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Bringing the Inside Out and the Outside in: The Therapeutic Relationship in Compassion Focused Therapy Chairwork

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Abstract

Chairwork is a central component in Compassion Focused Therapy (CFT). Despite its importance, there has been no prior research on the relational factors underpinning the application of chairwork in CFT. There is also a general paucity of research on the role of the therapeutic relationship in chairwork across modalities. This paper analyses data from interviews with 21 clients following a CFT chairwork intervention to ascertain how relational factors influenced their experience of this method. An Interpretative Phenomenological Analysis (IPA) found three main themes: 1) direction and coaching during enactment; 2) externalisation: bringing the inside out and outside in; 3) regulation and trust: the relational requirements to 'let go'. The implications of these findings, both for the delivery and training of chairwork, are then discussed in the context of CFT.

Keywords

Chairwork; compassion focused therapy; therapeutic relationship; depression; shame

1. Introduction

1.1 Compassion-Focused Therapy

Compassion-focused therapy (CFT) is an evolutionary based model that draws upon affective neuroscience, attachment theory, and developmental and social psychology. The model is grounded in an evolutionary functional analysis of social motivational systems (e.g., for cooperation, for sex, for competition, and for care) and emotional systems (e.g., to respond to threat, to seek resources, and to gain contentment/safeness) [1]. The approach also emphasises the complex and conflictual ways in which the human mind has evolved, whereby the relatively 'new brain' competencies of cognition (such as reasoning, mentalisation, and imagination) interact with 'old brain' motives and emotions to create and exacerbate human distress. To mitigate and work with the potential destructiveness of the evolved mind, CFT aims to cultivate compassionate and affiliative motives (and related competencies) that are associated with mammalian caring. To this end, CFT focuses on developing compassion and care in its various intrapersonal and interpersonal flows: i.e., compassion from self-to-others, from others-to-self, and from self-to-self.

CFT was originally developed to support clients with high levels of self-criticism and shame. However, for clients prone to these experiences, receiving compassion can trigger various threat-based reactions and deepen the self-criticism and shame that CFT was designed to treat. Such reactions highlight the central dilemma in utilising compassion-based approaches: i.e., how do you encourage clients to experience compassion and care when it is the very stimulus that creates threat? Within CFT, threat-based reactions to compassion are formulated as fears, blocks, or resistances (FBRs) and become a core focus of treatment [2]. *Fears* refer to various concerns about the experience of compassion and its potential consequences; *blocks* refer to practical or contextual factors that prevent the experience of compassion despite a desire to do so; and *resistances* occur when a person chooses not to engage with compassion because they perceive it as unhelpful. For CFT therapists, FBRs are respected and formulated as historically adaptive ways in which a person has learnt to manage threat and unmet needs within key attachment relationships [3]. Whilst FBRs are addressed in various ways (such as chairwork or targeting imagery associated with attachment memories), the therapeutic relationship offers a key means to explore, process, and change the client's relationship to care, so that 'what is feared is also the source of their healing' [4] (p. 19).

The therapeutic relationship in CFT is typically theorised within attachment theory terms [5]. The therapist is deemed to model a healthy attachment figure in offering core functions of a secure attachment relationship. These include the desire of the client to *seek proximity* with the therapist as a source of support and care; the use of the therapist as *secure base* from which to explore, take risks, and face difficulty; and for the therapist to provide a *safe haven* to soothe and regulate distress [6]. As Gilbert [5] has asserted, 'caring behaviours are multiple and multi-textured', with the therapist required to take on 'different roles at different points along the therapeutic journey' (p. 387). The CFT therapist's role is therefore multifarious: as soothing agent; as cheerleader for the client's maturation and self-agency; as guide in the provision of psychoeducation etc. In demonstrating these multiple aspects of the care-giving role, the therapist is also deemed to function as a model for the client's own 'compassionate self'.

The therapeutic relationship within CFT can also be conceptualised in terms of social mentalities. Social mentalities refer to how socially mediated motives organise the mind in different ways to facilitate specific relational roles. Such roles form reciprocal, interpersonal patterns such as: caring to cared-for; dominant to subordinate; or mutual co-operation. One task of the CFT therapist is to stimulate care-based and co-operative reciprocation between therapist and client, encouraging the client to experience novel interactional roles (e.g., to become the 'cared for'). Research suggests the priming of social mentalities in interpersonal relationships has a significant influence in how people relate to themselves [7]. Gilbert [8] has theorised that social mentalities are also recruited in self-to-self relating, so that one aspect of the self can, for example, provide care for another. The therapeutic relationship therefore has a potential influence in both interpersonal and intrapersonal forms of relating for the client.

Despite the importance placed on the relationship in CFT, there is limited empirical research on the subject. A case-study by Matos et al., [9] emphasised the role of the therapeutic relationship in fostering the kind of safeness required for clients to engage in CFT's experiential exercises. The study also suggested the therapeutic relationship functions as the 'primary intervention' with which to work through FBRs that arise during their practice. The authors suggested a dynamic and iterative process whereby the therapeutic relationship is deepened by the rupture and repair that occurs when engaging with experiential practices and the FBRS they generate. In this way, the therapeutic relationship is deemed 'the most powerful "experiential technique" we use in CFT' [9] (p. 4). Other studies touching on the role of therapeutic relationship have included interviews with CFT therapists. A delphi study of CFT therapist competencies emphasised the authentic modelling of the compassionate self and provision of safeness [10]. Similarly, in exploring therapist perspectives of working with FBRs, Steindl et al. [3] suggested that cultivating safeness and connection in the therapeutic relationship is vital for engaging with FBRs. Currently, however, there is no in-depth research focused on clients' perspectives or experiences of the therapeutic relationship in CFT.

1.2 Chairwork

In practice, CFT is an integrative and multi-modal approach. There is a particular emphasis on experiential and enactive methods to support shifts in feeling and motivational states. Such interventions include imagery, acting techniques, body-based interventions, and chairwork (Bell, 2022).

Chairwork has been defined as a collection of experiential practices 'which utilise chairs, their positioning, movement, and dialogue to bring about change' [11] (p. 3). The approach has a hundred-year history with its roots in the psychodramatic approach of Moreno [12] and the experiential methods of Perls [13]. Chairwork is found within many therapeutic modalities, creating a multitude of creative applications underpinned by a variety of conceptual frameworks. To simplify and integrate the various applications of chairwork, Pugh and Bell [14] have identified unifying principles and processes that underpin its practice. These include the principle of *self-multiplicity* and the process of *separation*, whereby aspects of the self (including internalisations of others) are differentiated, externalised, and concretised using chairs. Parts of the self are then *animated* via personification (imagining a part of the self in an empty chair) or embodiment (enacting the role of a part whilst in the chair). The *information exchange* between parts is then developed and deepened by facilitating *talk* or dialogue: e.g., speaking to an empty chair or changing roles and chairs to speak

from both sides. Ultimately, the type of *transformation* that is sought via this enactive dialogue depends on the modality in which the chairwork is applied.

In CFT, the aim of chairwork is to build compassionate dialogues between aspects of the self. Typically, this involves utilising the 'compassionate self' to enact care-based social mentalities via chairs. Bell [15] has previously suggested that chairwork in CFT is an 'ideal match of theory and method' (p. 456) for the following reasons: 1) chairwork offers CFT a means to differentiate and explore multiple interactions and conflicts between patterns of mind; and 2) a single chairwork exercise can be used to potentiate multiple flows of compassion by role-reversing between chairs. Such factors are evident in the 'set-pieces' of chairwork within CFT, such as two-chair compassionate dialogue. In this method, the client is supported to access the compassionate self in one chair, generate compassion towards a vulnerable/distressed 'self' in the second chair, and then switch chairs to receive their own self-generated compassion [15]. Other set pieces (described further in the Method section) involve utilising the compassionate self to work with internal conflicts. One involves enacting a self-critical dialogue between two chairs before the compassionate self is used to generate compassion for both the criticised and critical selves (e.g., understanding the fears that drive the critic) [16]. Another method is termed 'multiple-selves' as it involves separating primary threat emotions using various chairs before relating to them with compassion [17].

Whilst the efficacy of chairwork has been researched and reviewed [18], there is a dearth of empirical research on the role and influence of the therapeutic relationship. Studies of chairwork within emotion focused therapy (EFT) have found clients benefit from observing, and reflecting on, other clients' chairwork during group-based formats [19], whilst an in-depth conversational analysis identified various relational processes that supported client engagement in the 'entry' stage of chairwork [20]. In terms of therapist factors, Pugh et al. [21], found that CBT therapists experienced fears related to client over-arousal and shame during chairwork and concerns about their own competency. Notably, clients with problematic self-criticism do report embarrassment and awkwardness, and fears of losing control, when engaging in chairwork [22]. The authors of the study asserted that 'the intensity and some-what unusual nature of this intervention call for special attention to the working alliance before clients are invited to engage' [22] (p. 139). In contrast, Pugh [23] has developed single-session chairwork, wherein chairwork is offered at the first and only meeting with the client, without the pre-emptory establishment of the working alliance. In a case study of this format, Pugh et al. [24] suggest a cyclical and mutually reinforcing interaction between the therapeutic relationship and practice of chairwork: i.e., the bond created in the heat of the experiential intervention appears to further both the therapeutic relationship and the reach of the technique.

Much of the clinical and conceptual writing on the therapeutic relationship and chairwork has been informed by the modalities in which it is delivered. In psychodramatic practice, the group session is led by the 'director' [25] who guides an identified 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 many modalities: for example, Goulding and Goulding [26] suggest the 'therapist is the director of the drama, writer of some of the lines, and occasionally interpreter' (p. 178). However, when chairwork is applied within person-centred traditions, Rogerian core-conditions are deemed essential requisites for the practice; as Elliot and Greenberg [27] assert: 'chair work simply won't work in the absence of a strong, genuine, caring, empathic counselling relationship' (p. 81). Similarly, in schema therapy, where the therapeutic relationship is

conceptualised as a form of 'limited reparenting', the therapist role during chairwork takes on active parental and protective qualities. For example, when using chairwork to address a client's critic (e.g., 'the punitive parent'), the schema therapist is encouraged to take part in the dialogue and 'fight' the critic on the client's behalf [28].

In surveying various forms of chairwork, Kellogg [29] has distinguished between 'modifying' and 'facilitating' therapeutic stances. In a facilitating orientation, the therapist creates space for different parts of the self to emerge and express themselves without a set agenda ('giving voice is the heart of the work; nothing else is needed' [29] (p. 172)). Such a stance is evident in approaches such as voice dialogue [30] and in Perl's [31] belief in the client's own emergent capacity for integration. In contrast, a modifying orientation is directive and goal-focused and can be found in the structured methods of CBT chairwork [32]. For Kellogg [29], the chairwork therapist has a repertoire of roles from which to choose: they might serve as *witness* to honour client disclosure; as *midwife* to facilitate and support natural processing; as *advocate* to defend or stand up for the client; as *catalyst* or active agent prompting change; or as *director.* In addition to such roles, Pugh [32] has highlighted various process and relational skills that facilitate chairwork. These include practical prompts and guiding actions that facilitate the enactment (such as encouraging movement between chairs or embodiment of roles) or can require the empathic involvement of the therapist in offering 'feeding lines' or 'doubling statements' that foster experiential connection and emotional expression [33].

1.3 Aims

Despite the importance given to the therapeutic relationship in both CFT and chairwork more generally, there is minimal evidence to guide the clinician or support the various conceptions of the therapist's role during chairwork or CFT. This current paper analyses data from clients who received either a self-critical [16] or multiple-selves [17] chairwork intervention with the aim of understanding what is experienced and valued by clients within the therapeutic relationship during these interventions.

2. Method

2.1 Recruitment and Sample

Twenty-one participants were purposively recruited from 'Improving Access to Psychological Therapies' (IAPT) teams within the Greater Manchester area. Participants were required to score 10 or above on the Patient Health Questionnaire (PHQ9) [34] and to have a 'provisional diagnosis' of Major Depressive Disorder' at the start of treatment. Table 1. below gives the participants' characteristics. All participants were undertaking CFT as part of their routine care and were interviewed by the first-author after receiving either the self-critic or multiple-selves intervention (discussed below).

Table 1 Participant characteristics.

Participant Pseudonym	Age	Gender	Ethnicity	Prior therapy	Chairwork intervention received
1. Elena	36	Female	White-Bulgarian	Counselling	Self-criticism
2. Anita	39	Female	Asian-British	CBT and counselling	Self-criticism
3. Jenny	26	Female	Chinese	Counselling	Self-criticism
4. Simon	24	Male	White-British	CBT and counselling	Self-criticism
5. Claire	29	Female	White-British	CBT	Self-criticism
6. Michael	47	Male	White-British	Counselling and EMDR	Self-criticism
7. Diana	34	Female	White-British	Counselling	Self-criticism
8. Sarah	19	Female	White-British	No prior therapy	Self-criticism
9. David	22	Male	White-Irish	Counselling	Self-criticism
10. Helen	41	Female	White-British	CBT and counselling	Self-criticism
11. Susan	53	Female	White-British	Counselling	Self-criticism
12. Jean	49	Female	White-British	CBT and counselling	Self-criticism
13. Chris	54	Male	White-British	Group therapy (unclear modality)	Multiple-selves
14. Kerry	38	Female	White-British	CBT	Multiple-selves
15. Anya	39	Female	Mixed-Other	Counselling and psychology	Multiple-selves
16. Tim	53	Male	Black-British	Counselling	Multiple-selves
17. Emma	26	Female	White-British	CBT	Multiple-selves
18. Alice	26	Female	White-British	No prior therapy	Multiple-selves
19. Charlie	36	Female	White-British	Counselling	Multiple-selves
20. James	53	Male	White-British	CBT and counselling	Multiple-selves
21. Amy	30	Female	White-British	EMDR, CBT, and counselling	Multiple-selves

The following measures were administered to all participants on the day of the intervention: Beck Depression Inventory (BDI-II) [35], Forms of Self-Criticizing/Attacking and Self-Reassuring Scale (FSCRS) [36], and Other as Shamer Scale (OAS) [37]. The mean results for the BDI-II for both the self-critic (SC) and multiple-selves (MS) groups indicated 'moderate depression' (SC, M = 25.75, SD = 12.16; MS, M = 26.88, SD = 24.53). Whilst not based on statistical analysis, the OAS results indicated that both groups (SC, M = 41.17, SD = 14.43; MS, M = 37.33, SD = 17.21) were above the average of a non-clinical sample (M = 20.0, SD = 10.1) [37]. The FSCRS results for both groups were as follows: inadequate-self (SC, M = 28.83, SD = 6.44; MS, M = 28, SD = 6.65), hated-self (SC, M = 8.25, SD = 4.09; MS, M = 8, SD = 4.47) and reassured-self (SC, M = 8.25, SD = 4.09; MS, M = 12.22, SD = 6.62). Compared to prior research on the FSCRS [38], the current participants' scores were higher than the clinical population on inadequate self (M = 27.47; SD = 7.51) but fell between clinical and non-clinical averages for the hated self.

All therapists involved in the studies had undertaken the minimum of an introductory training in CFT (typically 3 days) in addition to specific training in the chairwork interventions. The ten

therapists involved in the study included seven females and three males; seven White-British, one British-Pakistani, one White-Irish and one White-Other. In addition to CFT, all participants were qualified in CBT.

2.2 Interventions

The specific steps of the CFT chairwork interventions are detailed elsewhere [16, 17]. In summary, the self-critic chairwork involves the client enacting a self-critical dialogue between two chairs (between the critical and criticised selves), before utilising a third chair for the compassionate self (the part of the self that embodies compassionate motives and competencies). The compassionate self is then used to support both the criticised self and to address the critic (understanding its fears and function). The multiple-selves chairwork separates the client's primary threat emotions (anxiety, anger, and sadness) into different chairs A single incident is then experienced from the embodied perspective of each emotional 'self' (with the client moving between chairs). Finally, the compassionate self is introduced in a fourth chair to address the emotional selves and respond to the same incident from a compassionate perspective.

2.3 Data Collection

Participants were interviewed individually, face-to-face, immediately following the chairwork session. Each interview was audio-recorded and transcribed by the first author. The interviews were semi-structured and based on the interview schedule outlined below (Table 2):

Table 2 Summary of interview schedule.

Interview schedule structure with examples
Introductory questions
Please tell me about your experience of the exercise.
Questions about enacting threat-based processes (e.g., the self-critic or different emotional selves)
E.g., please describe what it was like to act out the self-critic 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?

2.4 Data Analysis

The analysis followed the six-stage process outlined by Smith et al. [39]. This process initially involved analytic notation and theme generation on a case-by-case basis, before developing super-ordinate themes across cases. A final narrative account of the analysis was produced and supported by quotes from the raw data. Acknowledging the interpretative role of the analyst in IPA [39], the

first author maintained a reflective diary to document and elaborate the analytic process. The second and third authors independently audited the transcripts, interpretative annotation, and creation of themes. None of the authors were therapists involved in the study. It should be noted that this article does not implement the newer terminology of IPA [40]; the research was completed prior to the publication of these changes.

2.5 Ethics

The study was approved by the University of Derby Psychology Research Ethics Committee and the NHS Health Research Authority (IRAS 250657 and 188390).

3. Analysis

Analysis of the data generated three, interrelated, super-ordinate themes (Table 3).

Table 3 Summary of themes and occurrences for relationship factors analysis.

Superordinate themes	Sub-themes	No. of participants for each theme
1. Direction and coaching during enactment	• Being directed and instructed in the task	15/21
	• Being coached to deeper expression	18/21
2. Externalisation: bringing the inside out and outside in	• Concealment and shame following externalisation	12/21
	• Bearing witness to internal experience	13/21
3. Regulation and trust: the relational requirements to 'let go'	• The need for trust and safeness to engage in chairwork	12/21
	• Regulation and modelling: soothing and compassion during the task	17/21

3.1 Theme 1. Direction and Coaching During Enactment

3.1.1 Being Directed and Instructed in the Task

Participants ascribed multiple roles to their therapists during chairwork. One such role was that of directing 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 psychological 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 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 the chair, speaking to the person in the chair.' (Michael)

Michael's allusion to Shakespeare 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 remain in role 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.

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, the exploratory and emotional nature of chairwork felt unnatural and alien in comparison to her usual *'factual environment'*; she required more specific instruction to feel contained. Similarly, Alice experienced frustration at the '*ambiguous*' nature of chairwork and perceived a need for more concrete direction. Whilst participants acknowledged their reactions were 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 immersed in 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 authority and

spontaneity in direction appears to have reduced the '*natural'* flow of dialogue between both client and therapist, and between the client's own internal selves.

3.1.2 Being Coached to Deeper Expression

In addition to directing tasks and procedures, therapists were also experienced, and referred to, as a '*coach'*. This coaching role focused 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. For other participants, therapists were valued for their persistence and resolution in coaching greater levels of disclosure and emotional expression.

'She not only 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 highlighted the encouragement she received to find her own voice and answers. Sarah's metaphor of her '*seams*' being picked away captures the therapist's role in loosening her various strictures and promoting disclosure. 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)

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.' (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'*. Her emphasis on encouragement reveals the positivity felt around the interactional element of chairwork. Other participants valued their therapists' verbal coaching in providing summaries and affirmations 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, the therapist's close attention to changes in present-moment experience and physical expression helped him *'instantly'* embody his various roles. James also noted how his therapist shifted his focus from '*what you are thinking'* to asking him, specifically, '*how does that physically make you feel*'. Therapists were also recognised as coaching new compassionate ways of relating to such experiences. This frequently involved the therapist 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*' appears to capture this process and dynamic, empowering Sarah to claim the insights as her own.

3.2 Externalisation: Bringing the Inside Out and Outside In

3.2.1 Concealment and Shame Following Externalisation

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 inherently 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, which she then 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 reported visceral feelings of shame and self-disgust at the intimacy of the exercise, whilst Elena experienced her usual comfortable familiarity with her therapist being suddenly replaced with a sense of being observed and scrutinised, as if by a stranger:

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

Other participants noted how 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)

The association of chairwork with being on stage, as if pressured to perform or entertain, was also shared by others. Participants reported a sense of pretence or charade to mitigate exposure and manage perceived external expectations. For Diana, this involved an intentional choice to '*fake*' her experiences to meet the 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 failing to meet the standards of the task and therapist appeared to restrict her access to authentic experience and expression. Similarly, Simon reported shaping his answers to please his therapist and say the things '*she might be hoping I say*'. The difficulty in being '*honest*'

in sharing internal experiences was also evident with regards to outwardly displaying self-critical anger. 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)

Jean appeared to expect disapproval from her therapist, making it '*difficult*' to give voice to the true nature of her criticism. She also noted how her swearing and anger differentiated her from her therapist, creating a sense of separateness from '*therapists'* who '*don't like*' the way she speaks and 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 her experiences appeared to create distance in the therapeutic relationship, leaving her carrying her more difficult 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. For Kerry, and others, the experience of trust in both one's self 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. Participants identified that working through such shame-based reactions with their therapist was ultimately 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)

Elena highlights the benefits of having someone there to help her work through these more difficult experiential aspects. The strength of the therapeutic relationship is integral to these explorations.

3.2.2 Bearing Witness to Internal Experience

In apparent contrast to the experiences detailed above, participants felt the exercise allowed them to be truly seen and accepted by their therapist. Externalising and sharing aspects of the self 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, 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 won't 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 investment, 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, such as unexpressed anger. Such '*latent'* experiences were recognised via observations on participants' non-verbal signs, such as posture, voice tone, and 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. The process of having her experiences reflected back to her via another, ultimately allowed her to become more knowable to herself.

3.3 Regulation and Trust: The Relational Requirements to 'Let Go'

3.3.1 The Need for Trust and Safeness to Engage in Chairwork

Participants emphasised how the chairwork intervention took place within a broader relational context. There was importance placed on an 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 total trust required to reverse her '*natural'* aversion to facing distress and self-analysis. Other participants similarly identified the therapeutic relationship as a key factor in overcoming their fears relating to both the process and content of chairwork. For Michael, a lack of trust in the relationship would have been a '*risk to the value gained from the session'*; he further reflected that such trust allowed him to '*let go*' and '*go into it more'*. 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 past experiences of accessing compassion with, and from, the therapist, had created a mutual trust and faith in the therapeutic process. This relationship helped overcome any '*scepticism'* he might feel. Other participants highlighted different qualities in their relationship that had grown over time. This included a shared sense of humour and playfulness with 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…if 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 by a deeper knowledge of the participants 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 ('*he changed the direction to accommodate it',* Alice). To be willing to attempt a task as emotive as chairwork, participants required a lived experience of their therapist as empathic, knowledgeable, and responsive.

3.3.2 Regulation and Modelling: Soothing and Compassion During the Task

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. When 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 his therapist's soothing qualities helped to '*settle you, then you can look at the anger*'. For Sarah, such relational safeness '*allowed'* her to take personal risks with compassion:

'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)

For Sarah, the safeness within the therapy relationship was contrasted with '*home'* and '*day-to-day life*', suggesting the relationship has unique qualities 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 offering 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 to 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' own 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, as indicated by Sarah, demonstrated that self-compassion and compassion from others were not mutually exclusive, but mutually reinforcing and interconnected.

4. Discussion

This is the first study to examine relational factors in CFT chairwork. An IPA analysis of a data-set of 21 clients (all of whom had undertaken a session of CFT chairwork) generated three superordinate themes relating to the therapeutic relationship. The initial theme, 'direction and coaching', captured two key elements attributed to the therapist during chairwork. The therapist was experienced as a stage director, managing procedural tasks and providing a containing structure, which allowed clients to become immersed in their roles. The therapist was also referred to as a coach and valued for deepening emotional connection and expression. The second theme, 'externalisation', illustrated the benefits and drawbacks of being observed when externalising and concretising personal material. Drawbacks included the triggering of intense feelings of shame and shame-based memories, causing concealment and appeasement within the relationship. In contrast, participants also experienced the therapist as a validating witness and source of objective reflection. The final theme, 'regulation and trust', highlighted the importance of having a strong relational bond before attempting chairwork, with the quality of trust repeatedly emphasised. The therapist was also recognised as a source of soothing and regulation during the intervention and as a model for participants' own self-to-self relating.

In relation to prior conceptions of the therapeutic relationship in chairwork, participants identified and valued elements of both facilitating and modifying stances in their therapists. In terms of a facilitative orientation, participants reported the benefits of their therapist acting as a 'witness' to their distress (a role previously posited by Kellogg [29]), and were valued for their presence and perspective rather than intervention. In this role, the therapist appeared to facilitate the kind of decentered observer position (seeing oneself as if from the 'outside') that Pugh [32] suggests is an integral part of chairwork. The therapists' modifying stance was most evident in their role as 'director' or 'guide' in leading participants through the procedural and practical tasks of the method. The notion of chairwork therapist as 'director' has links to chairwork's origins in psychodrama and its language of theatre [25]. Notably, participants found that increased levels of instruction and authority from their therapists during chairwork provided certainty, structure, and containment.

From within psychodramatic literature, Kellerman [41] has warned of the potential for idealization and enforced obedience when therapists adopt the powerful role of 'director'. Yet, rather than enacting unhelpful dominance-subordination dynamics (which is perhaps a risk in the client group interviewed), the therapists' active role was experienced as a form of supportive scaffolding which fostered interpersonal safeness and enhanced self-agency.

Therapists were also experienced as both facilitator and agent of change when 'coaching' emotional connection, expression, and regulation. Such emotional connection was fostered by the therapist's close attunement to the client's body and somatic experiences, persistence in uncovering layers of emotional material, and celebration of gains made. The therapist also helped to modulate between affective states by coaching changes to posture, gesture, and breathing. The therapists were also noted for their own embodiment and provision of soothing qualities and care. 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 [42, 43]. For productive emotional processing to occur, Greenberg and Pascual-Leone [44] 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 match this description well, highlighting the therapists' dual role as both brake and accelerator of affect during experiential work. Participants emphasised the benefit of having an external regulator of their emotions to provide them the confidence and shared 'drive' to access and process greater levels of emotion.

CFT literature has discussed the therapeutic relationship in terms of attachment theory, specifically the use of the therapeutic relationship as a secure base from which to engage in new and difficult behaviours and as a safe haven to regulate distress [5]. In the present study, the qualities and functions of a secure attachment relationship were evident in participants' accounts of the therapeutic relationship- from the soothing-safeness felt with the therapist to modulate threat-based emotional reactions (safe haven) to the coaching, reinforcing, and celebrating of the client's engagement with the task (secure base). Participants also utilized their therapists as a compassionate model, internalizing them as a healthy 'internal working model' for their own compassionate self. Such a finding echoes broader literature on the subject which suggests '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' [45] (p. 56). There is perhaps the potential within CFT for the therapist to be more active and intentional in modelling the compassionate self during chairwork by 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 a precedent in schema therapy's 'limited reparenting' [46] and could be adapted within a CFT frame.

The various roles attributed to the therapist during CFT chairwork can also be understood through the lens of social mentality theory [15]. 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 their receipt of care 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 processes [47]. 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. Future research might explore the relationship between alliance quality and outcomes in CFT chairwork.

Despite the benefits of relationship factors in facilitating the chairwork process, participants reported intense feelings of shame at being exposed to their therapists. Prior literature has found self-critical clients report embarrassment and awkwardness when engaging in chairwork [22] and can conceal the true extent of the self-criticism during experiential treatment [48]. 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 interpersonal stress. Whilst such aversive in-session experiences are distressing and potentially disruptive to the task, Nodtvedt et al., [48] suggest that sharing distressing emotions live during experiential treatment can allow 'corrective' emotional experiences to be provided, modelling acceptance and compassion in ways that mirror the findings of the current paper and that of Matos et al. [9]. The expectations of negative judgement, pressure, criticism, or lack of 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) [49]. If identified and shared, shame-based experiences within CFT chairwork may therefore provide therapeutic opportunities 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 participants' 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 [46]. Whilst Pugh's [23] single session chairwork utilizes chairwork in the first and only session, it may be that the presence of shame, self-criticism, and/or depression, require a longer development of relational rapport. It remains an empirical question as to when, during a course of CFT therapy, chairwork is optimally utilized. Further research might also examine what factors in the therapeutic relationship allow chairwork to be expedited. Such factors might include the use of humour and playfulness which was valued by the participants in the current study.

Taken as a whole, the findings suggest the therapeutic relationships is an essential and inextricable factor in various aspects of CFT chairwork. This is in keeping with the line of argument that the 'therapeutic relationship cannot be viewed as a nonspecific variable that is merely auxiliary to other active components in treatment' [50] (p. 277). CFT chairwork is fundamentally grounded in relationships: between parts of the self, between client and therapist, and within multiple flows of compassion. The findings of the study 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.

Author Contributions

TB conceived and designed the study, collected the data, led the data analysis and wrote the manuscript. JM, JE and PG contributed to the design, data analysis and drafting of the manuscript. MP contributed to the drafting of the manuscript and discussion of analytic themes. All the authors approved the final version of the manuscript.

Competing Interests

The authors have declared that no competing interests exist.

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