threat-based emotion (e.g., the anger of the critic).
21	Chairwork can be experienced by clients as highly exposing, which can trigger feelings of shame. Whilst initially problematic (creating distance in the therapeutic relationship), there is the potential for clients to receive corrective emotional experiences when sharing distressing material. The client's shame-based reactions can also be explored in terms of transference and projection for additional insights and learning.
22	The depth of the relational history between therapist and client is important when engaging in CFT chairwork. It can be beneficial to establish trust, shared knowledge, and feelings of relational safeness before starting chairwork. This may well be more important in clients with problematic shame and self-criticism. The depth of safeness

	and trust within the relationship appears to foster greater confidence in the method and an increased capacity for creativity and play.
23	Clients who have a highly rational and over-controlled style of processing and relating might initially find chairwork difficult. The spontaneous and playful nature of chairwork may well help this client group to experiment with new ways of behaving and relating if their initial resistance can be overcome.
24	Chairwork exercises can be approached as experiential assessments. When encountering difficulties in accessing, leaving, differentiating, or tolerating particular self-states, such difficulties can provide helpful information about a client's internal world. For example, if emotional voices appear to be blending together (e.g., the 'anxious self' continuing to speak over the 'angry self'), this can reveal an important relationship. Rather than conceptualising such events as performance 'failures', such blocks or problems can then become the 'path' and focus for treatment.

Strengths, limitations, and research recommendations

This section discusses the strengths and limitations of the project and builds upon the suggestions for future research already made within the discussion.

The four markers of high-quality IPA, as posited in a recent paper by Nizza et al., (2021), have proved helpful when reflecting on the relative strengths of the project. In terms of constructing a compelling narrative (marker one), chapters six to nine provide a coherent story of client experiences across two chairwork interventions. A benefit of studying two interventions, which cultivate and target similar processes, is that convergence and divergence (marker two) are more apparent across a broader range of participants. The analysis of participant experience from the second intervention deepened and extended insights gained from the study of the first, allowing for the development of a richer and more nuanced experiential account of shared phenomena (marker three). In a further enactment of the interpretative cycle, the insights gained from study two had me return to the raw data of the first study for further analysis, clarifying the presence and importance of relationship factors across both studies (as seen in chapter nine). This is perhaps one example of the close analytic reading required for IPA (marker four), demonstrating the iterative movement between part and whole, within and across cases. The ways in which the

project sought to meet general benchmarks for quality in qualitative research are discussed in chapter 5.

A strength of the project is the idiographic commitment shown throughout the analytic process. Participant's accounts were analysed on a case-by-case basis, before moving to group-level thematic development, and a conscious effort was made to meet each participant account on its own terms. This was facilitated by keeping a reflective diary and discussing my analysis in supervision to acknowledge and manage my evolving expectations and assumptions between cases. The same methods were used to monitor for the importation of extant formal theory (such as the evolutionary framework of the CFT model) during the analytic process. The analytic narratives are written in a way that allows for specific participants to be tracked throughout (and across) the studies, so that individual voices can be heard. The verbatim quotes are also spread across multiple participants to include and promote the accounts of a variety of individual contributors.

The data generated in the study was suitably phenomenological in nature, resulting in themes relating to embodiment, the experiencing and expression of subjective experience, the experience of 'self', moments of high emotion and 'hot cognitions' (all areas suitable for IPA, as outlined by Smith et al., 2009). The accounts generated at interview were also fittingly reflective in character, with participants actively encouraged to make-sense of their experiences and its importance within their broader life-world. A strength of the analysis section is its emphasis on 'different levels of experiential significance' (Nizza et al., 2021, p.375) and the hermeneutic cycling between part and whole. Such a movement is evident in the fine-grain analysis of specific words from a participant's account (e.g., their verb-choice, use of metaphor, or temporal-framing), and the contextualisation of its meaning when reviewing the account as a whole. An example is the analysis of Susan's spatial language (referring to a self's 'place' or position') and the insights this provided into her efforts to 'map out' her inner-world in the concrete positioning of chairs. A strength of the project therefore lies in the balance between providing a 'thick' reading of resonant details within a participant's account and the willingness to make 'grounded' interpretative claims of wider significance. The reflexivity section below discusses the personal difficulties encountered in making this interpretative 'leap'.

One of the limitations of the project is the lack of diagnostic test for Major Depressive Disorder as part of the eligibility criteria. Both studies could have been strengthened by utilising the Structured Clinical Interview for DSM-V Disorders (SCID-5) (APA, 2016) to provide greater evidence of a depressive 'disorder' in the sample. However, such diagnostic interviews are not typically used within primary care IAPT services where the research was based. In terms of ecological validity, the project incorporated screening and assessment processes used by IAPT therapists as part of their core duties (National IAPT Programme Team, 2011). This included the use of screening measures with set clinical 'cut-off' points, the requirement for a 'provisional diagnosis' of depression as assed by qualified clinicians, and the application of additional disorder-specific measures (e.g., the BDI). Participants were, however, not excluded for the presence of co-morbidity, and there is the potential that the presence of other 'disorders' influenced participants' experiences and reports.

Given the idiographic, qualitative focus of the current project, additional research might explore the presence of the findings in a larger sample, using questionnaires and quantitative methodology. Both the multiple-selves and self-critic exercises could be evaluated empirically as stand-alone interventions. It remains unknown whether either intervention creates any 'objective' changes in symptomology relating to mood, shame, or self-criticism, or whether the interventions increase levels of compassion or self-reassurance on psychometric measures. For the multiple-selves intervention, measures of emotional differentiation or regulation might also be utilised in future studies (e.g., Licht & Chabot, 2007). Changes in compassion could be measured across its multiple flows, using the Compassion Engagement and Action Scale (Gilbert et al., 2017), which was not published when this project began.

It would also be of interest whether benefits reported in the studies are retained over time, how clients utilise or incorporate their new learning into their daily lives, and how clients fare when faced with 'real-life' stressors (such as a contemporaneous interpersonal conflict). In terms of the self-critic chairwork, it remains unclear whether the intervention delivers lasting benefit in the intensity or frequency of self-criticism, whether it influences depressogenic behaviour, and whether self-to-self relating is significantly altered over time. In terms of the multiple-selves

intervention, it is unknown whether meta-emotional traits are meaningfully changed (future research might utilise meta-emotional scales- e.g., Mitmansgruber et al., 2009) and whether improvements are made in emotional regulation, interpersonal coping, or attitudes towards emotions (all of which are factors that influence depression, e.g., Yoon et al., 2018). One potential would be to conduct research with follow up interviews over different time-points.

It is also acknowledged that, in both studies, there was an appreciable variance in the number of CFT therapy sessions preceding the chairwork intervention (e.g., from session 6 to 16 in study one). There was also considerable divergence in the type of interventions undertaken before chairwork. It therefore remains an unanswered question as to when chairwork should be introduced within a course of CFT and what should precede it to optimise its effectiveness. Whilst there was a minimum training requirement for eligible therapists, further research might explore whether specific therapist characteristics and training experiences influence outcome. The majority of therapists involved in the study use CBT as their main modality of therapy; future research might therefore assess whether therapists drawn from other modalities (e.g., person-centered counselling) apply CFT chairwork in a different manner, creating different outcomes.

The importance of relationship factors to the chairwork tasks was not predicted during the design stage of the research but was identified when reviewing the resultant corpus of data. The interview schedule was therefore not tailored to explore the relationship dynamics experienced by clients and there is the potential that this reduced the richness and variety of responses. Further research might build upon the findings here to examine relationship factors during specific stages of CFT chairwork, such as enlisting consent, shifting to the compassionate self, or reviewing the intervention. It is also acknowledged that, as participants were selected by their therapists, the sample in the study may be biased towards ‘positive’ cases where client were well engaged in treatment and the therapeutic bond was well established. Initially the project sought to explore therapists’ experiences of delivering chairwork by interviewing each participant’s therapist after the intervention. This stage of the research was later discarded as the data was not sufficiently ‘phenomenological’ for IPA analysis: it typically involved therapists reflecting on their client’s experiences rather than reflecting on their own. Despite not fitting with the aims

and methodology of this current project, further research might focus on therapists' experience of delivering CFT chairwork, exploring factors that impede or facilitate chairwork delivery, how client blocks or 'resistances' are navigated during the task, or what influences the decision-making process to offer chairwork.

Further research might also compare imaginal and chairwork interventions for self-criticism. Gilbert (2007) has previously suggested that using mental imagery to visualise the inner critic can create insights into its nature and function. Subsequently, the compassionate self can be focused on the inner critic via imaginal means to acknowledge its role and to care for what drives it (Irons & Beaumont, 2017). Such imaginal practices share common features with self-critic chairwork but lack chairwork's emphasis on movement and embodiment. Further research might evaluate and compare both interventions and explore whether such enactive processes have any additive benefits or create different forms of change. It would be of interest to assess whether an imagery-based intervention is experienced as more private than chairwork and how this influences the experience of shame-based exposure within the relationship. The multiple-selves chairwork could similarly be compared to written methods, whereby each emotional self is articulated via expressive writing (Kolts et al., 2018), or group-based applications of the framework, using a 'white-board' rather than enactive methods (Cattani et al., 2022). Exploring the potential to adapt both the self-critic and multiple-selves chairwork to alternate forms of delivery is particularly important given the move to online working during the COVID pandemic. Research on online adaptations has highlighted both the benefits and obstacles of digital chairwork (Pugh et al., 2021), and suggestions have been made to revert to a 'process-based' orientation to guide new developments (Pugh & Bell, 2020).

Additional areas for future research include the potential to devise and evaluate home-practice following the chairwork intervention. This might include techniques to continue dialogic or relational exchanges such as letter-writing: for example, writing from the compassionate self to the self-critic. Journaling or expressive writing might also be utilised to continue emotional processing and integrate evidence-based narrative approaches that elaborate or change the stories told by specific voices (Olthof et al., 2018). 'Awareness homework' has been suggested following chairwork, as a means to transform 'automatic processing into controlled processing'

(Elliot & Greenberg, 2021, p.90), but this has not been evaluated. Another area for further research is the way in which participants were able to experience themselves from both inside and outside during chairwork, with the potential to manipulate this experimentally within a therapy context. Petrocchi et al. (2017) have already targeted the same processes when incorporating a mirror into self-compassion practices. Whilst empirical studies are warranted, 'the distinction between the body as subject and body as object is a phenomenological distinction' (Zahavi, 2019, p.83). Further phenomenological research could focus specifically on this notion of self-compassion as both a giving and receiving process, and explore whether externalisation facilitates both 'flows'. One example might be to investigate how soothing-rhythm breathing is experienced by clients as this practice can involve offering soothing touch to oneself. Again, phenomenogy is the ideal vehicle to explore the kind of 'double-touch' and 'double sensation' discussed by Husserl and Merleau-Ponty (Morris, 2010), whereby the body is both giver and receiver of sensation.

The study of the self-critic chairwork focused on only one form of self-criticism. Whilst self-criticism can have many forms, functions, and sources (see chapter two), Gilbert (2007) has repeatedly made a distinction between 'self-improving self-criticism' (p. 281) and self-hatred. This distinction is maintained in the Forms of Self-Criticizing/Attacking and Self-Reassurance Scale (FSCRS) (Gilbert et al., 2004) which was used within this project. Self-hatred and contempt, feelings of self-disgust, and a desire to hurt or destroy the self or aspects of it, are more commonly experienced in clinical samples (Gilbert, 2010; Gilbert et al., 2004). Gilbert (2007) has suggested self-hatred 'can be linked to the degree of depression and other complexities, such as personality disorders' (p.281). Gilbert (2010) has previously framed the voice of self-hatred as an internalisation of an abusive external relationship, and participants in the first study did link their critic to external voices from their past. Examples of such internalisation were discovered via imagery generated during the exercise which suggests a potential benefit of using imagery to identify the origin of such hostile self-relating. It is also of note, that participants in these studies reported elevated levels of self-hatred on the FSCRS measure when compared to non-clinical samples (Baiao et al., 2015) (see chapter 5 for details). Whilst self-hatred and self-criticism are not mutually exclusive, a potential limitation of the current project is that participants high in self-hatred were not excluded from the sample, and

that the interview schedule did not specifically ask about self-hatred to explore or differentiate its influence.

Gilbert (2010) has previously suggested that if the inner critic is felt to be the voice of a past abuser, then therapy should proceed by labelling it as “not self”, inviting it to leave, or handling it assertively, ‘with empty chair work, or with trauma rescripting’ (Gilbert, 2010, p.170). These suggestions have received minimal elaboration within CFT literature and there is the potential to develop and evaluate CFT specific intervention for ‘abusive’ voices. Schema therapy, for example, includes imaginal and chair-based confrontations with abusive figures or ‘parent modes’ as a core element of its evidence-based approaches for personality disorders (Arntz & Jacob, 2013). Historic role-play or dyadic psychodrama (Arntz & Weertman, 1999; Beck et al., 1990; Roediger et al., 2018) are also chair-based means for re-enacting upsetting memories to challenge internalised attributions of blame and fault. Trauma-focused CFT chairwork has been suggested as a means to utilise the compassionate self to address internalised abusive ‘others’ (Bell, 2022), but these methods remain unevaluated. Future research might clarify how CFT chairwork might be adapted to activate or address the anger, ‘rebellion’, guilt, and grief, that are typically encountered when challenging parental views of the self (Gilbert & Irons, 2005).

In terms of the multiple-selves exercise, further research might examine whether the unblocking and activation of one emotion (such as anger), correlates with reductions in other emotions (such as anxiety) following the exercise. Such a finding would support the theoretical assertion that the expression of healthy defences (such as angry self’s assertiveness) obviates the need for maladaptive emotional reactions and coping (e.g., anxious self’s submissiveness and monitoring of other’s minds) (Gilbert, 1992). Similarly, further research might empirically explore whether CFT chairwork that facilitates the expression of external anger reduces the levels of internalised anger and self-criticism (as has been suggested in prior EFT studies; Kramer & Pascual-Leone, 2015). It would also be of interest to investigate whether feelings of safeness and soothing (associated with compassionate mind training) influence the client’s depth of experiencing and expression of threat-based emotion, and in return, whether the expression of threat-based emotions and related protective strategies increases feelings of personal safeness.

The multiple-selves exercise used within the current project focused on socialisation and experiential psycho-education, utilising a memory of a recent interpersonal conflict. The same format can be used for the emotional processing of intrusive memories that typify post-traumatic stress disorder (PTSD) (Hackmann et al., 2004). This method might involve targeting a specific traumatic memory and facilitating the full expression of each threat-focused emotion via chairwork with an emphasis on accessing emotions that were restricted or absent during the peri- or post-traumatic period. Whilst CFT multiple-selves processing is used in this way by NHS trauma services (Deborah Lee, personal communication), there is currently no research to support its use. A similar emotion-focused approach to trauma-memory processing is found in the work of Cloitre et al., (2020) (who suggest separating 'narratives' of fear, shame, and loss) and in EFT orientations to trauma and imaginal confrontation (Paivio & Pascual-Leone, 2010). The current project highlights how chairwork's concrete structure and externalisation procedures could offer a containing alternative to imaginal re-scripting of traumatic memories. A multiple-selves approach might be integrated into historic role-plays, whereby chairwork is used to re-enact and change painful interactions from the past (Arntz and Weertman, 1999). CFT chairwork might offer additional benefits over traditional approaches to trauma in its use of the compassionate self to modulate emotional experiencing (i.e., as a source of soothing or encouragement) or to integrate self-experiences that are fragmented during traumatic processing. This maybe particularly pertinent during attachment-based trauma where motives and affective experiences are in inherent conflict (e.g., the child seeks care from the parent that has caused the harm) (Fisher, 2017).

Focusing on intrusive memories in depression using the multiple-selves framework holds particular promise. Intrusive memories in depression are common experiences, create intensive feelings of 're-experiencing' a distressing event, and are 'likely to play a significant role in maintaining the patient's depressive mood' (Patel et al., 2007, p.2573). For clients with intrusive memories and depression, imagery rescripting has a large and lasting treatment effect on mood, even as a stand-alone intervention (Brewin et al., 2009; Wheatley et al., 2007). Transformations in imaginal rescripting for depression focus on creating experiences of compassion/soothing and mastery/power, and in changing meaning in the 'fires of affect' (Wheatley & Hackmann, 2011), all of which overlaps with the experiences reported during the multiple-selves work. Similarly,

shame memories function like trauma memories (in terms of their intrusive 're-experiencing' qualities) and act as 'central' reference points for a person's self-identify (Matos & Pinto-Gouveia, 2014; Pinto-Gouveia & Matos, 2011). The multiple selves method could well be developed to target shame memories in depression and offer a novel means for processing such 'touchstone' memories that act as a turning point for an individual's sense of self.

Reflexivity

As discussed throughout the project, the analytic process within IPA is acknowledged as an inherently interpretative endeavour: 'for IPA, analysis always involves interpretation' (Smith et al., 2009, p.35). IPA is underpinned by hermeneutic philosophy and methods and foregrounds the interpretative role of the researcher. Smith et al. (2009) are explicit about the impossibility of 'screening out' personal assumptions and acknowledge Heidegger's (1927/62) assertion that 'an interpretation is never a pre-suppositionless apprehending of something presented to us' (p.192). Instead, Smith et al., (2009) encourage an ongoing reflection on the way in which the researcher's 'fore-structures' gives access to phenomena but also de-limits what can be known. Understanding is deemed to arise from 'working out the fore-structures in terms of the things themselves' (Heidegger, 1927/62, p.195), so that the researcher's fore-structures are discernable and recursively shaped by engagement with the subject of study. The idea of 'bracketing' in IPA is therefore seen as an 'enlivened' and cyclical process which can only ever be 'partially achieved' (Smith et al., 2009, p.25). The practice of interpretation therefore requires continuous reflexive engagement to acknowledge the dynamic and complex way in which understanding is derived. As mentioned above, the analysis in this project was supported by keeping a contemporaneous reflective diary. A summary of my reflections is offered below.

In approaching the topic, I acknowledged that my interpretations would be grounded in my personal experience and practice as a psychotherapist specialising in CFT. I expected the chairwork practices to be effective, based on my own application of the method, and recognised my hope that the approach would be beneficial, well-received, and meaningful for participants. Given the potential for this orientation to shape my analysis and focus, I sought to balance this influence by actively listening for neutral or negative experiences in participants' accounts. I also avoided the use of jargon and theoretical terms to reduce the professional short-cuts taken when

formulating and categorising client experience as a therapist. Whilst acknowledging that psychological theories, such as attachment theory, are important in my own sense-making and personal ‘horizon’, I sought to engage with each client’s experiences on their ‘own terms’, simplifying my language and questioning my own authority over the meaning given to specific phenomena. One such example was in the client’s use of the term ‘compassion’. Within CFT, the term has a specific, operationalised meaning, and I was aware of some internal disagreement with how clients articulated their understanding and experience of compassion. In catching my own reaction, I was able listen more openly to what was being shared with me and what I had missed in my initial ‘critical’ interpretation; in turn, this orientation expanded my own perception of how compassion can be understood and applied. This openness of attitude, and willingness to be challenged and changed by the ongoing dialogue between fore-structure and subject, appears in keeping with Gadamer’s (1960/1990) statement that ‘dialectic consists not in trying to discover the weakness of what is said, but in bringing out its real strength’ (p.367). The idea of transformation occurring in dialogue appears to be particularly apposite given the nature of the project (the dialogical exchange between percepts in chairs) and its aims (to learn directly from client experience).

The influence of my dual role (as a clinician and researcher) was also noted during the interview process. As a therapist I have benefitted from training in questioning and listening skills, with an emphasis on building interpersonal trust and safeness. As a CFT practitioner, I have also experienced working with clients with high levels of shame and relational threat. Whilst these skills may have supported participant engagement and disclosure during the interview process, I also identified a tendency to be overly empathic, confounding the role of therapist and researcher. Examples of this included the validation of particular experiences which, on listening to audio recordings of such interviews, appeared to subtly reinforce and encourage the selective sharing of specific experiences. To mitigate and manage this influence, I sought feedback on my interview transcriptions, attended IPA interview training, and practiced with my peers. I was also able to recognise the specific occasions which appeared to stimulate my expressions of empathy (e.g., when sadness was shown) and reflect on my related presumptions (e.g., that sadness is the expected and ‘natural’ response to being criticised). By seeking to remain curious and neutral when these occasions recurred, I was able to identify experiences and perceptions in participants

that challenged my own: for example, in discovering how certain participants valued the self-critic's anger and sought to re-channel, rather than reduce, it's power.

I also used my reflective diary to monitor the impact of my past depression (see introduction) on my assumptions and analysis. This included a broader reflection on my motivation to work with this client group and my (over)investment in contributing to the alleviation of the distress that depression causes. I reflected that my personal experiences offered access to insights that can, perhaps, only be derived from lived experience (such as the physicality of aspects of depression), yet these same insights acted to obscure my openness to difference. I reflected on a tendency to assume my experiences were universal in people with depression and acknowledged how invested I had become in privileging my 'authentic' perspective, making me less flexible in my analysis. To monitor for this influence, and mitigate confirmation bias, I sought to document my assumptions about depression and repeated each stage of analysis to identify variance and contradictions to my anticipations. I also recommenced personal therapy to provide an additional safe space in which to acknowledge and reflect on the legacy of my depression outside of the analytic process but also to support it. Much of my reflection was informed by the work of Dwyer and Buckle (2009) and their discussion of the strengths, complexities, and problems of conducting qualitative analysis from an 'insider' perspective. Utilising the concept of 'membership status', I further reflected on how my status as both 'insider' and 'outsider' could be leveraged to generate multiple perspectives on the same experience (moving away from any claims to a single truth, but rather seeking to create a situated and perspectival account of multiple truths).

Another area where I was aware of challenges and transformations in my fore-structures was in 'discovering' the importance of relational factors to the chairwork process. In retrospect, this appears to have been a significant 'blind-spot' during the initial analysis of the first study. In reviewing my reflective diary and my analytic note-keeping I can identify a narrowing of focus on chairwork as a technique (and on what is specific about it as a procedure) at the cost of considering common factors shared with other methods and modalities. Only when working with the larger corpus of data, with participants across both studies, did the importance of relationship factors become more apparent. This led to a re-reading and analysis of each client, to produce the

final narrative account in chapter nine. Whilst providing a helpful reminder of the ‘thoroughly partial’ nature of understanding (Richardson, 2000), it also highlighted the potential benefit in utilising a large sample of participants, or the possibility of combining and comparing studies to build towards more general claims (utilising, for example, the analytic induction methods proposed by Robson 1993). However, bringing together such a large number of participants pushed at the limits of idiography, as individual voices were subsumed within the group-level analysis. Whilst utilising Smith et al.’s (2009) suggestions for analysing larger samples (e.g., using tables to show the spread of themes), I particularly made use of supervision to prevent the thinning of analysis or reliance on numerical (quasi-quantitative) measurements of ‘recurrence’ of themes across cases.

I also reflected on my initial reluctance to move beyond a descriptive analysis of participants’ accounts towards my own interpretation of their meaning. As Nizza et al. (2021) have asserted, in IPA ‘quotes should not be left to speak for themselves but require further analysis on the part of the researcher to explore their significance’ (p.375). I can acknowledge that I was guilty of the kind of ‘novice’ practice addressed in Smith et al.’s (2009) comment that ‘novice researchers tend to be too cautious, producing analyses that are too descriptive’ (p.103). I reflected that my hesitancy related to concerns of speaking over, or speaking for, other people and made links to personal ‘rules’, relating to my own upbringing, requiring me to defer my voice whilst privileging that of others. Acknowledging this influence encouraged me to take greater ownership of my own contributions and make greater interpretative ‘risks’ when analysing the significance in the accounts of others. Such ‘risks’ were discussed in supervision and evidenced in the detailed analysis of specific elements within the text (as discussed above). This repeated looping of the hermeneutic cycle- moving between part and whole- strengthened my ability and confidence to ‘dig deeper’ (Smith et al., 2009, p.103) in my interpretations.

Chapter summary and conclusion

This chapter started with a summary of the project and a re-statement of the research question: ‘how do clients with depression, self-criticism, and shame experience chairwork interventions in CFT?’. This question was then addressed by generating and discussing six project-level super-ordinate themes: self-multiplicity; externalisation and personification; using the body

(embodiment, enactment, and movement); emotional activation and complexity; integrating and transforming with compassion; relational factors and the therapist's multiple roles. The meaning and significance of each theme was explored in dialogue with relevant prior literature: utilising the literature to explain and contextualise the findings, and utilising the findings to illuminate, challenge, or extend the extant literature.

In terms of self-multiplicity, the project's findings were related to core chairwork principles and discussed in the context of social mentality theory. Key findings highlighted the role of self-multiplicity in the broadening of self-concept, the identification of relationships between selves, and the normalisation of self-complexity. The theme of externalisation and personification was discussed in terms of self-immersion and self-distancing, and the development of an 'observing ego' to gain a reflective overview of parts and their relationship. Within this theme, the role of imagery was discussed as means to aid personification, to make links with memory, and to mark change. The theme of 'using the body' was explored in terms of accessing implicit knowledge, deepening connection to selves, and, conversely, disconnecting from selves (e.g., via movement between chairs). A discussion of embodiment linked the project's findings to broader theories, such as embodied cognition, and highlighted its importance to the treatment of depression.

The discussion continued with the theme of emotional activation and complexity and considered the importance of emotional differentiation and activation within the treatment of depression. Discussion points included the role of emotion in self-criticism and the presence of idiosyncratic emotional profiles in participants (which were explained via theories of emotional conditioning and arrested defences). The theme of integrating and transforming with compassion was explored in the broader context of CFT literature and theory, including the consideration of core compassionate skills and attributes. The integrative role of the compassion and the compassionate self was further elaborated and linked to broader psychological theory and chairwork practice. The final theme focused on relationship factors and the multiple ways in which the therapist was experienced during the interventions. The findings were conceptualised within the context of both CFT and chairwork literature and the various ways in which the therapeutic relationship can be understood and utilised. The analysis emphasised the need for therapists to move flexibly through multiple roles with contrasting functions (e.g., both

amplifying and soothing the client's emotions), whilst being attentive to experiences of client shame and exposure.

The primary aim of the project was to produce an interpretive phenomenological account of clients' experiences of CFT chairwork to understand what was learnt and valued from the interventions. This aim has been achieved via the analysis and discussion above. The secondary aim of the project was to improve how CFT chairwork is trained and delivered. To meet this aim, a set of clinical guidelines has been produced, based on insights gained from the analysis of client experience. The guidelines include the intentional amplification of chairwork's mechanisms of change- such as the modulation between self-immersion and self-distancing- as well as process suggestions to facilitate the method. CFT specific recommendations were also made to clarify and operationalise the role of the compassionate self within chairwork practice. The chapter ended with a reflection on the project's strength and limitations, and a section of personal reflexivity. The research was discussed in the context of established markers of quality in IPA, and the way in which they were achieved. The strengths of the project included the commitment to idiography throughout the analytic process and the retention of individual voices within the group-level narrative. The limitations of the study included the lack of a diagnostic test for depression, and the potential bias towards positive cases given the recruitment strategy. Recommendations for future research included adapting and evaluating CFT for self-hatred (as differentiated from self-criticism), comparing the effects of chairwork and imagery interventions on the same material, and exploring whether the insights and benefits reported during the research are retained overtime or create any significant impact on clinical symptomatology.

In conclusion, the project contains the first research conducted on CFT chairwork and suggests the method is both well-tolerated and effective in facilitating compassionate self-to-self relating. In terms of implications for the practice of chairwork, the project presents novel findings on chairwork process (such as the spontaneous changes of imagery) whilst providing qualitive accounts that support and extend prior research findings (e.g., regarding the importance of embodiment) and clinical practice (e.g., regarding the benefit of 'speaking to' rather than 'about' a part of the self). In terms of the implications for CFT theory and practice, the research highlights the integrative and relation-forming role of the compassionate self and provides

evidence that clients appreciate and understand this integrative function. The findings also indicate ways in which the therapeutic relationship can be understood and utilised within CFT, particularly when engaging in experiential methods.

The project demonstrates how the use of chairwork in CFT is a complementary match of method and theory. For example, chairwork offers CFT a concrete means to demonstrate the power of switching motives and mentalities, and how this creates markedly different forms of self-relating. Chairwork can also be used in CFT to increase the differentiation of threat-based states to facilitate the focused application of compassion. In practice, chairwork was shown to be intensely relational and dialogic in nature, allowing clients to enact the giving and receiving of compassion across its multiple flows, all within the same exercise. Chairwork not only externalises internal relationships, allowing them to be witnessed and engaged with compassionately, but also facilitates the internalisation of compassionate external relating, with the therapist's actions during the exercise being used as a compassionate model for participants' self-to-self relating.

Both the chairwork procedures studied in this project showed promise for clients with depression, self-criticism, and shame. The self-critic chairwork was particularly helpful in highlighting the impact of harsh, rank-based internal relating and its activation of subordinate/submissive mentalities that maintain depression and shame. The same exercise helped participants to disengage from such internal roles and experience a new, care-based, way of working with the threat-system and the idiosyncratic fears that drive it. The multiple-selves exercise highlighted the emotional complexity in depression, helped participants to explore and express healthy defences that can be blocked by depression, self-criticism, and shame, and allowed for both emotional differentiation and integration using the compassion mind.

Finally, the project affirms the importance of promoting and privileging client voices when seeking to develop psychotherapies and clarify their mechanisms of change. IPA has proved to be an ideal methodology to address the highly emotional, personal, and relational experiences generated during chairwork. The phenomenological orientation of IPA was well suited to the multi-sensory and affective nature of the chairwork's experiential methods and provided a

method of enquiry to explore the role of embodiment and enactment in the approach. The phenomenological turn away from ‘objective’ reality and towards phenomena as it arises to consciousness created access to rich introspective and perceptual details in participants, such as how the self was experienced as an ‘other’ when imagined on an empty chair. The significance of such experiences was understood by applying the hermeneutic methods of IPA and navigating the complex nature of intersubjective meaning-making as it occurred within the psychotherapy process and interpretative analysis. The aim to fore-front client voices was also served by the influence of idiography in IPA and the commitment to understand and embrace what is unique to each case. As the first research on CFT chairwork it is fitting that the development of the method is shaped by the voices of those that matter most.

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