'A definite feel-it moment': Embodiment, externalization and emotion during chair-work in compassion-focused therapy

Abstract

Chair-work is an experiential method used within compassion-focused therapy (CFT) to apply compassion to various aspects of the self. This is the first study of CFT chair-work and is focused on clients' lived experiences of a chair-work intervention for self-criticism. Twelve participants with depression were interviewed following the chair-work intervention and the resulting data was examined using Interpretative Phenomenological Analysis (IPA). Three superordinate themes were identified: 'embodiment and enactment', 'externalizing the self in physical form' and 'emotional intensity'. The findings suggest the importance of accessing and expressing various emotions connected with self-criticism, whilst highlighting the potential for client distress and avoidance during the intervention. The role of embodying, enacting and physically situating aspects of the self in different chairs is also suggested to be an important mechanism of change in CFT chair-work. The findings are discussed in terms of clinical implications, emphasizing how core CFT concepts and practices are facilitated by the chair-work process.

INTRODUCTION

Compassion-focused therapy

Compassion-focused therapy (CFT) is an integrative psychotherapy model that draws upon evolutionary, developmental and social psychology; affective neuroscience; and Buddhist psychology (Gilbert, 2010). The therapy focuses on the cultivation and application of compassion for both self and others and was originally developed for clients with high-levels of self-criticism and shame. In CFT, compassion is defined as 'a sensitivity to suffering in self and others with a commitment to try to alleviate and prevent it' (p11, Gilbert, 2017). Compassion is seen as rooted in evolved caring motivational systems and their physiological infrastructure, and the therapy highlights the ways in which different motivations organize a range of physiological and psychological processes (Gilbert, 2005).

As a psychotherapy model CFT has been shown to be effective for a variety of mental health disorders in clinical populations (see Leaviss, & Uttley 2015, for an early systematic review). In application, CFT is a multi-modal therapy that integrates various psychotherapeutic approaches to access and direct affiliative motivations, emotions and competencies associated with compassion (Gilbert, 2010). CFT includes 'compassionate mind training' which involves activities such as mindfulness and

attention training, compassionate imagery and somatic focusing, before applying the

client's 'compassionate mind' to areas of difficulty and need. This latter task can involve

interventions such as expressive letter writing, exposure tasks, memory re-scripting and

chair-work (Gilbert, & Irons, 2005).

Chair-work in psychotherapy

'Chair-work' denotes a group of experiential psychotherapeutic techniques that

incorporate chairs, the positioning of chairs and the client's movement between them.

The chair-work method has a rich history in psychotherapy, originating in psychodrama

(Moreno, 1948) and developed in gestalt therapy (Perls, 1973) and emotion-focused

therapy (EFT) (Greenberg, Rice, & Elliott, 1993). Chair-work has also featured in the

development of both cognitive and behavioural therapy (see Pugh, 2017) and plays

significant role in integrative therapies, such as schema therapy (e.g. Arntz, & Jacob,

2013). Given the various therapeutic modalities in which chair-work is applied, there is

considerable variation in its form and function (e.g. chair-work might be focused on

enacting 'external' or 'internal' dialogue depending on its inter- or intra-personal focus).

There are also various conceptualizations of its mechanism of action which include: the

development of metacognitive insight and decentering (Chadwick, 2003), emotional

processing (Diamond, Rochman, & Amir, 2010) and the development of a plurality of

internal 'voices', 'schemas' or 'mentalities' that can be heard, understood and related to

in novel ways (e.g. Arntz, & Jacob, 2013; Gilbert, 2010).

Whilst much of the outcome research on chair-work is preliminary (see Pugh, 2017, for review), technique comparison studies have been notable in demonstrating how chair work had a greater impact in reducing mental health problems such as depression, anxiety and self-criticism, when compared to 'relationship conditions' alone (e.g. Stiegler, Molde, and Schanche, 2017). Chair work has also been shown to outperform written cognitive interventions, in key clinical areas, when addressing the same material (de Oliveira et al., 2012). Stand-alone studies of chair-work have shown particular benefit in targeting and reducing self-criticism and associated emotional distress (e.g. Shahar et al., 2011). In terms of client experience of chair-work, research has highlighted the emotionally intense but transformative nature of the approach, frequently identifying a movement from initial aversion to greater intra-personal awareness and insight (e.g. Stiegler, Binder, Hjeltnes, Stige, & Schanche, 2018).

CFT chair-work and its application with self-criticism

CFT is distinctive in introducing 'the compassionate chair, and building up the feelings, tolerance, insights and strengths of this part of the self' (p167, Gilbert, 2010). Once developed, the compassionate chair, or compassionate 'self', is utilized to focus on other parts of the self via chair-work dialogue, embodiment and enactment. This can include empty-chair work (e.g. focusing compassion towards an imagined 'other') and two-chair work (e.g. creating a dialogue between the compassionate self and a vulnerable 'self'), but typically involves interventions between multiple self-parts using a larger number of chairs (Gilbert, & Irons, 2005; Kolts, 2016).

One such intervention (and the intervention used in this study) involves creating a dialogue between the compassionate self, the self-critic and the criticised part of the self. Whilst emotion-focused therapy utilizes a two-chair method to dialogue between the 'critic' and 'experiencing' chairs when addressing self-criticism (Greenberg et al., 1993), CFT incorporates the compassionate self, on a third chair, to bring a compassionate motivation and mentality to both the 'critical' and 'criticised' parts of the self. Rather than seeking to eject or soothe away the self-parts that are in conflict, the compassionate self works with them as important voices: this involves engaging with the critic to understand its functions, fears, needs and history. If, however, the critic is an 'intrusion' (i.e. the voice of an abusive other) the compassionate self is used to assertively respond: e.g. the voice is differentiated from the 'self' and addressed via trauma-informed interventions (Gilbert, 2010). The use of compassion to integrate such threat-based parts of the self differentiates CFT chair-work from, for example, schema therapy, where one of the explicit goals of self-critic chair-work is to 'fight the punitive adult mode' (p224, Arntz & Jacob, 2013).

The CFT intervention described above can be conceptualised using social mentality theory. A social mentality is a pattern of cognition, emotion and behaviour that facilitates the enactment of social motives (Gilbert, 2000). Such mentalities create reciprocating self-other roles in pursuit of evolved biosocial goals (e.g. to care and be cared for; to compete; to form sexual relationship; to co-operate) (Gilbert, 2000). Due to the evolution of higher-order cognition in humans, and our capacity for self-reflection and awareness, 'social mentalities are activated not only in relations with others but also in relations

within the self' (p524, Hermanto, & Zuroff, 2016). Self-criticism can be therefore be understood as internally mirroring and adapting a competitive, rank-based, mentality: with one part of the self dominating and subordinating another (Gilbert, & Irons, 2005). The CFT chair-work intervention offers an experiential means of shifting from a harsh, internal competitive mentality, linked to threat monitoring, to an internal care-based mentality and the associated role that compassion has on emotional regulation and threat management (Gilbert, 2005).

An exploratory focus with depression

The current study is the first of CFT chair-work and aims to explore the experiences and understanding of clients who have undertaken the intervention for self-criticism. The study utilizes the qualitative methodology of Interpretative Phenomenological Analysis (IPA) (Smith, Flowers, & Larkin, 2009) which offers a means to balance phenomenological description with interpretative insight and has been frequently used to explore clients' lived experience of psychotherapy (including CFT, e.g. Lawrence, & Lee, 2013).

This study focuses on the experiences of clients with depression, due to the significant role of self-criticism on the development and maintenance of depression (e.g. Ehret, Joormann, & Berking, 2014). In contrast, self-compassion has been found to be negatively related to depression and self-criticism (e.g. Ehret, et al. 2014; Joeng, & Turner, 2015). Therefore, an intervention that has the potential to increase self-

compassion, whilst reducing self-criticism, holds particular promise for the treatment of depression.

Research aims

In summary, the purpose of the current study is to explore how clients with depression experience, receive and understand a specific compassion-focused chair-work intervention that targets self-criticism. Ultimately, the aim is to utilize the insights gained from clients' direct experience to provide therapists and trainers an opportunity to understand and further develop the intervention and its use.

METHOD

Recruitment and eligibility

In accordance with the idiographic methodology of IPA, participants were recruited via 'purposive' methods, and the selection of a 'homogenous' sample to represent a specific phenomenon in a specific context (Smith et al., 2009). As introduced above, such homogeneity was sought via the selection of clients with a 'provisional diagnosis' of Major Depression Disorder (the use of 'provisional diagnosis' is a routine function of therapists in primary care NHS settings). The Beck Depression Inventory (BDI-II) (Beck, Steer, & Brown, 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, Spitzer, & Williams, 2001) at commencement of treatment. Scoring 10 or above on the PHQ9 is regarded as the 'cut off' for clinical

depression as defined by NHS 'Improving Access to Psychological Therapies' (IAPT) governance (National IAPT Programme Team, 2011).

For an IPA study, participant numbers are typically small to facilitate a detailed, case-level exploration of individual experience and meaning-making (Smith, & Osborne, 2003). For this project, a relatively large sample size of 12 participants was chosen to 'capture' the complexity and variety of experience in people with depression, whilst remaining small enough to allow close attention to each case.

Eligible participants had to be receiving CFT as part of their routine treatment within a primary care IAPT psychological service. As CFT focuses on self-criticism and shame (Gilbert, 2010), the following measures were taken at the time of interview: Forms of Self-Criticizing/Attacking and Self-Reassuring Scale (FSCRS) (Gilbert, Clark, Hempel, Miles, & Irons, 2004) and Other as Shamer Scale (OAS) (Goss, Gilbert, & Allan, 1994).

Eligible therapists were required to have undertaken basic training in CFT (typically 3 days in length) and specific training in the chair-work intervention. They were also required to have a core-profession (e.g. nursing or clinical psychology) and/or be accredited by a therapeutic or professional body (e.g. British Association of Behavioural and Cognitive Psychotherapies).

To ensure therapist fidelity to the intervention, the therapy session was audio-recorded and listened to by the principal researcher. The intervention was required to contain the

following core steps: the client embodies the self-critic on one chair and expresses self-criticism outwards to an empty chair; the client moves to the opposite chair to 'receive' the criticism, verbalising their experiences; this process can be repeated before the client moves to a third chair and reflects on the interaction they experienced; in this third chair the client is supported to access and embody their 'compassionate self' and to respond to both the 'critic' and 'criticised' parts of the self with compassion (this involves focusing on the fears and unmet needs behind the critic) (please contact the principal researcher for copies of the training material). In CFT the 'compassionate self' is intentionally created via imagery and acting techniques and becomes an organizing focus for developing and enacting compassionate attributes and skills. To be eligible for the study, therapists were required to have trained the client in specific 'compassionate self' practices prior to the intervention (see Gilbert, 2010).

Participant information

The table below describes the participants' characteristics.

Table 1: Participant characteristics

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 behaviour therapy) EMDR (eye-movement desensitization and reprocessing therapy)

Participants scored a mean of 25.75 (SD=12.16) on the BDI-II at interview; a score of 20-30 indicates 'moderate depression' (Beck et al., 1996). Participants also scored M=41.17 (S=14.43) on the OAS, which is significantly higher than the findings from a university student population (M=20.0, SD=10.1) (Goss et al., 1994). The scores of the FSCRS were as follows: inadequate self (M=28.83; SD=6.44), reassured self (M=15.33; SD=3.82); and hated self (M=8.25; SD=4.09). Compared to prior research on the FSCRS by Baiao, Gilbert, McEwan, & Carvahlo (2015), the current participants' scores averaged higher than the clinical population on inadequate self (M=27.47; SD=7.51) but fell between clinical and non-clinical averages for the reassured self and hated self.

Eight therapists were involved in the study and the mean number of years practicing as a therapist post-qualification was 6.33. The session number when the intervention took place varied between cases, ranging from session 6 to session 17 (M=11.08).

Qualitative data collection and the interview process

The data was collected via a face-to-face, one-to-one interview using a semi-structured format, which is advocated by Smith et al, (2009). An interview schedule (see table 2 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 the use of prompts, and the structure of the interview, was flexibly and responsively applied to facilitate disclosure and participant choice (as suggested by Smith, & Osborne, 2003).

Table 2: Interview schedule

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 your experience of bringing compassion to different parts of yourself? **Questions regarding chair-work** E.g. Overall, 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? If so how?

The interviews were one-off and conducted by the first author at the participant's clinic, immediately after the session when the intervention was delivered. They varied in duration from 24-39 minutes and were recorded digitally for verbatim transcription. The participants' personal information was anonymized during transcription.

Analysis

Data was analysed using the structured six-stage process described by Smith et al. (2009). The analysis proceeded on a case-by-case basis, initially involving close, line-by-line reading and written notation at descriptive, linguistic and conceptual levels (Smith et al., 2009). Salient emergent themes were identified, and such themes were refined and integrated into super-ordinate themes via processes such as abstraction, subsumption, polarisation and contextualisation (see Smith et al., 2009). The sequence of analysis was repeated for each case, before patterns in superordinate themes were identified across cases.

In IPA, the analytic process is acknowledged as inherently interpretative, thereby requiring a commitment to reflexivity and reflective analysis (Smith et al., 2009). As the primary analyst, the lead author maintained a reflective diary to identify personal 'fore structures', expectations and conclusions, monitoring for their impact whilst also noting the dynamic way in which the analytic findings changed and shaped them. The primary author acknowledges his role as a CFT therapist and trainer and the potential this has to influence interpretation and analysis, for example, in making assumptions that the approach is beneficial. As an example of the active use of a reflective diary, when this

assumption was noted, the raw data was returned to in order to explore potential exceptions and contradictions to this expectation. The analysis was regularly audited during the analytic process by the second and third authors, resulting in thematic development being triangulated, negotiated and refined.

Ethics

The study gained ethical approval from the NHS Health Research Authority (IRAS no. 188390) and the University of Derby.

RESULTS

The study presents three super-ordinate themes for a detailed exploration of their occurrence and significance (see Table 3 below).

Table 3: Summary of themes

Superordinate and sub-ordinate themes	No. of participants for each theme
1. Embodiment and enactment	12/12
2. Externalizing the self in physical form	12/12
3. Emotional intensity -Accessing and experiencing emotion -Overwhelming emotion and avoidance	 12/12 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 realized 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 the affective connection to each self, such enactment also led to new insights into their 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 emphasized 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 utilized 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 vocalization 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 vocalization created a speaker and hearer so that each self was both and literally and metaphorically 'heard'.

Theme 2: Externalizing the self in physical form

Externalizing '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 visualize 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 organizing and arranging their externalized selves in chairs across the room. Similarly, the placement of the chairs 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 symbolize 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 externalized self, in the form of a chair, also facilitated vocalization 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 (externalized 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 realized, 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 emphasized 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 utilized 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 recognize 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.

Discussion

The participants' experience of shifting between different mentalities and motives (i.e. between the critical and compassionate 'self') was marked by significant changes in emotional and bodily experience. Such changes acted as affective and somatic markers for each 'self', with participants gaining insight into the presence, functions, motivation and impact of each mode of self-relating via their emotional and bodily feedback. The identification, and contrasting, of various emotions during the exercise was key in highlighting the difference between compassionate and critical self-relating. Participants were particularly struck by the presence of more vulnerable emotions (such as anxiety),

which they reflected had been previously obscured by their identification with the angry and attacking 'part' of the critical relationship. As such, participants' emotional reactions were the primary means of acknowledging the full distress and impact created by self-criticism and an internal competitive social mentality (Gilbert, 2000). Such findings support assertions made by Gilbert (1992) and Greenberg, & Watson (2006) that a variety of emotions should be assessed for, and targeted, when working with depression: highlighting its emotionally dynamic and multifaceted nature, and the need to discriminate and process 'core' affective states beneath a global depression of mood.

The findings also revealed participants' use of their bodies both to access and deepen their connection to various 'selves'. Automatic reactions were extended by an intentional physical inhabitation and enactment of each self, whilst such enactment offered further insight into the nature and function of each self. The body was frequently used to influence the mind (e.g. by changing or holding a posture) and the resultant changes in mind were most vividly articulated in the body (including the frequent use of body-based metaphor to illustrate subjective experience). Whilst the literature on embodied cognition addresses such bi-directional influences between body and cognition (e.g. Varela, Thompson, & Rosch, 2016), and experimental findings demonstrate the impact that manipulating body states can have on mood, memory and cognition (e.g. Michalak, Rohde, & Troje, 2015), it is striking that the study found participants were actively and instinctively using such influence and manipulation to access different 'selves' in a clinical setting. Notably, participants frequently utilized this phenomenon during the research interviews- changing their posture and gestures to aid their recall of particular

'selves'- which has wider clinical implications for how clients might independently use the body to re-access particular insights and states of mind from the session.

Whilst CFT utilizes various body-focused interventions, the enactive and embodied nature of chair-work appears to be particularly well suited to its holistic emphasis on creating changes in feeling states, motivation and mentality. Based on participants' accounts, clinicians could maximize the synergies between body, emotion and cognition via various means during the chair-work. This might include: a greater encouragement for clients to notice and track bodily experience; increased prompts to use posture and gestures to connect to, express and anchor to various self-states; providing 'live' feedback on changes the therapist notices in the client's body (to aid awareness); or the amplification of clients' bodily expression via the therapist's mirroring. Whilst these have been suggested in chair-work literature (e.g. Perls, 1969; Kellogg, 2015) there has been minimal prior research on these subjects to support their integration.

The findings also demonstrate how the process of externalizing parts of the self in physical form and space provided participants with a novel means to differentiate, symbolize, organize and explore their inner experience. Linking each self to specific chairs allowed for the physical shifting of positions that created a correlated internal 'shift' in mental perspective and feeling, so that participants' inner and outer worlds appeared to over-lap and interact: figurative 'space' was created for reflection, confirming previous findings that chair-work facilitates a 'decentered' metacognitive capacity (Chadwick, 2003). Such movement, physical distancing and externalization

could be highlighted and used in a targeted way with clients who over-identify with a particular self or social mentality. 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'). Whilst previous researchers (e.g. Pugh, 2018) have suggested this form of collaboration during chair-work, this contrasts with the directive facilitation of earlier practitioners of the approach (e.g. Perls, 1969).

Another notable finding was the way in which the externalization of internal relationships in the form of a dialogue between chairs, encouraged parallels to be made between participants intra and inter-relating. Participants were shocked to hear the contempt and hostility of their criticism expressed as if to another human being. This phenomenon (the self treated as 'other') also facilitated self-compassion in participants who had previously only been able to express it externally. Interesting parallels can be drawn to experimental literature which suggests that changing self-talk from first-person to third-person facilitates greater emotional regulation (e.g. Moser et al., 2017). Such conflation and comparison between self and other relating links to 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). In CFT, switching to the compassionate self allows clients to move behind the hostility of the critic and recognise unmet needs for recognition, acceptance and care. The chair-work process appeared to support this shift by recruiting the participants' capacity to give compassion to others, with the self-critic becoming an 'other' in the opposite chair. CFT, however, makes an important distinction

between self-criticism that is rooted in fears of comparison and rejection, and self-criticism that is rooted in internalizing an abusive 'other' (Gilbert, 2010). In the later, the critic is labelled as an 'abuser' and chair-work can be used in a different way than illustrated here.

It is also noteworthy that participants positively compared CFT chair-work to their prior cognitive treatment, contrasting the chair-work's 'feel-it' moments to the rational focus of verbal or written work. As identified by participants, it could be argued that CFT chair-work acts to link 'head' based propositional meaning with 'heart' based implicational processing (Teasdale, & Barnard, 1993), whilst supporting prior findings that chair-work is more effective at meaning and emotion change than verbal interventions on the same subject (e.g. de Oliveira et al., 2012). The emotional, embodied and multi-sensory nature of CFT chair-work might therefore be conceptualised as reducing 'rational-emotional dissociation' (Stott, 2007) whilst increasing 'depth of experiencing' (a factor associated with improved clinical outcomes in experiential practice, e.g. Pascual-Leone & Yeryomenko, 2016).

The intensity of emotional arousal and expression experienced during the CFT exercise is a hallmark of chair-work and echoes previous literature on the technique (e.g. Steigler et al., 2018). In the current study, participants associated such intensity of feeling with various therapeutic benefits including a perception of increased emotional tolerance, mastery and understanding. Prior chair-work literature has explained such benefits using paradigms of emotional processing or exposure (Pugh, 2017), but such benefits

are also suggestive of improved emotional self-efficacy, capacities linked to greater emotional self-regulation (e.g. Caprara, Giunta, Pastorelli, & Eisenberg, 2013). Participants reported an ability to shift in and out of extremes of emotion with relative ease, supporting the suggestion that chair-work could be a potent means for teaching emotional regulation and resilience (Kolts, 2016). The exercise also offers a means to explore anger in a novel way, with participants discovering their anger as potential new source of 'energy' to be redirected externally for assertive means. This lends some support to theories that self-criticism (and depression) can be related to problems with externalizing anger and the inhibition of external defences (e.g. Gilbert, Gilbert, & Irons, 2004).

Whilst the high intensity of emotion in the exercise was deemed a useful and necessary part of treatment, such intensity was experienced as aversive by over half of participants. This reflects prior findings that participants feel 'scared' and in 'shock' when commencing chair-work (Robinson, McCague, & Whissell, 2014). It is of note that whilst positive correlations have been found between high levels of expressed emotion during chair-work and clinical outcomes (Greenberg, & Malcom, 2002), chair-work has been associated with higher attrition rates when compared to verbal interventions (Paivio, & Nieuwenhuis, 2001). Such findings suggest a degree of caution but also, as in the current study, considerable benefit in persevering beyond initial reactions and fears. This conclusion reflects Carryer and Greenberg's (2010) suggestion that 'optimum' levels of emotional arousal for the experiential treatment of depression should be 'moderate', but that treatment should, in the short-term, elicit a 'full level of emotional

expression' (p196). These findings also highlight the need for clinicians to be particularly attuned to their client's levels of distress and to develop the capacity to stimulate and down-regulate emotion to facilitate the task.

As the first research on CFT chair-work, this study suggests the chair-work format complements and facilitates many of CFT's major therapeutic strategies, such as: the unblocking of various 'flows' of compassion, the differentiation and integration of various threat-based experiences, the emphasis on experiential and emotional change, and the focus on shifting motivations and social mentalities (Gilbert, & Irons, 2014). The limitations of the current study include the lack of a structured diagnostic interview for depression, yet such interviews are not commonly applied within primary-care psychological services where the research took place. Whilst experimental studies of CFT chair-work's effectiveness are required, further qualitative explorations of clients' lived experience of such interventions could clarify and improve the application of the therapy and guide its clinical training. Directions for future research could include the use of the intervention in presentations other than depression; the impact of increasing collaboration in the placement of chairs in the room; the influence of bodily gesture, posture and movement in chair-work; and the role of the therapeutic relationship in facilitating the approach.

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