University of Minho
School of Psychology

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Chair Work and Client Change Process in Emotion-Focused Therapy

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Pedro Brandão Lourenço

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Doctoral Thesis in Applied Psychology

Advisors
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University of Minho, July 28, 2021

Signature: 

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and whatever is done by only me is your doing, my [dear significant others]
i carry your heart[s] with me, i carry it in my heart
E. E. Cummings

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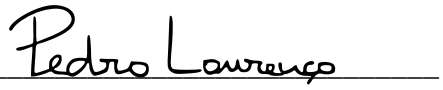
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STATEMENT OF INTEGRITY

I hereby declare having conducted this academic work with integrity. I confirm that I have not used plagiarism or any form of undue use of information or falsification of results along the process leading to its elaboration. I further declare that I have fully acknowledged the Code of Ethical Conduct of the University of Minho.

University of Minho, July 28, 2021

Pedro Cabral Brandão Martins Lourenço

Signature: 

RESUMO

Trabalho de Cadeiras e Processo de Mudança do Cliente em Terapia Focada nas Emoções

O foco da investigação processo–resultado é identificar os aspetos úteis da terapia que são responsáveis por resultados clínicos positivos. A nossa investigação foca-se nos processos do cliente dentro dos eventos clinicamente significativos de trabalho de cadeiras—diálogo de duas cadeiras, encenação de duas cadeiras, trabalho de cadeira vazia—e os seus efeitos na mudança do cliente em terapia focada nas emoções (TFE).

A TFE é um tratamento empiricamente validado para a depressão que integra o trabalho de cadeiras como componente central da sua intervenção para resolver dificuldades específicas de processamento emocional—divisões internas entre partes do self e assuntos inacabados com outros significativos—relacionadas com esquemas emocionais depressivos centrais. Em consonância com a teoria e prática da TFE, investigações anteriores sugerem que resultados terapêuticos relevantes no final do tratamento podem ser alcançados através da inclusão de intervenções com trabalho de cadeiras nos procedimentos de tratamento e através da resolução bem-sucedida de dificuldades de processamento emocional endereçadas pelo trabalho de cadeiras. No entanto, na nossa opinião, devido a questões metodológicas nesses estudos, o contributo efetivo dos processos do cliente na resolução destas tarefas terapêuticas para a melhoria sintomática e para a profundidade de processamento emocional ao longo da terapia permanece empiricamente indeterminado.

Nesta tese desenvolvemos um método para rastrear o progresso do cliente no trabalho de cadeiras ao longo da terapia, baseado nos modelos de resolução destas tarefas da TFE, o que permitiu a execução de dois estudos empíricos para investigar os efeitos longitudinais do trabalho de cadeiras nos sintomas clínicos e no processamento emocional. A amostra para os nossos estudos foi composta por 10 clientes com depressão leve a moderada, que receberam tratamento durante 16 sessões de TFE; os processos terapêuticos destes clientes foram analisados na íntegra com a referida medida de resolução do trabalho de cadeiras. No primeiro estudo, a intensidade dos sintomas clínicos foi avaliada com o Beck Depression Inventory–II e o Outcome Questionnaire–10.2, e, no segundo estudo, a profundidade de processamento emocional foi avaliada com a Experiencing Scale.

Utilizando modelos multinível e procedimentos de análise de dados longitudinais, os resultados dos nossos estudos empíricos determinaram que o progresso da resolução do trabalho de cadeiras dos clientes predizia significativamente, sessão a sessão, a diminuição dos sintomas clínicos e o aumento da profundidade de processamento emocional. Apesar das suas limitações, a nossa investigação enfatiza a relevância clínica de se endereçarem divisões internas e assuntos inacabados através de trabalho de cadeiras durante o tratamento de estados depressivos.

Palavras-chave: trabalho de cadeiras; diálogo de duas cadeiras; encenação de duas cadeiras; trabalho de cadeira vazia; depressão; processamento emocional; processo–resultado.

ABSTRACT

Chair Work and Client Change Process in Emotion-Focused Therapy

The focus of process–outcome research is on identifying the helpful aspects of therapy that are responsible for positive clinical outcomes. Our research focuses on the client processes within clinically meaningful events of chair work—two-chair dialogue, two-chair enactment, and empty-chair work—and their effects on client change in emotion-focused therapy (EFT).

EFT is an empirically-supported treatment for depression that integrates chair work as a central component of its intervention to resolve specific emotional processing difficulties—conflict splits between parts of the self and unfinished business with significant others—related to underlying core depressive emotion schemes. In line with EFT theory and practice, previous research suggests that relevant therapeutic outcomes at treatment termination may be achieved by including chair work interventions in treatment procedures and through the successful resolution of emotional processing difficulties addressed in chair work. In our view however, due to methodological issues within these studies, the actual contribution of the client processes in resolving these therapeutic tasks to symptom improvement and to depth of emotional processing throughout therapy remains empirically undetermined.

In this thesis we have developed a method for tracking client progress in chair work throughout therapy, based on EFT's resolution models for these tasks, which allowed the execution of two empirical studies to investigate the longitudinal effects of chair work on clinical symptoms and on emotional processing. The sample for our studies was composed by 10 clients with mild to moderate depression, who received treatment during 16 sessions of EFT; the entire therapeutic processes of these clients were analyzed with the abovementioned measure of chair work resolution. In the first study, intensity of clinical symptoms was assessed with Beck Depression Inventory–II and Outcome Questionnaire–10.2, and, in the second study, depth of emotional processing was assessed with Experiencing Scale.

Following multilevel models and longitudinal data-analytic procedures, the results from our empirical studies determined that clients' chair work resolution progress significantly predicted session by session decrease in clinical symptoms and increase in depth of emotional processing. Despite its limitations, our research emphasizes the clinical relevance of addressing conflict splits and unfinished business through chair work when treating depressive states.

Keywords: chair work; two-chair dialogue; two-chair enactment; empty-chair work; depression; emotional processing; process–outcome.

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BDI–II	Beck Depression Inventory–II
β	coefficient
CWCS	Chair Work Coding System
ECW	empty-chair work
EEs	emotion episodes
EFT	emotion-focused therapy
EXP	Experiencing Scale
HLM	Hierarchical Linear Modeling
M	mean
OQ–10.2	Outcome Questionnaire–10.2
OQ–45.2	Outcome Questionnaire–45.2
p	p-value
Ph.D.	Doctor of Philosophy
R^2_{adj}	adjusted R-squared
SD	standard deviation
SE	standard error
t	t-statistics
TCD	two-chair dialogue
TCE	two-chair enactment

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CHAPTER I

INTRODUCTION

Life is just one damn thing after another.
But for people who come into therapy, here's the discouraging thing
—that life has become the same damn thing over and over again.
John Weakland

Psychotherapy works for a number of psychological conditions (for comprehensive reviews, see Lambert, 2013; Wampold, 2001; Wampold & Imel, 2015) and, undoubtedly, *proper* psychotherapy (i.e., bona fide interventions; Wampold et al., 1997) is effective in the treatment of depression (for the latest robust evidence, see Cuijpers et al., 2021; Munder, et al., 2019). While the debate may still be ignited around dichotomies such as *absolute versus relative efficacy* or *efficacy versus effectiveness* (Lambert, 2013; Wampold, 2019; Wampold & Imel, 2015), the focus of psychotherapy research has largely shifted to the processes and mechanisms of change (Braakmann, 2015; Crits-Christoph et al., 2013; Kazdin, 2007, 2009, 2014). Rather than establishing treatment efficacy/effectiveness, researchers are more than ever interested in understanding how clients change as a result of a psychotherapy process (Crits-Christoph et al., 2013; Hardy & Llewelyn, 2015). Ergo, the field of therapeutic change process research has been remarkably prolific in investigating client change process from a multitude of different variables, measures, designs, and methods (Crits-Christoph et al., 2013; Elliott, 2010; Gelo & Manzo, 2015; Hill & Lambert, 2004; Orlinsky et al., 2004). The present doctoral thesis falls within the large-scoped umbrella of therapeutic change process research (specifically, process–outcome research) and explores the effects of chair work on client change, in an effort to provide further empirical evidence that substantiates a client change process through which emotion-focused therapy works.

Chapter I begins with the research purpose and design of this thesis, aiming to contextualize and justify the development of its empirical studies; it also comprises a brief synthesis of some key principles and concepts of emotion-focused therapy and of chair work, focusing solely on the essential relevant aspects for this thesis that are underdeveloped in Chapters II and III. Chapter II was designed to provide a comprehensive overview of the development of a method for tracking client progress in chair work throughout therapy and illustrate its application to a clinical case using clinical vignettes and detailed descriptions of moment-by-moment client processes. Chapter III contains the empirical studies that we have developed thus far on the effects of chair work. Lastly, in Chapter IV we discuss the major conclusions from our empirical studies and their implications for clinical practice, as well as the limitations of our work and prospective research efforts.

Research Purpose and Design

Understanding how and why psychotherapy brings about change has long sprouted a *great debate* among psychotherapy researchers (Budd & Hughes, 2009; Luborsky et al., 2002; Marcus et al., 2014; Rosenzweig, 1936; Wampold, 2001; Wampold & Imel, 2015), on whether the processes and mechanisms of change at play are the commonalities among treatments (i.e., common factors) or the unique techniques employed (i.e., specific factors). Early advocates of the common factors have departed from the "Dodo Bird Verdict" (i.e., outcome equivalence between therapies; Carroll, 1865; Rosenzweig, 1936) to infer that the effects of psychotherapies must not reside in their unique intervention strategies (Luborsky et al., 1975; Strupp & Hadley, 1979). Such claim for the primacy of non-specific factors gained momentum through subsequent meta-analyses of comparative outcome studies of psychotherapies (for transdiagnostic meta-analyses, see Shapiro & Shapiro, 1982a, 1982b; Smith & Glass, 1977; Smith et al., 1980; Wampold et al., 1997; for depression-specific meta-analyses, see Barth et al., 2013; Cuijpers et al., 2008, 2012, 2020; L. A. Robinson et al., 1990; Wampold et al., 2002) and meta-analyses of component (either dismantling or additive; for definition, see Borkovec, 1990; Borkovec & Castonguay, 1998) outcome studies (Ahn & Wampold, 2001; Bell et al., 2013; Flückiger et al, 2015). Alongside this extensive body of research, a plethora of comprehensive lists of empirically-supported common factors (from which the therapist–client relationship factors of alliance and empathy clearly stand out; Elliott et al., 2019; Flückiger et al., 2019) and several noteworthy integrative frameworks of psychotherapeutic factors have been derived (Castonguay, 1993, 2011; Cuijpers, Reijnders, & Huibers, 2019; Duncan et al., 2010; Frank, 1961; Frank & Frank, 1991; Goldfried, 1980; Grencavage & Norcross, 1990; Hubble et al., 1999; Lambert, 1992; Lambert & Ogles, 2004; Orlinsky, 2009; Orlinsky & Howard, 1986; Rosenzweig, 1936; Wampold, 2001, 2015; Wampold & Imel, 2015; Weinberger & Rasco, 2007). Rough estimates of the therapeutic factors contributing to client outcome in psychotherapy have also been drafted (Lambert, 1992, 2013; Norcross & Lambert, 2019), suggesting that, compared to technique factors, common factors may account for twice the explained variance in psychotherapy outcome (30%); however, to hold the combined weight of these estimates of explained variance in perspective, it is worth highlighting that the latest estimates on the total variance of psychotherapy outcome stresses the manifest preponderance of client contribution (30% of the total variance) and the unexplained nature of psychotherapy outcome (35% of the total variance; Norcross & Lambert, 2019).

Despite the arguments extolling common factors' role in psychotherapy outcome, the current state of the "common versus specific factors debate" seems to have reached a reasonable stall point, with both factions recognizing the importance of either factors as significant processes and mechanisms

of change in any bona fide psychotherapy (Hofmann & Barlow, 2014; Mulder et al., 2017; Wampold, 2015, 2019)—*and possibly for sound reasons*. In fact, as hinted by a few illustrious common factors' theorists in their respective models, treatment *procedure* or *ritual* (i.e., technique) constitutes a vital aspect in any given cogent and coherent psychotherapy (Frank, 1961; Frank & Frank, 1991; Wampold, 2001; Wampold & Imel, 2015). Without prejudice to the vast empirical evidence around common factors (for comprehensive reviews, see Wampold, 2001, 2015, 2019; Wampold & Imel, 2015), most arguments downplaying specific factors may be reasonably debatable. First and foremost, outcome equivalence between therapies does not represent evidence for the role of common factors as the sole processes and mechanisms of change in psychotherapy, due to the inherent etiological complexities of psychological disorders and their multivariate equifinal treatment pathways; distinct intervention strategies may yield equivalent outcomes by targeting discrete processes/mechanisms and producing system-wide changes in the heterogenic dimensions of a particular disorder (Cuijpers et al., 2020; Cuijpers, Reijnders, & Huibers, 2019; DeRubeis et al., 2005; Lemmens et al., 2016; Norcross, 1988). Furthermore, the polarizing concepts of "common" and "specific" in this context might have been perpetuating a false dichotomy between the factors under discussion, as suggested by recent empirical evidence supporting their correlation (Felice et al., 2019; Tschacher et al., 2014); pragmatically, in real-world psychotherapy outside a research dome, common factors are most likely actuated through specific factors in such inextricable manner that the hypothesis of their independence is at least counter-intuitive (Butler & Strupp, 1986; Castonguay, 1993, 2000, 2011; McAleavey & Castonguay, 2015; Mulder et al., 2017).

To the overarching question of which processes and mechanisms of change account for psychotherapy outcomes, the crude cumbersome answer persists, perhaps due to the utterly complex nature of the psychotherapeutic phenomena—*evidence is not enough* (Crits-Christoph et al., 2013; Cuijpers, Cristea, et al., 2019; Cuijpers, Reijnders, & Huibers, 2019; Lemmens et al., 2016; Lorenzo-Luaces & DeRubeis, 2018; Mulder et al., 2017). Given this longstanding plateau in the quest for the processes and mechanisms of change in psychotherapy (Kazdin, 2007, 2009, 2014; Lemmens et al., 2016), our cautious stance in consideration to the faux bivariate debate paradigm is that investigating therapeutic techniques, which in themselves are embedded with purported common factors (e.g., therapist–client relationship elements), is a viable path to understand the mechanisms of treatment processes responsible for client change in psychotherapy. Our belief and expectation is that studying specific factors such as therapeutic techniques proves to be an accessible way of understanding how psychotherapy works because the results might be more straightforward and informative for clinical practice. In our view, the purpose of studying specific ingredients such as therapeutic tasks is to

demonstrate that a particular therapeutic technique (e.g., chair work) does in fact activate the intended underlying processes (e.g., client processes in the resolution of chair work tasks) and that these exact same processes lead to client change in terms of clinical improvement and other relevant outcomes (e.g., clinical symptoms and emotional processing). This deliberate sequence is the definite intended purpose of the research efforts contained within this doctoral thesis and aims to provide (modest) empirical evidence that the client processes involved in the resolution of chair work tasks effectively promote positive changes in clinical symptoms and in emotional processing.

The Context and Nature of Chair Work

Prior to elaborating on why and how we studied the effects of chair work, a necessary contextualization of chair work within the framework of emotion-focused therapy for depression is due.

Emotion-focused therapy (EFT; Elliott et al., 2004; Greenberg & Goldman, 2019a; Greenberg et al., 1993; Greenberg & Watson, 2006) is an integrative neo-humanistic-experiential psychological treatment that "synthesizes elements of person-centered therapy (Rogers, 1959), Gestalt therapy (Perls et al., 1951), experiential therapy (Gendlin, 1996), and existential therapy (Frankl, 1959; Yalom, 1980) with modern emotion, cognitive, attachment, interpersonal, psychodynamic, and narrative theory in a dialectical constructivist metatheory" (Greenberg, 2017a, p. 7). Rather than providing an exhaustive review of all these elements embodying EFT (for such a comprehensive review, see Elliott et al., 2004; Greenberg, 2017a), we outline the most relevant aspects underpinning chair work interventions.

A cornerstone of EFT is its dialectical constructivist and emotion-centric perspective on human functioning (Elliott et al., 2004; Greenberg, 2017a, 2019a, 2019b). Within this composite perspective, human experience derives from the perennial, dialectical exchanges between an implicit emotion system and an explicit meaning system—"emotions move us, whereas meaning is what we live by" (Greenberg, 2017a, p. 49). Emotion is an innate biological system of adaptive functioning through which complex situational information is promptly processed and evaluated on the basis of its significance to our welfare, generating action tendencies directed at relevant needs—emotions organize experience into emotion schemes and confer meaningful directionality to our existence (Elliott et al., 2004; Frijda, 2000; Greenberg, 2017a, 2019a; Greenberg & Paivio, 1997; Greenberg & Safran, 1987). Emotion schemes are "internal emotion memory structures that synthesize affective, motivational, cognitive, and behavioral elements into internal organizations that are activated rapidly, out of awareness, by relevant cues.... [to] produce experience and action as their output (Greenberg, 2017a, pp. 39–40). From a clinically relevant structural perspective, emotion schemes are thought to present the following component elements, all of which necessary for adequate processing of lived experiences (Elliott et al., 2004): perceptual-situational

environmental cues, bodily-expressive sensations, symbolic-conceptual representations, motivational-behavioral tendencies, and a nuclear organizing process of the whole conscious emotional experience. Functional experiencing then involves a coherent articulation of all these sequenced elements, without which significant life events may not be fully processed and integrated in our internal narrative structure. As such, emotion schemes are at the core of human functioning in healthy states and, perforce, psychological dysfunction as well (Greenberg, 2019a, 2019b). These emotional response systems mesh the complex network that forms our internal field and its multiple dynamic self-organizations (Greenberg & J. Pascual-Leone, 1995, 2001). At any given moment in time, we are the manifestation of whatever implicit dialectical synthesis emerges from the constellation of our situation-elicited emotion schemes to form a particular self-organization—"one of many possible selves" (Greenberg, 2017a, p. 33) that may be brought to conscience when reflected upon and explicitly symbolized. This emerging process reflects the ephemeral, partial nature of multiple self-aspects as constituents of one's mutable sense of self, which is a fundamental premise for emotional change through the path of "listening" to more adaptive "voices" in the self; however, multivocality of the self also implies the possibility of overpowering relations between different self-aspects at the expense of healthy aspects of experience (Elliott & Greenberg, 1997; Greenberg & J. Pascual-Leone, 1995; Stiles, 1999).

With respect to emotion experience and responses, EFT establishes a practical typological distinction on the basis of their suitability (to eliciting situations) and functional potential (for appropriate action): primary adaptive, maladaptive, secondary reactive, and instrumental (Elliott et al., 2004; Greenberg, 2015, 2017a, 2019a; Greenberg & Safran, 1987, 1989). Primary adaptive emotion responses emerge directly and consistently with prompting situations, orienting thought and behavior toward adequate action. By opposition, despite emerging in direct reaction to eliciting situations, maladaptive emotion responses prevent appropriate action because of inconsistent fitting to current situations and their basic overlearned nature. Secondary reactive emotion responses emerge in direct, effective overlap of preceding primary adaptive emotion responses, subverting the healthy functioning potential of the latter due to its (often) painful nature. Regardless of consciousness or volitive aspects, instrumental emotion responses emerge to exert a covert manipulative effect on others and restrict their actions.

Under (and even beyond) EFT terms, healthy human functioning implies adaptation to life situations by means of multifaceted internal experiences, flexible responses, and coherent narratives, all of which coordinated and organized in a complex internal field (Greenberg, 2019a; Greenberg & J. Pascual-Leone, 2001). In EFT, most psychological disorders are seen as resulting from dysfunctional

emotion processes such as unawareness or avoidance of internal states, impairment in emotion regulation, maladaptive emotion responding, and difficulties in narrative construction and meaning creation, as well as related dysfunctional self–self and self–other processes (Elliott & Greenberg, 1997; Greenberg, 2017a, 2019a; Greenberg & Watson, 2006). The problem of lack of awareness dwells on avoided or disclaimed, unsymbolized and unintegrated primary emotional experience (or component aspects), resulting in unfunctional action and unmet needs. The issue of maladaptive emotion schemes occurs when "present functioning is ruled by the past and imposes the past on the present" (Greenberg, 2017a, p. 58); the indiscriminate repetition of overdeveloped emotional reactions, often learned through recurrent inadequate responding of early significant others to prior display of innate adaptive emotions, hinders primary viable internal experiences and adaptive responses to current life events. With effect, considering these mechanisms of dysfunction, the primary aims in EFT are to (1) guide clients in the process of reprocessing, reowning, and assimilating primary emotional experience into their complex self-organization system, and (2) help them access and transform maladaptive emotion schemes through memory reconsolidation processes and novel emotional experience to achieve changes in the organization of the self (Greenberg, 2017a, 2019a; Greenberg & Goldman, 2019b; Greenberg et al., 1993).

The process of EFT is guided by the overarching principle of facilitating in-session therapeutic work embedded in an empathically attuned, collaborative therapeutic relationship (Elliott et al., 2004; Greenberg, 2015, 2017a; Greenberg et al., 1993; Watson, 2019). All therapeutic work is grounded on immediate client states and follows the compass of deepening client experiencing and promoting emotional processing (Greenberg, 2017a; Greenberg & Goldman, 2019b; Herrmann & Auszra, 2019). A process-directive, marker-guided intervention strategy serves as a framework for targeting specific types of identifiable in-session emotional processing difficulties through therapeutic tasks (Elliott et al., 2004; Greenberg, 2017a; Greenberg et al., 1993). Over nearly half a century, EFT clinicians and researchers have adapted and developed resolution models for an extensive portfolio of experiential therapeutic tasks (Elliott et al., 2004; Greenberg et al., 1993): empathy-based tasks (e.g., empathic exploration for problem-relevant experiences, empathic affirmation for vulnerability), relational tasks (e.g., alliance dialogue for therapy complaints or withdrawal difficulties), experiencing tasks (e.g., clearing a space for attentional focus difficulties, experiential focusing for unclear feelings), reprocessing tasks (e.g., meaning work for meaning protests, systematic evocative unfolding for problematic reaction points), enactment tasks (e.g., two-chair dialogue for self-evaluative splits, two-chair enactment for self-interruption splits, empty-chair work for unfinished business), among other groups of tasks. These provide EFT therapists with a set of

tools to address an array of emotional processing difficulties presented transversally across discrete diagnoses (Greenberg, 2017a; Timulak & Keogh, 2020).

Chair work tasks are perhaps the most representative component of the Gestalt heritage in EFT (Greenberg, 2017a; Perls, 1947; Perls et al., 1951). In their indigenous form, these methods were used in Gestalt therapy as literal experiments to help clients integrate polarizing aspects of the self (self-concept versus self-actualization) and allow previously interrupted organismic experiencing/needs (Perls, 1969, 1973; Perls et al., 1951). Combined with client-centered relationship conditions (i.e., empathy, genuineness, and unconditional positive regard; Rogers, 1951) and experiential focusing principles (i.e., deepening of experience; Gendlin 1962, 1996), these Gestalt experiments were further developed in the context of EFT through a task-analytic methodology (Greenberg, 1984a, 2007; Rice & Greenberg, 1984). Such research-informed refinement (Greenberg, 1979, 1980, 1983, 1984b; Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002; Greenberg & Webster, 1982) lead to the specification of the client processes and therapist intervention counterparts involved in the successful resolution of distinct emotional processing difficulties—*self-evaluation splits*, *self-interruption splits*, and *unfinished business*. Since then, chair work tasks as known today—*two-chair dialogue* for self-evaluation splits, *two-chair enactment* for self-interruption splits, and *empty-chair work* for unfinished business—have been a widely recognizable hallmark of EFT, particularly in the treatment of depression, anxiety, and complex trauma (Elliott & Shahar, 2019; Elliott et al., 2004; Greenberg & Watson, 2006; Khayyat-Abuaita & Paivio, 2019; Paivio & A. Pascual-Leone, 2010; Salgado et al., 2019; Watson & Greenberg, 2017; Watson et al., 2019).

Two-Chair Dialogue for Self-Evaluation Splits and Two-Chair Enactment for Self-Interruption Splits. Conflict splits between parts of the self, either self-evaluative or self-interruptive, are conceptualized as a struggle between a dominant, critical/censoring aspect of the self and a submissive, more fundamental aspect of the self (Elliott & Greenberg, 1997; Elliott et al., 2004; Greenberg & Goldman, 2019b; Greenberg & Watson, 2006). These depressogenic ways of treating oneself result from internalized standards of the ways one should be or feel, through which relevant aspects of experience, feelings, and/or needs are systematically disregarded or dismissed (Elliott et al., 2004; Greenberg & Watson, 2006).

In self-evaluation splits, a harsh and critical part of the self (the "critic") attacks a more fundamental part of the self (the "experiencer"). This evaluative and coercive stance towards oneself is typically embedded in such hostility and disgust that leaves the person feeling worthless, ashamed and ultimately defeated (Elliott et al., 2004; Greenberg & Watson, 2006). Two-chair dialogue for self-evaluation splits targets this core depressive process of self-criticism with the goal of promoting self-acceptance and

foster a dialectical integration between the conflicting parts of the self (Elliott et al., 2004; Greenberg & Watson, 2006). In two-chair dialogue clients are guided through a dialogue between the two parts of the self in opposition, alternately taking the roles of the inner critic (i.e., the part of the self that criticizes) and of the experiencing self (i.e., the part of the self that is criticized) in separate chairs. Enactment of the dialogue departs from having the self-critical part (inner critic) address its harsh criticisms in such a concrete, pungent manner that conveys the usual hostility and disgust for the *weak–bad* experiencing self. Moving on to the experiencing self's chair, clients are then supported in exploring and expressing the evoked emotional reactions in response to the self-critical attacks, where clients often collapse into powerlessness and hopelessness. These initial steps of the two-chair dialogue task evidence the constant presence and harmful impact of the self-critical voice and its role in the maintenance of the depressive state in which clients become stuck (Greenberg & Watson, 2006). Resolution of this emotional processing difficulty involves an assertion of the experiencing self's needs and the subsequent softening of the previously harsh inner critic into compassion. The shift involved in this emotional transformation on both sides is followed by a negotiation between these two parts in order to achieve an integration in terms of the experiencing self's needs and the inner critic's values and standards (Elliott et al., 2004; Greenberg & Watson, 2006).

In self-interruption splits, an oppressing and censoring part of the self (the "interrupter") restricts emotional experience and blocks the full expression of a more adaptive part of the self (the "experiencer"). Persistently disowning or disclaiming important aspects of emotional experience inhibits the access to relevant needs and their associated action tendencies, leaving clients stuck in an unintegrated sense of themselves coupled with feelings of hopelessness and resignation (Elliott et al., 2004; Greenberg & Watson, 2006). Two-chair enactment for self-interruption splits addresses this core depressive process of disowning emotional experience by supporting active self-expression and empowerment of the previously neglected part of the self (Elliott et al., 2004; Greenberg & Watson, 2006). In two-chair enactment clients are guided through a dialogue that fosters contact among the two opposing parts of the self, interchanging between the interrupter (i.e, the disowning part of the self) and the experiencing self (i.e., the disowned part of the self) in distinct chairs. The dialogue begins with the self-censoring part (interrupter) actively enacting the particular way in which it exerts the interruption of emotional experience, embodying the concrete physical and verbal components of such process of emotional blockage. The experiencing self is then invited to differentiate the inner experience of having its emotional experience despised and disowned by the interrupter with such contempt. These early stages of the two-chair enactment serve the dual purpose of increasing awareness of agency in the self-interruptive activity and

evoking a healthy insurgence against the interruptive part of the self and its injunctions. Resolution of this emotional processing difficulty occurs through the unconstrained expression of the previously suppressed emotional experience and the assertion of the corresponding unmet need (Elliott et al., 2004; Greenberg & Watson, 2006).

Empty-Chair Work for Unfinished Business. Unfinished business with significant others is characterized by the presence of persistent unresolved negative feelings in relation to a significant other (Elliott et al., 2004; Greenberg & Goldman, 2019b; Greenberg & Watson, 2006). The unprocessed nature of the feelings of hurt and resentment associated to early experiences of neglect, abandonment and/or abuse in the relationship with significant others perpetuate the longing for the unmet interpersonal needs that were disregarded in those relationships, with an enduring interference on current relationships (Elliott et al., 2004; Goldman & Greenberg, 2015; Greenberg et al., 1993; Greenberg & Watson, 2006). Empty-chair work for unfinished business promotes the emotional processing of these unresolved negative feelings by helping clients access and fully express those feelings to an imagined other in an empty chair (Elliott et al., 2004; Greenberg & Watson, 2006). In empty-chair work clients are invited to make psychological contact with their internal view of a significant other through a guided process of re-experiencing and addressing previously inhibited primary emotions such as sadness and anger. This process empowers clients into legitimizing their entitlement to the unmet interpersonal needs and propels them to assert themselves to the imagined other in the empty chair. Depending on the nature of the unfinished business, resolution of this emotional processing difficulty also involves a shift in the client's perspective of the significant other, either through enhanced understanding that usually leads to forgiveness or by holding the other accountable for past injury (Elliott et al., 2004; Greenberg & Watson, 2006).

Why We Studied the Effects of Chair Work?

In addition to the undermentioned brief scientific justification of why we studied the effects of chair work, a short consideration resembling a disclosure statement is relevant at this point. As a clinical psychologist and as a psychotherapy researcher, the author of this thesis is invested in EFT and is a founding partner of the Portuguese Society of Emotion-Focused Therapy. Such interest dates back a decade ago to the author's role in a randomized controlled trial where EFT was one of the treatments being compared, which enabled contact with the sample's psychotherapy sessions. Thus, in all honesty, the departing point for the research endeavor of this thesis was also dependent on personal interest and the professional opportunity to do so.

For conciseness, the details of previous research on the effects of chair work are described in each of the empirical studies from Chapter III; in this topic we focus on the overall conclusions of these studies and highlight what remains unclear about the effects of chair work on clinical symptoms and on emotional processing. The aggregated findings of previous studies suggest that relevant therapeutic outcomes at treatment termination (including clinical symptoms) may be fostered by including chair work interventions in treatment procedures (Ellison et al., 2009; Goldman et al., 2006; Greenberg et al., 2008; Greenberg & Watson, 1998; Paivio & Greenberg, 1995; Shahar et al., 2012; Stiegler et al., 2018a) and through the successful resolution of the emotional processing difficulties addressed in chair work (Greenberg & Malcolm, 2002; Greenberg & Webster, 1982). In our view however, empirically, these tentative conclusions remain as partially unsubstantiated inferences about the role of chair work in symptom improvement, due to the (almost exclusive) use of pre-post cross-sectional data collection and correlational data analysis procedures in these studies. Such methodological issues disregard the temporal dimension of psychotherapy as a dynamic process and inhibit any causal inferences on the effects of chair work tasks. An important prerequisite to determine causality is establishing timeline precedence between variables, assessed at multiple timepoints, ensuring that the independent variable changes before the outcome (Kazdin, 2007, 2009, 2014). In turn, notwithstanding the deliberate use of several therapeutic tasks (including chair work) in EFT to specifically promote the emotional processing of painful internal experiences (Elliott et al., 2004; Greenberg et al., 1993; Greenberg & Watson, 2006), the effective contribution of these techniques to client's depth of emotional processing throughout treatment remains empirically intangible and, therefore, essentially theoretical. Thus, in light of the abovementioned empirical gaps, our research objectives were to ascertain empirical support for the role of chair work in emotion-focused therapy by testing the assumptions that the process of reaching higher stages of resolution in chair work tasks would be longitudinally associated with a decrease of clinical symptoms in the following session (study 1, Chapter III) and with higher levels of emotional processing in the following session and at therapy termination (study 2, Chapter III).

How We Studied the Effects of Chair Work?

The process–outcome research paradigm posits the investigation of the relationship between clinically meaningful in-therapy processes and therapeutic outcomes to ascertain the change processes/mechanisms of psychotherapy (Crits-Christoph et al., 2013; Elliott 2010; Gelo & Manzo, 2015; Kazdin, 2007, 2009, 2014; Orlinsky et al., 2004). Within this frame of process–outcome research, we approach the question of how we studied the effects of chair work by defining the methodological aspects of our research (the empirical studies from Chapter III) in terms of design, data collection, and

data analysis; for this purpose, the process–outcome research characterization outlined by Gelo and Manzo (2015) served as our structural guide.

Categorically, the primary focus of our research is a specific factor (i.e., therapeutic technique). However, the way through which we set out to study this particular therapeutic technique (i.e., chair work) clearly deviates from the standard component studies. Instead of simply adding or removing techniques from treatments in experimental designs, our research focuses on client performances within the therapeutic techniques (i.e., client resolution processes in chair work tasks) as the process variable of interest.

Our research followed a non-experimental longitudinal group design to determine if the client processes involved in the resolution of chair work tasks promote positive outcomes in terms of clinical symptoms (study 1, Chapter III) and emotional processing (study 2, Chapter III), in a sample of emotion-focused therapy clients from a previous randomized controlled trial. Respectively, these methodological aspects allowed us to study the phenomenon of chair work ensuring adequate ecological validity, to consider time-related variations by assessing process and outcome variables across multiple points, and to increase the adequacy of the generalization of results.

In our empirical studies (Chapter III) we conceptualized "chair work" as a process variable and "clinical symptoms" and "emotional processing" as outcome variables. Particularly for "emotional processing", assessed at a within-session micro-level of observation, this differentiation between process and outcome variables is tenuous and merely artificially operationalized as separate to understand how psychotherapy works (Gelo & Manzo, 2015); for instance, despite its theoretically-bound conceptualization as an outcome variable (as explained in the previous section), "emotional processing" is simultaneously a clinically meaningful change process and an immediate outcome of the treatment. It has been suggested that treatment outcomes may be conceptualized at multiple levels of change beyond post-treatment outcomes (*big O's*), including in-session intermediate outcomes—the *little o's* (Greenberg, 1986; Greenberg & Pinsof, 1986). In addition to these conceptualizations, we also borrow from Doss's sequential model of psychotherapy change (2004) to frame our research: hypothetically, chair work techniques (i.e., therapy change processes) promote in-session resolution processes of conflict splits and unfinished business (i.e., client change processes) that transform maladaptive emotion schemes (i.e., change mechanisms), which in turn lead to symptom improvement (i.e., ultimate outcomes).

With respect to data collection in our research, assessment was carried out at an in-session level throughout the entire treatment for the process variable "chair work", at a post-session level throughout the entire treatment for the outcome variable "clinical symptoms", and at an in-session level at repeated

time-points for the outcome variable "emotional processing". Beyond enhancing the dependability of our research (Crits-Christoph et al., 2013), assessing process and outcome variables in such a systematic way over time enables multiple process–outcome timespans to be examined and to demonstrate both a timeline ordering and precedence between the variables at stake in the nonlinear psychotherapeutic phenomena—these are important prerequisites to establish causality (Gelo & Manzo, 2015; Hayes et al., 2007; Kazdin, 2007, 2009, 2014; Laurenceau et al., 2007). As for the assessment instruments, we developed a micro-processual observational measure to assess the within-session process variable of "chair work" at a moment-by-moment level (Chapter II); the outcome variable "clinical symptoms" was assessed with standard self-report measures (Beck Depression Inventory–II and Outcome Questionnaire–10.2; A. T. Beck et al., 1996; Lambert et al., 2005) and the outcome variable "emotional processing" was assessed with a micro-processual observational measure (Experiencing Scale; Klein et al., 1969, 1986).

Regarding data analysis in our research, we employed longitudinal data-analytic procedures to depict the temporally dynamic psychotherapeutic phenomena more reliably and allow causal inferences about the role of the independent variable in the dependent variables (Orlinsky et al., 2004; Salvatore & Tschacher, 2012). Wittingly, we (mostly) relied on multilevel models, considering time as a quantitative variable and accounting for both intraindividual (within-person level) and interindividual (between-person level) variability, to determine the temporal course of the process variable and estimate its predictive effect over the outcome variables (Tasca & Gallop, 2009).

CHAPTER II

TRACKING CLIENT PROGRESS IN CHAIR WORK: A CLINICAL ILLUSTRATION

Elizabeth: Instead of being at war, we're at peace.
Therapist: You no longer say 'she'—you say 'we'.
Session 11

Developing a Method of Tracking Client Progress in Chair Work

In order to investigate the effects of performing chair work tasks, our initial challenge was to operationalize emotion-focused therapy's (EFT) chair work tasks' resolution models (see Table 1) in a practical coding system. Our path towards creating a coding manual involved (1) compiling comprehensive descriptions of target client processes, (2) defining reliable coding criteria, (3) systematizing coding procedures, (4) defining appropriate interrater agreement indices, and (5) structuring training procedures.

1. *Target client processes*. Elliott et al.'s (2004) thorough descriptions of the client processes involved in the successful resolution of the three chair work tasks (i.e., two-chair dialogue for self-evaluation splits, two-chair enactment for self-interruption splits, and empty-chair work for unfinished business; see Table 1) were complemented with prototypical examples from other relevant sources (e.g., Greenberg et al., 1993; Greenberg & Watson, 2006; Watson et al., 2007) and supplemental disambiguation criteria for each stage.
2. *Coding criteria*. The unit of analysis was defined as the communicative (inter)actions within in-therapy processes of chair work events, considering all verbal and non-verbal elements of communication (i.e., speech, tone of voice, body-language, facial expression). Given that the focus of the analysis is circumscribed to the client, therapist's interventions were only considered as a source to contextualize client's processes along the resolution stages of chair work. Markers (i.e., stage 1) from each chair work task were to be excluded from the analysis, as these represent a manifestation of emotional processing difficulties but not effective therapeutic work. To ensure methodological validity, a criterion of 'active chair work' was to be enforced in the qualitative analysis: only events where plausible contact between parts of the self is observed (i.e., the client must be addressing either experiencer, critic, interrupter, or significant other) are to be considered as valid chair work event segments. Consequently, instances of mitigated chair work and post-enactment reflections are disregarded.
3. *Coding procedures*. Following common recommendations for qualitative data analysis (e.g., Hill & Lambert, 2004; Mörtl & Gelo, 2015), the full extent of the video-recorded therapy sessions was to be analyzed by pairs of raters (i.e., co-rated). Procedural coding guidelines

encompass session-by-session independent ratings, followed by discussion meetings to compute interrater agreement and establish consensus on possible divergences. After a trial period, we dropped the possibility of using general qualitative data analysis software packages (e.g., NVivo) or even specialized video analysis software (e.g., ANVIL) due to the necessary learning curve to make the coding process viable. Raters are tasked to identify three types of components: beginning and end delimitations of the chair work event segment, the type of task and the resolution stage presented. Technical coding guidelines were then outlined to ensure standardized coding procedures for all raters: use of timestamps (i.e., hh:mm:ss) for chair work event segment's delimitation; use of codes for the task/stage presented (i.e., TCD/TCE/ECW - 2/3/4/5/6); identify which part of the self is being enacted (i.e., experiencer or critic/interrupter/significant other); brief description including the reasoning for the assigned code (task/stage), accompanied by a representative short transcription. To ensure consistency and reliability in the qualitative analysis, pairs of raters were to be constituted with a more experienced principal rater with prior training and clinical experience in EFT (i.e., the author of this doctoral thesis).

4. *Interrater agreement*. To asses interrater agreement and ensure adequate standards, the following indices were to be computed for the three types of components identified by raters: percentage of agreement on chair work event segments' delimitation, $Cohen's\ \kappa$ (Cohen, 1960; Fleiss et al., 2003; Landis & Koch, 1977) on the type of tasks, and $Intraclass\ Correlation\ Coefficient$ (two-way random-effects model, average measures, absolute agreement; Cicchetti, 1994; McGraw & Wong, 1996; Shrout & Fleiss, 1979) on the resolution stages.
5. *Training procedures*. Training components were outlined in a stepped approach (i.e., in ascending difficulty) to allow trainees to progressively build their knowledge and analytical skills of clients' processes in chair work. To guide this approach, several support materials were elaborated for each step of the training (e.g., essential reading material, summary presentation about the coding system, coding grids with automated functions, video excerpts of previously analyzed therapy sessions, correction grids). The process of training other raters in the coding system was to be conducted by a more experienced rater with prior training and clinical experience in EFT (i.e., the author of this doctoral thesis).

Table 1

Client processes in the chair work tasks

	TWO-CHAIR DIALOGUE	TWO-CHAIR ENACTMENT	EMPTY-CHAIR WORK
Stage 1	Marker confirmation: *Client describes split in which one aspect of self is critical of, or coercive toward, another aspect. Broadly, client describes two aspects, whether attributed or in somatic form.*	Marker confirmation: *Client engages in or describes how one part interrupts another part.*	Marker confirmation: *Client blames, complains, or expresses hurt or longing in relation to a significant other.*
Stage 2	Initiating two-chair dialogue: *Client clearly expresses criticisms, expectations, or "shoulds" to self in concrete, specific manner.*	Entry: *Client actively enacts own possible self-interruptive process in concrete specific manner.*	Setting up and starting: *Client speaks to imagined other and expresses unresolved feelings (e.g., resentment, hurt).*
Stage 3	Deepening the split: *Primary underlying feelings and needs begin to emerge in response to the criticisms. Critic differentiates values and standards.*	Deepening: *Client contacts and differentiates feelings of passivity and resignation.*	Differentiating meaning and expressing primary emotions: *Client differentiates complaint into underlying primary feelings and experiences and expresses relevant emotions (e.g., sadness, anger, fear, shame) with a high degree of emotional arousal.*
Stage 4	New experiencing and self-assertion: *Client clearly expresses needs and wants associated with a newly experienced feeling.*	Partial resolution: *Client clearly expresses interrupted emotion.*	Expressing and validating unmet needs: *Client experiences unmet needs as valid and expresses them assertively.*
Stage 5	Softening of the critic: *Client genuinely accepts own feelings and needs and may show compassion, concern, and respect for self.*	Self-assertion: *Client clearly expresses need associated with the emotion.*	Shift in representation of other: *Client comes to understand and see other in a new way, either in a more positive light or as a less powerful person who has or had problems of his or her own.*
Stage 6	Negotiation: *Client gains clear understanding of how various feelings, needs, and wishes may be accommodated and how previously antagonistic sides of self may be reconciled.*	Full resolution: *Client feels empowered and envisages or plans new actions in the world in order to meet need.*	Self-affirmation and letting go: *Client affirms self and lets go of unresolved feeling by understanding, forgiving, or holding other accountable.*

Note. Adapted from *Learning Emotion-Focused Therapy: The Process-Experiential Approach to Change* (pp. 223, 239, 246), by R. Elliott, J. C. Watson, R. N. Goldman, and L. S. Greenberg, 2004, American Psychological Association (https://doi.org/10.1037/10725-000). Copyright 2004 by the American Psychological Association.

The end product of the aforementioned process, the Chair Work Coding System (Lourenço et al., 2018) consists in a method of systematic identification of the sequential stages of client processes towards resolution in the chair work tasks (see Table 1), allowing researchers to track client's progress throughout therapy. Following Hill and Lambert's (2004) classification of dimensions of process measures and Mörtl and Gelo's (2015) characterization of qualitative methods, the Chair Work Coding System (Lourenço et al., 2018) may be described as follows:

- A top-down, microanalytic approach to qualitative data analysis in psychotherapy process research based on an a priori category system, addressing mostly content but also structural aspects in client's communicative (inter)actions.
- A qualitative process measure focusing on client processes, with particular attention to client's overt behaviors, though not disregarding client's covert reactions or experiences.
- Its theoretical basis is clearly humanistic-experiential and it values rater's perspective of evaluation and knowledge of client processes in emotion-focused therapy.
- Its analyses capture macroprocess units that require global judgments of events, i.e., the set of client behaviors that characterize each stage of a given chair work task.
- An interval scale type of measurement ranging from two (task initiation) to six (task resolution), since every task progresses through a succession of stages of resolution.
- An observational mixed-type data generating scale with an overlap between process and outcome, as each particular client process within a given stage may also in itself be conceived as an outcome in terms of degree of resolution. In this sense, at a pragmatic level, it derives qualitative data (i.e., client processes) that may be transformed into quantitative data (i.e., degree of resolution).

A Clinical Illustration Through Elizabeth's Case

The entire therapeutic process of Elizabeth was analyzed for the purpose of this clinical illustration, identifying events of chair work and tracking her progress through its resolution stages across therapy (see Table 1 for a comprehensive description of the client processes in the chair work tasks). The coding procedures followed the Chair Work Coding System's manual (Lourenço et al., 2018) and are described in depth in the empirical studies from Chapter III, where the systematic identification of chair work events in a sample of clients allowed us to study the effects of resolving chair work tasks. Regarding Elizabeth's case, a pair of raters with prior experience in the systematic identification of chair work events analyzed each session independently before the discussion meetings, where interrater agreement indices

were calculated and disagreements were resolved by consensus. The pair of raters obtained excellent agreement standards on all indices: percentage of agreement on chair work event segments' delimitation was 85.57%, $Cohen's\ \kappa$ (Fleiss et al., 2003; Landis & Koch, 1977) on the type of tasks was 1.00, and $Intraclass\ Correlation\ Coefficient$ (Cicchetti, 1994) on the resolution stages was .88.

Introduction to Elizabeth's Case

Elizabeth was around 40 years old at the time of therapy, divorced, mother of three children, and was employed. Upon evaluation she was diagnosed with recurrent moderate Major Depressive Disorder (American Psychiatric Association, 2013). Elizabeth came to therapy feeling guilty for having deprived her children from a stable family context, evidenced by the presence of self-criticism in relation to her role as a mother. She also carried a resentment towards her father, accompanied by a longing for her missed childhood. As a child and throughout adolescence, Elizabeth was frequently exposed to domestic violence, witnessing her father's physical and emotional abuse towards her mother. Elizabeth's main depressive symptoms were increased irritability and an overall lack of interest in daily activities. Her Beck Depression Inventory–II (BDI–II; A. T. Beck et al., 1996) scores were 31 at intake and 1 at the end of treatment, and based on the criteria of reliable and clinically significant change (Jacobson & Truax, 1991; Lambert & Ogles, 2014) for the same symptom intensity measure she was considered a recovered case. Her Outcome Questionnaire–45.2 (OQ–45.2; Lambert et al., 2013) scores were 96 at intake and 14 at the end of treatment. Elizabeth underwent 16 sessions of emotion-focused therapy (EFT) according to Greenberg and Watson's (2006) and Elliott et al.'s (2004) guidelines.

Chair Work Evolution in Elizabeth's Case

Elizabeth performed chair work tasks on sessions 3, 4, 5, 6, and 11, where she engaged in two-chair dialogue for self-evaluation splits and empty-chair work for unfinished business. Figure 1 depicts chair work evolution in Elizabeth's case, where we can observe her progress through the resolution stages of each task throughout therapy. Following we will present an intensive account of Elizabeth's chair work throughout therapy, with clinical vignettes and detailed descriptions of her moment-by-moment processes.

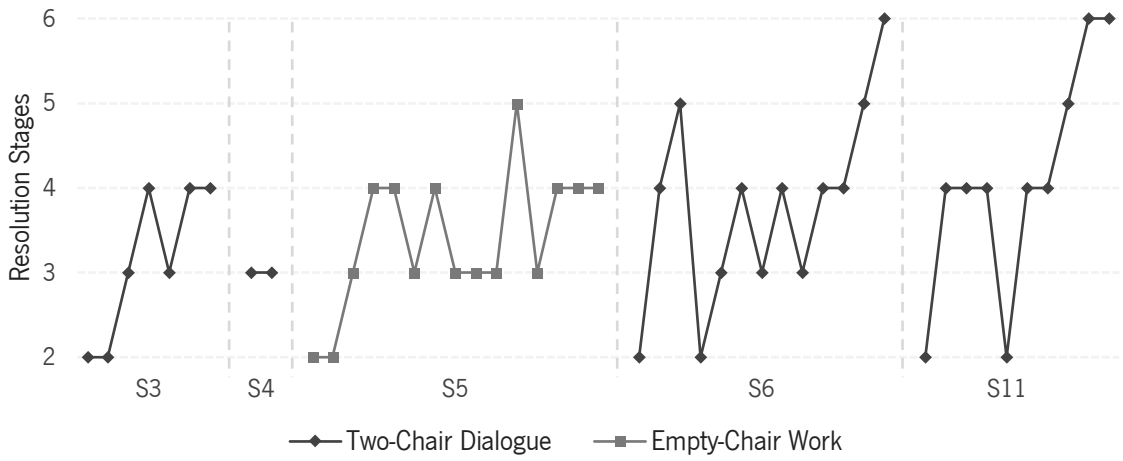


Figure 1. Elizabeth's chair work events throughout therapy. Points represent the particular resolution stage of each chair work event segment, discriminating the type of task.

Session 3

Elizabeth mentioned a relentless voice that threw harsh considerations about her role as a wife and as a mother. The therapist fed the elaboration of such voice in the context of two-chair dialogue and set the structure of the task by giving voice to Elizabeth's inner critic. Elizabeth moved to the inner critic's chair and immediately began to cry, covering her face in shame with both her hands. While at the inner critic's chair, Elizabeth threw strong accusations about her past conduct that questioned her self-worth. Particularly, her inner critic targeted the decision of leaving her ex-husband.

> **Therapist:** Let's try and put her here (pointing at the chair), this side of yours that draws accusations, that tells you you're a disgrace. Tell her, "you're a disgrace".
>
> **Elizabeth: [inner critic]** You're a disgrace! Why have you done this to your children? Imagine when they find out about this, aren't you ashamed? A woman of your age? You're a disgrace! Where are your moral standards? **[TCD–stage2]**
>
> **Therapist:** "Where are your moral standards?"
>
> **Elizabeth: [inner critic]** Where are the values your parents gave you? You have no values! You reached your lowest, you have no ability to be a mother, a wife, or to be respected by anyone! **[TCD–stage2]**

After moving to the experiencing chair, Elizabeth remained crying in silence and sighed for the first few minutes. She then began to express her underlying feelings in response to her inner critic's relentless accusations. Listening to a potentially assertive stance, the therapist encouraged Elizabeth to stand up for herself. While at the experiencing chair, Elizabeth rejected the way her inner critic made her feel and endorsed her past decisions.

Therapist: (touching the experiencing chair) Can you move here? Allow yourself to stay in touch with what you're feeling right now. Let it come. How does she make you feel?

Elizabeth: [experiencer] (crying) You make me feel like trash, but I know I'm not. You're being very unfair to me. **[TCD–stage3]**

Therapist: Tell her that, "You're very unfair".

Elizabeth: [experiencer] You're very unfair. Very critical and very unfair. You have no right. **[TCD–stage3]**

Therapist: "You have no right", tell her again.

Elizabeth: [experiencer] (raises her voice) You have no right to massacre me. You don't have the right to talk about these things, to make me feel the way you do, because I'm not any of that. I'm not that trash you make me feel I am. **[TCD–stage4]**

Therapist: "You have no right to make me feel that way."

Elizabeth: [experiencer] I won't allow you to massacre me again, I won't allow it. Enough! It's completely unfair of you to make me feel like trash. The things I did, I did them for the right people, at the moment I needed to do it, and not because I'm trash or because I'm a disgrace. **[TCD–stage4]**

Sensing the need for separation from the inner critic, the therapist suggested an enactment using actual physical separation between the two parts of the self. Elizabeth stood up, (figuratively) picked the inner critic roughly with her arms, threw it in the trash bin, and returned to the experiencing chair.

Therapist: What do you feel like doing to her?

Elizabeth: Wrap her, go outside, put her in the trash bin and let her stay there.

Therapist: Do you want to do this right now?

Elizabeth: [experiencer] I needed to take this weight off of me. She's very heavy, very heavy. I felt so heavy. It's a relief! **[TCD–stage4]**

Therapist: Stay with that feeling. Take a deep breath and just feel it within yourself.

After such enactment, Elizabeth accessed a feeling shift of relief and the therapist invited her to deepen the experiential contact with such bodily-felt experience.

Session 4

Elizabeth arrived at session four feeling deeply vulnerable and became very emotionally activated when mentioning an overwhelming feeling of guilt in relation to her past decisions, particularly regarding her ex-husband. The therapist suggested that Elizabeth addressed this guilt through two-chair dialogue and Elizabeth immediately collapsed into powerlessness just by looking at the inner critic's chair and

imagining its presence. The therapist supported Elizabeth's exploration of her helplessness and resignation.

Elizabeth: [experiencer] I don't know if I'll be able to say anything to her (inner critic) today. She is stronger than me, today she is bigger than me. Today I'm unable to speak to her, today she's more powerful than me. **[TCD–stage3]**

Therapist: "Today you're more powerful than me."

Elizabeth: [experiencer] I have no strength to deal with her, no energy. I really can't. **[TCD–stage3]**

Therapist: "You leave me like this."

Elizabeth: [experiencer] Today I'm small, very small. Tiny, scared, alone, completely lost. I'm tiny, I can't deal with her. **[TCD–stage3]**

Therapist: "I can't even look at you."

Elizabeth: [experiencer] (sobbing) No, no, I can't. **[TCD–stage3]**

The therapist proceeded with helping Elizabeth deal with this overpowering experience by offering empathic prizing responses for her vulnerability, following empathic affirmation of her feelings and not proceeding with the two-chair dialogue task.

Session 5

Elizabeth elaborated on why she felt her father hated her. The therapist suggested that they create the opportunity for Elizabeth to talk to her father in the context of empty-chair work. Elizabeth started invoking the imagined presence of her father in the empty chair by describing him in a negative fashion, portraying the particular way in which she perceived him. Elizabeth then initiated the imagined dialogue with her father by inquisitively questioning him about his lifelong attitude towards her and afterwards, embedded in her experience of being his daughter, accused him for his faults in her upbringing.

Elizabeth: (pointing at the empty chair) My father sat there, right?

Therapist: How is he? Can you picture him there?

Elizabeth: [experiencer] He's there with that usual look on his face, frowning his eyes, with the usual sullen and suspicious look on his face towards me. **[ECW–stage2]**

Therapist: What would you like to say to him?

Elizabeth: [experiencer] What have I done to you? Why do you hate me so much? Why do you treat your children differently? Ever since I can remember, you've done it. **[ECW–stage2]** You have made me the worst person in the world, you're ashamed of me, you tell everyone that I'm a bad mother, you want to turn my children against me, you're jealous of the relationship I have with my

mother. Aren't you ashamed of saying that you help your daughter but she doesn't deserve it? Aren't you ashamed? Is that something one should do to their children? **[ECW–stage3]**

Accessing her unresolved feelings left Elizabeth feeling disgusted by her father, which brought up an interpersonal need of separation that propelled her to tell her imagined father that she rejected everything that came from him. After pushing the imagined presence of her father away, Elizabeth asserted her self-worth by comparing herself with her father. Alongside her self-affirmation process, Elizabeth also began to give voice to the unmet needs that stem from the childhood relationship with her father.

Elizabeth: [experiencer] You are worthless! You were worthless as a husband, you were worthless as a father, and you've done everything at your disposal to be worthless as a grandfather. It's sad! **[ECW–stage3]** (pushing with her hands) I don't want to be like you! **[ECW–stage4]**

Therapist: What are you doing with that gesture (pushing with her hands)?

Elizabeth: I'm pushing away all the evilness he's giving me (pushing with her hands).

Therapist: "I don't want the things you make me feel."

Elizabeth: [experiencer] I don't want anything from the way you make me feel. I'm not any of that. I'm not any of that, period (raises her voice). **[ECW–stage4]**

Therapist: Tell him how you are.

Elizabeth: [experiencer] Unlike you I didn't remain in a sick relationship that harmed my children. The money you have won't buy you any friendship, the love from your children, and the time you've wasted away from them. That money and those values you cherish are nothing more than sad values that won't do you any good. The most noble values that you should've gave us—the values of empathy, tolerance, forgiveness, of family and home, of peace—all of these you'll never be able to buy. That's why you're a much poorer person than I am. In my house there's peace, because I contribute to it, there's respect between me and my children. **[ECW–stage4]**

Elizabeth's self-assertion towards her father was also intertwined with self-affirmation in regard to past decisions involving her ex-husband. Following her self-affirmation process, the therapist prompted Elizabeth to further differentiate her unmet need. After Elizabeth reaffirmed the need of separation from her father, the therapist invited her to step into the significant other's chair, but Elizabeth blatantly rejected the idea of enacting her father's persona.

Elizabeth: [experiencer] I eliminated the person (ex-husband) that my mother should've eliminated from our house—you. I eliminated that person that went against the value of respect, against the values I cherish. **[ECW–stage4]**

Therapist: "Against the family values I cherish."

Elizabeth: [experiencer] He was someone that was a part of the family without actually taking any part on it. Anyone that is just there without being present should be sent away, and that's what my mother should've done with you. I have three children, you're alone. I have friends, you're alone. I have family, you're alone. So who's got reasons to be ashamed? I don't need people like you. I need what I have, my children, my family, my home. I have a home now and I never had one. **[ECW–stage4]**

Therapist: "You never gave me one."

Elizabeth: [experiencer] You never gave me one, you prevented me from having one. I would like to forgive you, but I won't be able to do it. **[ECW–stage4]**

Therapist: "I can't forgive you."

Elizabeth: [experiencer] I'm unable to forgive you. I mean you no harm, but you're someone I'd like to see removed from my life. I think that the best thing for me would be to never see you again in my life. **[ECW–stage4]**

Therapist: Can you move here (pointing at the empty chair)? What do you have to say to your daughter?

Elizabeth: I don't know. I don't know because I refuse to step in his shoes.

Further in the session, Elizabeth mentioned her father's differential attitude towards her and her brother. The therapist fed the exploration of Elizabeth's unmet interpersonal need and she asserted her entitlement to her father's care.

Elizabeth: He encourages my brother, he supports him, he's always complementing him, he's proud of my brother. Not that I'm jealous of my brother, but...

Therapist: But you wanted that for yourself. As a daughter you needed to feel that.

Elizabeth: I wanted what I am entitled to, what I deserve.

Therapist: Tell him (pointing at the empty chair).

Elizabeth: [experiencer] I don't want charity. I want what's mine by right. **[ECW–stage4]**

Therapist: Say that again, "I want what's mine by right".

Elizabeth: [experiencer] I want what's mine by right. As a daughter, I'm as entitled as my brother. It was your duty. Your duty as a father was to be human enough to understand that you should not trample over someone that needs support. **[ECW–stage4]**

Therapist: "You should've supported me."

Elizabeth: **[experiencer]** You should've supported me, should've appreciate me, and you didn't do any. **[ECW–stage4]**

Therapist: You missed a father in your life.

Elizabeth: **[experiencer]** Very much, I missed it a lot. I missed a father, not this one, but a father. I would give anything not to be your daughter. **[ECW–stage4]** You've always hurt me, but you won't do it anymore. Because I do not carry that resentment anymore. **[ECW–stage5]**

Therapist: What do you carry now?

Elizabeth: **[experiencer]** Revolt, a lot of revolt. A lot of anger, a lot of revolt, and perhaps also hate. **[ECW–stage5]**

After expressing and validating her unmet needs, Elizabeth held her father accountable for his wrongdoing and ultimately saw him as flawed and worthy of her lingering bad feelings.

Session 6

Elizabeth described a pressure to be available and help others, mentioning a voice that accused her of being insensitive and selfish. The therapist suggested two-chair dialogue. While at the inner critic's chair, Elizabeth accused herself of being insensitive to others and made threats about the future.

Therapist: In which things are you still able to get to her?

Elizabeth: **[inner critic]** I know that she's very afraid of loneliness. **[TCD–stage2]**

Therapist: How do you scare her?

Elizabeth: **[inner critic]** Today she has everyone. A few years from now she'll be alone. And when she's all alone she'll feel the same way her father does. And I'll be there when this happens. **[TCD–stage2]**

Therapist: You'll be there to tell her what?

Elizabeth: **[inner critic]** (pointing her finger) You'll have someone to point a finger at you just as you did to others. You'll have people being insensitive to you just as you are insensitive to them. **[TCD–stage2]**

Therapist: So, you're saying, "You're insensitive towards your father and when you're all alone I'll remind you of that".

Elizabeth: **[inner critic]** Years will go by, you'll be all alone, and I'll be there. **[TCD–stage2]**

Therapist: "To blame you for being insensitive."

Elizabeth: **[inner critic]** To blame you. My time will come again. I don't disappear, I simply fall asleep. When the time comes, I'll show up again. **[TCD–stage2]**

While at the experiencing chair, Elizabeth momentarily adhered to the concerns about the future. The therapist read into Elizabeth's facial expression and offered an empathic exploration response. Instead of revolving around the threats made by her inner critic, Elizabeth quickly focused on recognizing her inner critic's positive role and established the conditions for their relationship.

Therapist: (touching the experiencing chair) Can you move here? What do you say to her?

Elizabeth: [experiencer] She's talking about the future and that worries me a lot. **[TCD–stage3]**

Therapist: By talking about the future she scares you.

Elizabeth: [experiencer] A lot. Everything we do now will affect our future. **[TCD–stage3]**

Therapist: And she convinces you that your current behavior will affect your future. What is she, a liar?

Elizabeth: [experiencer] I don't think so. She has her role, trying to balance me. **[TCD–stage4]**

Therapist: Somehow, she has the role of reasoning with you, but you think she's been exaggerating?

Elizabeth: [experiencer] A lot. Her presence doesn't disturb me if it has a balancing role. It only disturbs me when it's more like a blaming voice. **[TCD–stage4]**

Therapist: Ok, tell her that, "I understand your role...".

Elizabeth: [experiencer] I understand and accept your presence in my life as long as you're a balancing voice and not a blaming one. Your role is not to frustrate or recriminate me—that's not your role. Your role is to balance me—not to blame me. I accept your presence, but within certain conditions. **[TCD–stage4]**

Afterwards, Elizabeth intertwined the expression of the underlying feelings associated to her inner critic's past ruthlessness with self-affirmation supported by her therapist. Elizabeth's assertive stance brought up a feeling shift in the way she perceived herself in relation to her inner critic and she recognized her inner critic as a part of herself.

Therapist: "You only harm me when you exaggerate."

Elizabeth: [experiencer] When you exaggerate, you only harm me. **[TCD–stage3]**

Therapist: "You hurt me."

Elizabeth: [experiencer] You hurt me a lot, you make me feel bad. You seriously hurt my life. **[TCD–stage3]**

Therapist: It was very difficult all these years when she accused you.

Elizabeth: [experiencer] All these years of conflicts between me and her were very difficult. There were times when I had no strength and she ruled everything. **[TCD–stage3]**

Therapist: "You annulled me many times."

Elizabeth: [experiencer] I didn't just feel annulled—I was really annulled. By this voice that made me feel worthless, despicable. **[TCD–stage3]**

Therapist: "You have no right to do this."

Elizabeth: [experiencer] No. You don't have the right to do this to me. I don't deserve that. **[TCD–stage4]**

Therapist: "I don't deserve that."

Elizabeth: [experiencer] I don't deserve that. **[TCD–stage4]**

Therapist: "I have value."

Elizabeth: [experiencer] I have value and I'll manage to balance things. **[TCD–stage4]**

Therapist: "I'll let you stay."

Elizabeth: [experiencer] With certain conditions. You can stay with certain conditions. I know that you have a role, but beyond that I won't allow you to speak. I won't allow it. **[TCD–stage4]**

Therapist: "That's enough."

Elizabeth: [experiencer] I'm done believing in what you used to say about me. Today I know what I am by myself—not through your words. It's much better for me to be bigger now and you small like this (gestures with her hand). **[TCD–stage4]**

Therapist: Today you feel big.

Elizabeth: [experiencer] She exists, and I allow her to exist, granted that she stays small and just gives her opinion whenever required. I'll listen to her, but I'm the one calling the shots. **[TCD–stage4]**

Therapist: Is it important for you to see her (inner critic) small?

Elizabeth: [experiencer] Yes. I know that she'll always be there because she's a part of me. In the right way she can and should be there. But not like she used to do because it was too painful. **[TCD–stage4]**

Elizabeth moved to the inner critic's chair, where her inner critic softened into compassion and offered future collaboration. After her inner critic softened, Elizabeth moved to the experiencing chair and

the sense of struggle between the two sides seemed to have vanished. While at the experiencing chair, Elizabeth felt genuinely accepted and worthy of her inner critic's acknowledgment.

Therapist: Can you step in here (touching the inner critic's chair)? Elizabeth's telling you that you can and should be in her life and be present, but with balance. And that she won't allow you to diminish her like you used to. How do you reply to this demand from her, to be there with certain rules?

Elizabeth: [inner critic] I agree. I think it's a fair demand. I think it's a good thing that you let me stay because I can be useful. I'm here for a reason. **[TCD–stage5]**

Therapist: "I want to help you, by being fair and being balanced."

Elizabeth: [inner critic] I'm going to help you to be fair and balanced, within your demands. **[TCD–stage5]**

Therapist: She said that your presence along these years was very painful for her.

Elizabeth: [inner critic] I know it was, I know it was. I know I've been truly effective in my mission of blaming her, of humiliating her, of recriminating her, of pointing my finger to her. I know all of that were strong moments for her. I made you believe you were someone that you were really not. **[TCD–stage5]**

Therapist: "You're not the person I told you you were. You have value." Is that what you're telling her?

Elizabeth: [inner critic] Yes. In a certain way I've always belittled her, discredited her. I made her discredit herself. And that's not true—she has value. And she's big, she's very big. **[TCD–stage5]**

Therapist: Can you say that to her again? "You're big!"

Elizabeth: [inner critic] You're big! I'm going to stay here. I'll always be here, paying attention. But I'll respect your boundaries because you're bigger than me. **[TCD–stage5]**

Therapist: Can you step in here (touching the experiencing chair). How is it for you to listen to her saying "you're big"?

Elizabeth: [experiencer] It's a well-deserved trophy. I think I deserve it. It's a well-deserved trophy. **[TCD–stage6]**

Therapist: It's nice to hear her recognizing this.

Elizabeth: [experiencer] Yes, yes it is—a lot. **[TCD–stage6]**

Therapist: Can you tell her, "This is a well-deserved trophy and it's important for me that you recognize this".

Elizabeth: [experiencer] It's important that after all this time that you massacred me you finally realize that I have value and that I'm big. I deserve that recognition (deep sigh followed by a smile). **[TCD–stage6]**

The therapist proceeded with supporting Elizabeth's exploration of the newly-emerged feelings of self-worth and inner-balance.

Session 11

Elizabeth began the session by reflecting on a few significant changes, focusing on her assertiveness toward others. The therapist helped her explore a kind of strangeness she felt toward being more assertive. Elizabeth elaborated on such strangeness, hinting at a self-critical process, and the therapist suggested two-chair dialogue. While at the inner critic's chair, instead of assuming a critical stance the inner critic emerged as protective and expressed its fears about Elizabeth's assertiveness.

Elizabeth: I feel that I'm being fair, but sometimes I question if I'm actually being selfish.

Therapist: (pointing at the inner critic's chair) Go there and tell that to Elizabeth, "You're being selfish". Make her question herself.

Elizabeth: [inner critic] You're having second thoughts because deep down you know you're being too extreme. I think I'm trying to reason with her. **[TCD–stage5]**

Therapist: You're afraid she's being too extreme. Tell her that, "I'm afraid...".

Elizabeth: [inner critic] By being extreme in this you may become someone you didn't want to be—someone cold and insensitive. **[TCD–stage5]**

Therapist: You're afraid that she becomes that person?

Elizabeth: [inner critic] Maybe. **[TCD–stage5]**

Therapist: Can you tell her you're afraid she becomes cold and insensitive?

Elizabeth: [inner critic] I have a certain fear of her crossing the boundaries of what is fair and be cold and insensitive. I want her to be fair to herself and I don't want that her justice is unfair to others—I want her to be in the middle. **[TCD–stage5]**

Moving on to the experiencing chair, Elizabeth acknowledged the inner critic's protective stance and reflected on the newly-forged collaborative relationship between the two parts of the self.

Therapist: Can you step in here (pointing to the experiencing chair)?

Elizabeth: [experiencer] I think that side is just warning me that if I'm too extreme maybe I'll become something I don't want to be. Maybe she's just drawing my attention. **[TCD–stage6]**

Therapist: "Be careful."

Elizabeth: [experiencer] Not that she's pointing her finger at me—it's more like she's alerting me. Right now she's not blaming me—she's just balancing me. **[TCD–stage6]**

Therapist: That balance you were looking for. She's just speaking to help you.

Elizabeth: [experiencer] We're not unbalanced—we're balanced. You're balancing me. **[TCD–stage6]**

Therapist: "You have that fear and I understand your fear."

Elizabeth: [experiencer] Exactly. You're fulfilling your mission, you're doing what I told you I expected from you. We won't have an argument, you'll stay there as usual. I won't be extreme, don't worry. We can rest assured. **[TCD–stage6]**

Therapist: It's as if this side...

Elizabeth: [experiencer] Instead of being at war, we're at peace. **[TCD–stage6]**

Therapist: It's as if that side is no longer the side that hurts you, as if you were closer. You no longer say "she"—you say "we".

Elizabeth: [experiencer] I think that's it. It's a good feeling to be able to realize that that side as moved closer to me in a smaller size. There's been balance, which brings me peace and quiet, and most of all it brings me security. The balance between the two sides brings me security. I feel more capable of making my own decisions. **[TCD–stage6]**

The therapist proceeded with deepening Elizabeth's exploration of the feelings and meanings resulting from the dialectical integration between parts of the self.

Brief Discussion of Elizabeth's Chair Work

The sole purpose of this clinical illustration was to figure as an example of the method of tracking client progress in chair work, as it was applied to the sample of clients used in the empirical studies of this thesis (Chapter III). Nonetheless, this systematic analysis allows a few considerations about Elizabeth's process of resolving her self-evaluation split through two-chair dialogue and her unfinished business through empty-chair work.

Early in therapy it became clear that Elizabeth's self-evaluation split would constitute a central piece of her therapeutic process. The presence of her harsh self-critical process seemed to be pervasive in her life, perpetrating feelings of shame by attacking her self-worth and impacting her daily mood. A glaring example of how Elizabeth's self-critical process has an overpowering effect on her occurs at session four, where the sole imagined presence of her inner critic in the chair renders her powerless. At this point in the two-chair dialogue Elizabeth's self is collapsed, in the sense that she was only capable of accessing her inner critic's stance along with feelings of weakness and shame (resolution stage 3).

Elizabeth felt a lifelong resentment towards her father, which seems to have stemmed from childhood deprivation and enduring mistreatment. Since Elizabeth did not reach full resolution (stage 6) on the empty-chair work task at session 5, she apparently did not seem to fully resolve her unfinished business with her father. Notwithstanding, despite not being able to let go of her unresolved negative feelings (resolution stage 6), Elizabeth was able to express and validate her unmet need for care by asserting her entitlement to a different, caring father (resolution stage 4) and to hold her father as worthy of her lawful anger for his persistent misconduct in their relationship (resolution stage 5). These final processes of Elizabeth's empty-chair work task might have been more suitable to her unfinished business than actually letting go of the resentment with her father, since she seemed to have come to terms with her missed childhood at the end of the task. In fact, although still including the process of letting go of bad feelings, it is suggested that the final resolution stages of the empty-chair work task with abuse cases might be more focused on the processes of holding the other accountable and moving on.

Elizabeth carried an overwhelming guilt for not providing a proper traditional family to her children, feeling that she had failed both as a woman and as a mother. Working through this guilt involved more obviously two-chair dialogue, but also empty-chair work. In the two-chair dialogue task from session 3 Elizabeth endorsed her past decision of leaving her ex-husband, opposing her inner critic's shaming accusations (resolution stage 4). In the empty-chair work task from session 5 Elizabeth's assertion towards her father was also intertwined with self-affirmation in regard to past decisions involving her ex-husband (resolution stage 4). Because her inner critic's ruthlessness from session 3 was somewhat different from the milder way it emerged in session 6, we hypothesize that Elizabeth's self-affirmation process in the context of empty-chair work in the previous session (session 5) may have facilitated this shift in her inner critic. This shift allowed Elizabeth to acknowledge her inner critic's balancing role in her life (resolution stage 4) and the struggle between the two parts seemed to vanish at the end of the two-chair dialogue task in session 6 (resolution stages 5 and 6). Thus, we hypothesize that in Elizabeth's case resolving her self-evaluation split was also aided by the process of resolving her unfinished business with her father.

Elizabeth has reached resolution stage 6 of the two-chair dialogue task in two instances, specifically in session 6 and in session 11. While in session 6 Elizabeth felt genuinely accepted by her inner critic and their relationship seemed to have been pacified, in session 11 she highlighted a collaborative relationship between the two parts of the self and reflected on the sense of wholeness that derived from their negotiation process. As such, Elizabeth's endpoint in the two-chair dialogue task was first through self-compassion (in session 6) and afterwards through a dialectical integration of different

self-aspects (in session 11). Although both instances are representative of full resolution processes of Elizabeth's self-evaluation split, these seem to differ in complexity and degree of resolution.

An abrupt symptom decrease seems to occur between session 4 and session 8 in Elizabeth's case (decrease of 27 points on the BDI–II and 74 points on the OQ–45.2). Moreover, Elizabeth remains asymptomatic (i.e., below clinical significance) throughout the remaining duration of therapy at least since session 8. In between those sessions, specifically on session 6, Elizabeth reaches resolution stage 6 of the two-chair dialogue task for the first time. At the end of the task Elizabeth's inner critic softens into compassion (resolution stage 5), acknowledging her self-worth and pledging to a more collaborative role. Such movement from her inner critic leaves Elizabeth feeling pacified and with a sense of self-acceptance (resolution stage 6). These final instances of the two-chair dialogue task purport some degree of resolution of Elizabeth's self-evaluation split that might have contributed to the subsequent symptom alleviation. Resolving emotional processing difficulties such as self-evaluation splits is thought to be paramount in the treatment of depressive states (Greenberg, 2017b; Greenberg & Goldman, 2019b; Greenberg & Watson, 2006), which may have been the case for Elizabeth. Lastly, the observed symptom improvement corresponds to the working phase of therapy where chair work was more intensively carried out and in which Elizabeth reached resolution stages 4 or above, as is theoretically expected by EFT's model (Elliott et al., 2004; Greenberg, 2017b; Greenberg & Goldman, 2019b; Greenberg & Watson, 2006).

CHAPTER III

ON THE EFFECTS OF CHAIR WORK: EMPIRICAL STUDIES

CHAIR WORK RESOLUTION PREDICTS CLINICAL IMPROVEMENT FROM DEPRESSION IN EMOTION-FOCUSED THERAPY[1]

1. Introduction

Emotion-focused therapy (EFT) is an empirically-supported treatment for depression (Society of Clinical Psychology, 2019; see Ellison et al., 2009; Goldman et al., 2006; Greenberg & Watson, 1998; A. L. Robinson et al., 2014; Watson et al., 2003) that integrates chair work as a central component of its intervention to resolve specific emotional processing difficulties related to underlying core depressive emotion schemes (Elliott et al., 2004; Greenberg, 2017b; Greenberg & Goldman, 2019a; Greenberg & Watson, 2006). Prior research suggests that using chair work interventions to resolve these emotional processing difficulties and achieving higher stages of resolution during such chair work may be associated to better therapeutic outcomes at the end of treatment (Ellison et al., 2009; Goldman et al., 2006; Greenberg & Malcolm, 2002; Greenberg et al., 2008; Greenberg & Watson, 1998; Greenberg & Webster, 1982; Paivio & Greenberg, 1995; Shahar et al., 2012; Stiegler et al., 2018a). Our aim in this study was to explore if clients' progression in chair work was related to the session by session decrease in clinical symptoms. Even though previous research suggests that chair work may be relevant to therapeutic outcome at the end of treatment, it remains unclear if the effective in-session resolution of this intervention has a direct impact in clinical symptoms throughout therapy. Our results may further substantiate our understanding regarding the processes that contribute to clients' improvement during the EFT treatment of depression.

1.1. Emotion-Focused Therapy for Depression and Chair Work

From an EFT perspective, core depressive emotion schemes are developed through early interpersonal experiences of neglect, abandonment, and/or abuse, resulting in inadequate, insecure, or blameworthy forms of self-organization (Elliott et al., 2004; Goldman & Greenberg, 2015; Greenberg, 2019b; Greenberg et al., 1993; Greenberg & Watson, 2006; Salgado et al., 2019). This underlying emotion scheme of a disempowered self may be triggered by current loss or failure experiences, impairing the person's capability to regulate and process the ongoing emotional distress (Elliott et al., 2004; Greenberg, 2019b; Greenberg & Watson, 2006). In the scope of EFT for depression, conflict splits

[1] Lourenço, P., Aguiar, C., Sousa, I., Mendes, I., Salgado, J., & Gonçalves, M. M. (2021) Chair work resolution predicts clinical improvement from depression in emotion-focused therapy [Manuscript in preparation].

between parts of the self and unfinished business with significant others are salient emotional processing difficulties closely related to core depressive emotion schemes and are at least partly responsible for feelings of powerlessness, hopelessness, contempt, and shame (Elliott et al., 2004; Greenberg, 2017b; Greenberg & Goldman, 2019b; Greenberg & Watson, 2006). As such, these particular emotional processing difficulties are addressed in EFT through specific therapeutic tasks of chair work that promote client active expression to heighten, access and transform the core depressive emotion schemes that are seen as the source of depression (Elliott et al., 2004; Greenberg, 2017b; Greenberg & Goldman, 2019b). These chair work tasks—two-chair dialogue, two-chair enactment, and empty-chair work—have been widely investigated through a task-analytic methodology (Greenberg, 1984a, 2007; Rice & Greenberg, 1984) and the step-by-step client processes involved in the successful resolution of their corresponding emotional processing difficulties have been specified for each task (Greenberg, 1979, 1980, 1983, 1984b; Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002; Greenberg & Webster, 1982). Although the particular client processes that compose the path towards resolution differ in each task (see Table 2 for a comprehensive description), the three chair work tasks share a general common structure where resolution progresses through a sequence of six stages of emotional processing (Elliott et al., 2004).

Conflict splits between parts of the self, either self-evaluative or self-interruptive, are conceptualized as a struggle between a dominant, critical/censoring aspect of the self and a submissive, more fundamental aspect of the self (Elliott & Greenberg, 1997; Elliott et al., 2004; Greenberg & Goldman, 2019b; Greenberg & Watson, 2006). These depressogenic ways of treating oneself result from internalized standards of the ways one should be or feel, through which relevant aspects of experience, feelings, and/or needs are systematically disregarded or dismissed (Elliott et al., 2004; Greenberg & Watson, 2006). In self-evaluation splits, a harsh and critical part of the self attacks a more fundamental part of the self. This evaluative and coercive stance towards oneself is typically embedded in such hostility and disgust that leaves the person feeling worthless, ashamed or fearful, and ultimately defeated (Elliott et al., 2004; Greenberg & Watson, 2006). Two-chair dialogue for self-evaluation splits targets the core depressive process of self-criticism with the goal of promoting self-acceptance and foster a dialectical integration between the conflicting parts of the self (Elliott et al., 2004; Greenberg & Watson, 2006). The process of resolution of self-evaluation splits in two-chair dialogue (see Table 2) progresses through six stages (1 = Part of the self is critical or coercive towards another; 2 = Expression of criticisms, expectations, or "shoulds"; 3 = Expression of primary feelings and needs / Differentiation of values and standards; 4 = Expression of needs and wants; 5 = Acceptance of feelings and needs; 6 = Negotiation

between parts of the self). In self-interruption splits, an oppressing and censoring part of the self restricts emotional experience and blocks the full expression of a more adaptive part of the self. Persistently disowning or disclaiming important aspects of emotional experience inhibits the access to relevant needs and their associated action tendencies, leaving clients stuck in an unintegrated sense of themselves coupled with feelings of hopelessness and resignation (Elliott et al., 2004; Greenberg & Watson, 2006). Two-chair enactment for self-interruption splits addresses the core depressive process of disowning emotional experience by supporting active self-expression and empowerment of the previously neglected part of the self (Elliott et al., 2004; Greenberg & Watson, 2006). The process of resolution of self-interruption splits in two-chair enactment (see Table 2) progresses through six stages (1 = Part of the self interrupts another; 2 = Enactment of the self-interruptive process; 3 = Expression of feelings of passivity and resignation; 4 = Expression of the interrupted emotion; 5 = Expression of needs; 6 = Empowerment and action planning).

Unfinished business with significant others is characterized by the presence of persistent unresolved negative feelings in relation to a significant other (Elliott et al., 2004; Greenberg & Goldman, 2019b; Greenberg & Watson, 2006). The unprocessed nature of the feelings of hurt and resentment associated to early experiences of neglect, abandonment and/or abuse in the relationship with significant others perpetuate the longing for the unmet interpersonal needs that were disregarded in those relationships, with an enduring interference on current relationships (Elliott et al., 2004; Goldman & Greenberg, 2015; Greenberg et al., 1993; Greenberg & Watson, 2006). Empty-chair work for unfinished business promotes the emotional processing of the unresolved negative feelings by helping clients access and fully express those feelings to an imagined other in an empty chair (Elliott et al., 2004; Greenberg & Watson, 2006). The process of resolution of unfinished business in empty-chair work (see Table 2) progresses through six stages (1 = Client complains or expresses hurt in relation to a significant other; 2 = Expression of unresolved feelings; 3 = Differentiation of meaning and expression of primary emotions; 4 = Expression and validation of unmet needs; 5 = Shift in the representation of the significant other; 6 = Self-affirmation and letting go of unresolved feelings).

Table 2

Client processes in the chair work tasks

	TWO-CHAIR DIALOGUE	TWO-CHAIR ENACTMENT	EMPTY-CHAIR WORK
Stage 1	Marker confirmation: *Client describes split in which one aspect of self is critical of, or coercive toward, another aspect. Broadly, client describes two aspects, whether attributed or in somatic form.*	Marker confirmation: *Client engages in or describes how one part interrupts another part.*	Marker confirmation: *Client blames, complains, or expresses hurt or longing in relation to a significant other.*
Stage 2	Initiating two-chair dialogue: *Client clearly expresses criticisms, expectations, or "shoulds" to self in concrete, specific manner.*	Entry: *Client actively enacts own possible self-interruptive process in concrete specific manner.*	Setting up and starting: *Client speaks to imagined other and expresses unresolved feelings (e.g., resentment, hurt).*
Stage 3	Deepening the split: *Primary underlying feelings and needs begin to emerge in response to the criticisms. Critic differentiates values and standards.*	Deepening: *Client contacts and differentiates feelings of passivity and resignation.*	Differentiating meaning and expressing primary emotions: *Client differentiates complaint into underlying primary feelings and experiences and expresses relevant emotions (e.g., sadness, anger, fear, shame) with a high degree of emotional arousal.*
Stage 4	New experiencing and self-assertion: *Client clearly expresses needs and wants associated with a newly experienced feeling.*	Partial resolution: *Client clearly expresses interrupted emotion.*	Expressing and validating unmet needs: *Client experiences unmet needs as valid and expresses them assertively.*
Stage 5	Softening of the critic: *Client genuinely accepts own feelings and needs and may show compassion, concern, and respect for self.*	Self-assertion: *Client clearly expresses need associated with the emotion.*	Shift in representation of other: *Client comes to understand and see other in a new way, either in a more positive light or as a less powerful person who has or had problems of his or her own.*
Stage 6	Negotiation: *Client gains clear understanding of how various feelings, needs, and wishes may be accommodated and how previously antagonistic sides of self may be reconciled.*	Full resolution: *Client feels empowered and envisages or plans new actions in the world in order to meet need.*	Self-affirmation and letting go: *Client affirms self and lets go of unresolved feeling by understanding, forgiving, or holding other accountable.*

Note. Adapted from *Learning Emotion-Focused Therapy: The Process-Experiential Approach to Change* (pp. 223, 239, 246), by R. Elliott, J. C. Watson, R. N. Goldman, and L. S. Greenberg, 2004, American Psychological Association (https://doi.org/10.1037/10725-000). Copyright 2004 by the American Psychological Association.

1.2. Chair Work and Therapeutic Outcome

Previous research on the effects of chair work has used distinct methodological designs and also focused on diverse therapeutic outcomes. Notwithstanding, these may be largely categorized in two main types: studies on the efficacy of chair work interventions ("efficacy studies"; viz., Ellison et al., 2009; Goldman et al., 2006; Greenberg et al., 2008; Greenberg & Watson, 1998; Paivio & Greenberg, 1995; Shahar et al., 2012; Stiegler et al., 2018a) and studies on the client process of resolving chair work tasks ("change process studies"; viz., Greenberg & Malcolm, 2002; Greenberg & Webster, 1982).

The studies conducted by Ellison et al. (2009), Goldman et al. (2006), and Greenberg and Watson (1998) compared the effects of client-centered and emotion-focused therapies in the treatment of depression. Through a methodological design similar to additive component studies, the results from these three studies concluded that the addition of emotion-focused interventions, including chair work and other experiential tasks (e.g., experiential focusing, systematic evocative unfolding), enhanced treatment efficacy when added to the client-centered relationship. Thus, all these studies compared outcomes achieved by client-centered therapy (i.e., client-centered relationship condition alone) and EFT (i.e., client-centered relationship condition plus experiential tasks). The combined results from these studies concluded that EFT achieved significantly better outcomes in terms of depressive and general symptom distress, self-esteem, and interpersonal functioning at the end of treatment (Goldman et al., 2006; Greenberg & Watson, 1998) and also led to a significantly greater reduction of depression and improvement of self-esteem at follow-up (Ellison et al., 2009). Altogether, the results from these three studies seem to hint at the idea that chair work interventions are at least partly responsible for the EFT's enhanced efficacy at treatment termination and follow-up.

In a somewhat similar approach but focusing on a single chair work task, Stiegler et al. (2018a) compared the effects of empathic attunement and two-chair dialogue in two sequential phases of the same treatment for self-critical clients with depression and/or anxiety. Results from this study showed that the phase in which two-chair dialogue was added to the intervention had a significantly greater effect on the reduction of symptoms of anxiety and of depression. In a study of the efficacy of two-chair dialogue with self-critical clients, Shahar et al. (2012) found that this intervention significantly reduced self-criticism, as well as symptoms of anxiety and of depression at the end of treatment and over a 6-months follow-up. The studies of Greenberg et al. (2008) and of Paivio and Greenberg (1995) compared the effects of empty-chair work and psychoeducation in clients with unresolved emotional injuries with a significant other. In Greenberg et al.'s (2008) study, the empty-chair work intervention was significantly more effective in improving global symptoms at termination and 3-months follow-up. In Paivio and

Greenberg's (1995) study, the empty-chair work intervention was significantly more effective in improving general symptoms and interpersonal distress at termination and up to 1-year follow-up.

Focusing on different chair work tasks but using similar methodological designs, the studies of Greenberg and Webster (1982) and of Greenberg and Malcolm (2002) related the client's process in two-chair dialogue and in empty-chair work to therapeutic outcomes at the end of their respective interventions by comparing "resolvers" and "nonresolvers". Clients were considered "resolvers" when they were judged to have performed the crucial components of resolution according to each chair work task's resolution model. At the end of their respective treatments, when compared to nonresolvers, resolvers of the two-chair dialogue task were significantly less anxious (Greenberg & Webster, 1982) and resolvers of the empty-chair work task had significantly greater improvements in symptom distress and interpersonal problems (Greenberg & Malcolm, 2002). Thus, results from both studies showed that clients whose processes included crucial components of task resolution (i.e., resolvers) had significantly better outcomes in measures of clinical symptoms and global functioning, meaning that resolving such emotional processing difficulties in a manner consistent with each chair work task's resolution model was associated to better outcomes at the end of treatment.

In our view, altogether, the studies described above suggest that therapeutic outcomes at the end of treatment may be enhanced through the use of chair work interventions (as per the efficacy studies) and by successfully resolving specific emotional processing difficulties through chair work (as per the change process studies). However, it remains unclear whether the process of resolving chair work tasks has an effect on symptom reduction diachronically throughout therapy. The methodological designs of the previous studies do not clarify the temporal relation between the resolution of chair work tasks and symptom improvement, specifically if the gradual resolution of these tasks precedes symptom change—such research question calls for a longitudinal design.

2. Research Purpose and Design

The current study explores the longitudinal relationship between client process in the resolution of chair work tasks and clinical improvement in depression. For this purpose, we analyzed all two-chair dialogue, two-chair enactment, and empty-chair work events from 10 clients of EFT (160 therapy sessions) and assessed their clinical symptoms throughout therapy. This allowed us to test the assumption that reaching higher stages of resolution in the chair work tasks would be associated with a decrease of clinical symptoms in the following session.

3. Method

3.1. Clients

The sample for this study (n = 10) was randomly drawn from the EFT sub-sample (N = 24) of the ISMAI Depression Project (Salgado, 2019), a randomized controlled trial that compared the efficacy of EFT and cognitive behavioral therapy in the treatment of mild to moderate Major Depressive Disorder (American Psychiatric Association, 2013). In the context of the randomized controlled trial, clients' eligibility was evaluated with the Structured Clinical Interview for the DSM–IV axis I (First et al., 1996) and axis II (First et al., 1997), aided by the completion of standard self-report measures (e.g., Beck Depression Inventory–II, Outcome Questionnaire–45.2). The eligibility criteria for the randomized controlled trial encompassed being diagnosed with mild to moderate Major Depressive Disorder, a Global Assessment of Functioning above 50, currently not being under any relevant medication or treatment, not presenting a high risk of suicide, and previously or currently not being diagnosed with bipolar, panic, substance abuse, eating, psychosis, borderline, narcissistic, antisocial, or schizotypal disorders. All participants received and signed an informed consent explaining the scope of their participation and stating the purposes of the research, agreeing upon the video-recording of therapy sessions and the development of future quantitative and qualitative studies based on their therapy process. The randomized controlled trial was conducted at the research lab of the University Institute of Maia – ISMAI in the north of Portugal.

The 10 clients that comprised the sample for this study were eight female and two male clients, with ages ranging between 24 and 48 years (M = 35.50; SD = 8.50). Regarding their marital status, four clients were married, four clients were single, and two clients were divorced. Regarding their educational level, five clients had a higher degree, four clients had the 12th grade, and one client had the 9th grade. Clients' Beck Depression Inventory–II (BDI–II; A. T. Beck et al., 1996) at intake ranged from 19 to 38 (M = 29.00; SD = 6.27) and from 1 to 23 (M = 9.00; SD = 7.47) at the end of treatment. Clients' Outcome Questionnaire–45.2 (Lambert et al., 2013) at intake ranged from 69 to 106 (M = 89.50; SD = 10.48) and from 14 to 93 (M = 57.50; SD = 22.85) at the end of treatment.

3.2. Therapists

The therapists (n = 4) of the clients that comprised the sample for this study were two female and two male therapists, with ages ranging between 31 and 42 years (M = 34.25; SD = 5.19). Their clinical experience ranged from 2 to 19 years (M = 8.25; SD = 7.59), specifically from 1 to 4 years (M = 2.50; SD = 1.29) of experience in EFT. All of them had training following the intervention manuals of

EFT (Elliott et al., 2004; Greenberg & Watson, 2006) prior to their participation in the randomized controlled trial and clinical supervision was conducted on a weekly basis. As for the client–therapist ratio, two therapists had three clients each and two therapists had two clients each.

3.3. Therapy

EFT is a humanistic-experiential approach that aims to help clients access and transform maladaptive emotion schemes to achieve changes in the organization of the self (Elliott et al., 2004; Greenberg & Goldman, 2019b). This is accomplished by attending to clients' immediate inner experience and through increased emotional awareness and regulation (Greenberg & Goldman, 2019b; Greenberg & Watson, 2006). The clients from this sample had a total of 16 sessions of EFT following the intervention manuals of Greenberg and Watson (2006) and of Elliott et al. (2004). The broad structure of the intervention protocol started with the exploration of the clients' main concerns and the development of a safe and supportive client–therapist relationship in the first three to four sessions, followed by active therapeutic work targeting the clients' emotional processing difficulties in all the remaining sessions of therapy. The last session was reserved for an overview of the therapeutic process and to ascertain the current state of the clients' change process. Regarding the working phase of therapy, roughly between sessions four and 15, clients and therapists initiated each session by exploring whichever problem-relevant topic was brought by the clients, making use of an empathically attuned stance to help clients deepen their emotional experience. Because EFT has a marker-guided task strategy intervention that targets different emotional processing difficulties by offering specific tasks to work with clients, therapists listened to and explored potential verbal and non-verbal client behaviors that signaled the need for further experiential work in the context of the therapeutic tasks proposed by the EFT approach (e.g., clearing a space, experiential focusing, systematic evocative unfolding, two-chair dialogue, two-chair enactment, and empty-chair work). Considering that the clients of this study were depressed, therapists were particularly attentive to unclear feelings, self-evaluation splits, self-interruption splits, and unfinished business markers, presenting clients with the opportunity to work on these emotional processing difficulties through experiential focusing, two-chair dialogue, two-chair enactment, and empty-chair work, respectively.

3.4. Symptom Intensity Measures

3.4.1. Beck Depression Inventory–II. The BDI–II (A. T. Beck et al., 1996) is a 21 items self-report measure to assess a constellation of depressive symptoms, situating their severity on a scale ranging from 0 (depression absent) to 63 (severe depression). Due to its good to excellent psychometric properties ($Cronbach's\ \alpha$ = .89; Steer et al., 2001), the BDI–II has been widely used in research.

3.4.2. Outcome Questionnaire–10.2. The Outcome Questionnaire–10.2 (OQ–10.2; Lambert et al., 2005) is a 10 items self-report measure to assess psychological distress, interpersonal relationships, and social role functioning. OQ–10.2 is sensitive to short time fluctuations on clients' symptomatic distress and situates global symptom severity on a 0 to 40 total score range. Due to its good psychometric properties ($Cronbach's\ \alpha$ = .77), the OQ–10.2 has been widely used in session-by-session monitoring of clients' progress.

3.5. Process Measure

3.5.1. Chair Work Coding System. The Chair Work Coding System (Lourenço et al., 2018) is based on an adaptation of the EFT chair work tasks' descriptions presented by Elliott et al. (2004), consisting in a method of systematic identification of these process-experiential tasks and the sequential stages of client processes towards their resolution. The coding system allows researchers to track clients' progression in the resolution of specific emotional processing difficulties throughout the therapeutic process, by means of the therapeutic work within the context of chair work tasks. There are three types of process-experiential chair work tasks identified by the coding system, namely: two-chair dialogue, two-chair enactment, and empty-chair work (Elliott et al., 2004; Greenberg & Watson, 2006). Each of these tasks was developed to address specific emotional processing difficulties, respectively: self-evaluation splits, self-interruption splits, and unfinished business. Following a six-stage sequential structure, from the elaboration of a marker to the full resolution, each stage of the chair work tasks depicts the clients' processes involved in the successful resolution of the corresponding emotional processing difficulty (described earlier; see Table 2), as well as the therapists' intervention counterparts that foster the clients' progression. The markers for each chair work task are regarded as the presence of emotional processing difficulties, which do not entail, in itself, actual chair work. As such, the coding system is an interval scale type of process measure that identifies the set of clients' behaviors that characterize each stage of the three chair work tasks, ranging from two (task initiation) to six (task resolution). The coding system is intended to capture active chair work event segments and therefore as a general rule the client must address either the critic/interrupter (in the case of two-chair dialogue and of two-chair enactment) or the significant other (in the case of empty-chair work), meaning that contact between parts of the self must be observable. In applying the coding system to therapy sessions, raters identify three types of components: beginning and end delimitations of the chair work event segment, the type of task and the resolution stage presented. Interrater agreements indices are computed for the three types of components.

3.6. Procedure

3.6.1. Outcome measurement. As per the protocol for the symptom measurement in the context of the randomized controlled trial, clients filled several symptom intensity measures at the beginning of therapy sessions, with the BDI–II (A. T. Beck et al., 1996) being filled every fourth session (1, 4, 8, 12, 16) and the OQ–10.2 (Lambert et al., 2005) being filled every session (1 to 16).

3.6.2. Process measurement. All therapy sessions of the 10 clients (160 sessions) were analyzed following the procedures of the Chair Work Coding System (Lourenço et al., 2018) to identify events of therapeutic work within the context of the chair work tasks and track the clients' progress through the sequential stages of task resolution throughout therapy. Five pairs of raters were constituted from a total of six raters to perform the analysis of each client's therapy process, where a more experienced principal rater (the first author of this paper) paired with the other five raters. The principal rater had prior training and clinical experience with EFT and was undergoing his Ph.D. in Applied Psychology; the other five raters were concluding their masters' degree in Clinical and Health Psychology. Raters coded each session independently, followed by discussion meetings to compute interrater agreement indices and afterwards resolve discrepancies by consensus. ***Training of raters.*** The principal rater trained the other raters in the Chair Work Coding System (Lourenço et al., 2018) prior to initiating the analysis of the clients that constituted the sample for this study, guiding them through the following consecutive steps: (1) reading and discussion of the coding manual; (2) coding of previously delimited excerpt examples of chair work events from sessions one and two from the "Emotion-Focused Therapy for Depression with Leslie S. Greenberg" DVD (American Psychological Association, 2007), identifying only the type of task and resolution stage presented; (3) coding of four to eight therapy sessions from two other clients drawn from the same randomized controlled trial, identifying the type of task and resolution stage presented as well as its chair work event segments' beginning and end delimitations; this last step was considered finalized only when the trainee raters reached adequate agreement standards for each type of interrater agreement index calculated, i.e., 70% for the percentage of agreement on chair work event segments' delimitation, .75 for $Cohen's\ \kappa$ (Fleiss et al., 2003; Landis & Koch, 1977) on the type of tasks, and .75 for $Intraclass\ Correlation\ Coefficient$ (Cicchetti, 1994) on the resolution stages. ***Interrater agreement.*** Interrater agreement was computed for each coding component identified, namely the delimitation of the chair work event segments, the type of task, and the resolution stage presented. The following interrater agreement indices were computed, respectively: percentage of agreement on chair work event segments, $Cohen's\ \kappa$ (Cohen, 1960), and $Intraclass\ Correlation\ Coefficient$ (two-way random-effects model, average measures, absolute

agreement; McGraw & Wong, 1996; Shrout & Fleiss, 1979). The interrater agreement on chair work event segments delimitation was calculated as twice the overlapping duration of the chair work event segments identified simultaneously by the pair of raters divided by the sum of the total duration of the chair work event segments independently identified by each rater; the product of this formula was then multiplied by 100 in order to obtain a percentage of agreement. The $Cohen's\ \kappa$ (Cohen, 1960) and the $Intraclass\ Correlation\ Coefficient$ (McGraw & Wong, 1996; Shrout & Fleiss, 1979) interrater agreement indices were calculated according to the field's recommendations and standards. The pairs of raters obtained good to excellent interrater agreement indices: percentage of agreement on chair work event segments delimitation ranged from 69.65% to 81.38% (M = 73.69%), $Cohen's\ \kappa$ (Fleiss et al., 2003; Landis & Koch, 1977) on the type of tasks ranged from .83 to 1.00 (M = .91), and $Intraclass\ Correlation\ Coefficient$ (Cicchetti, 1994) on the resolution stages ranged from .74 to .89 (M = .85).

3.6.3. Data analysis. In our data analysis we used the BDI–II total score as a measure of clients' depressive symptoms every fourth session, the OQ–10.2 total score as a measure of clients' general symptoms in all sessions, and the 'resolution stage mean' of each session as a measure of clients' chair work resolution stage. 'Resolution stage mean' refers to the clients' average resolution stage of chair work in a given session taking into consideration the time spent in each chair work resolution stage (i.e., time-weighted mean). The variable 'resolution stage mean' was considered in the statistical analysis in the logarithmic scale given the distribution of this data in the original scale. With this transformation the variable became with a Normal distribution.

Given the nested nature of our data, with sessions nested within clients, our data analysis approach focused on multilevel mixed-effects models through the use of Hierarchical Linear Modeling (HLM; Raudenbush & Bryk, 2002) with subject-specific random effects. In HLM we model a response variable Y_{ij} measured for subject i at time t_{ij} as a function of time (t_{ij}) and other possible predictors ($predictors_{ij}$). The Equation is assumed as

$$Y_{ij} = \beta_o + \beta_1 * t_{ij} + \beta_2 * predictors_{ij} + U_i + Z_{ij} \quad (1)$$

where U_i is the subject-specific random effect with Normal distribution and variance ν^2 and Z_{ij} is the measurement error with Normal distribution and variance τ^2.

In order to understand the evolution of the variables of interest throughout the therapeutic process, our first step was to compute separate models of their longitudinal progression as a function of time. For this we computed Equation 1 without the component $predictors_{ij}$, only with the effect of time

(t_{ij}). For each separate model the response variable Y_{ij} takes the form of BDI–II, OQ–10.2, and 'resolution stage mean' (see Table 3).

Afterwards, to test the longitudinal effect of chair work on depressive symptoms, we computed Equation 1 with previous sessions' chair work resolution stage ('resolution stage mean') as $predictors_{ij}$ for the response variable Y_{ij} as depressive symptoms (BDI–II) at sessions 4, 8, 12, and 16, having also the time t_{ij} effect (e.g., the 'resolution stage mean' from sessions 1 to 3 predicting the BDI–II from session 4, the 'resolution stage mean' from sessions 4 to 7 predicting the BDI–II from session 8, and so on; see Table 4).

Finally, to test the longitudinal effect of chair work on general symptoms and vice-versa, we computed two separate models in the same form as Equation 1. For the first model we considered as $predictors_{ij}$ the previous session's chair work resolution stage ('resolution stage mean') to predict next-session general symptoms (OQ–10.2) as the response variable Y_{ij} (e.g., the 'resolution stage mean' from session 1 predicting the OQ–10.2 from session 2, the 'resolution stage mean' from session 2 predicting the OQ–10.2 from session 3 and so on; see Table 5, model E). In the reverse model the $predictors_{ij}$ was considered the previous session's general symptoms (OQ–10.2) to predict next-session chair work resolution stage ('resolution stage mean') as the response variable Y_{ij} (e.g., the OQ–10.2 from session 1 predicting the 'resolution stage mean' from session 2, the OQ–10.2 from session 2 predicting the 'resolution stage mean' from session 3, and so on; see Table 5, model F).

All analyses were computed using the nonlinear mixed-effects modeling (nlme) package (version 3.1-142; J. Pinheiro et al., 2019) for R (version 3.6.1; R Core Team, 2019).

4. Results

4.1. Descriptive Statistics of Active Chair Work

Active chair work was found in 74 of the 160 sessions that were analyzed. The number of sessions per client with active chair work varied between four and 10 (M = 7.40; SD = 2.37). From the total time in active chair work, the percentage of time per task was 60.79% in two-chair dialogue, 30.47% in empty-chair work, and 8.74% in two-chair enactment. The percentage of time per chair work resolution stage was 30.60% in stages 2, 46.83% in stages 3, 14.37% in stages 4, 5.09% in stages 5, and 3.11% in stages 6.

4.2. Longitudinal Progression of Clinical Symptoms and of Chair Work

HLM (Raudenbush & Bryk, 2002) analysis of the longitudinal progression of depressive symptoms (BDI–II), of general symptoms (OQ–10.2), and of chair work resolution stage ('resolution stage mean') indicated that time (sessions) was a significant predictor of all variables throughout treatment (see Table 3).

Table 3

Longitudinal Progression of Depressive Symptoms (BDI–II), of General Symptoms (OQ–10.2), and of Chair Work ('resolution stage mean')

	Models and Fixed Effects	$Coefficient$	SE	t	p	R^2_{adj}
	Session predicting Depressive Symptoms					
A	Intercept (β_0)	24.67	2.53	9.73	<.000	.59
	Session (β_1)	-.94	.17	-5.50	<.000	
	Session predicting General Symptoms					
B	Intercept (β_0)	23.73	1.54	15.40	<.000	.57
	Session (β_1)	-.44	.07	-6.54	<.000	
	Session predicting Chair Work					
C	Intercept (β_0)	.87	.07	12.84	<.000	.36
	Session (β_1)	.02	.01	3.16	.002	

Depressive symptoms, as measured by the BDI–II every fourth session, showed to be negatively associated with time (sessions), decreasing on average .94 each session, R^2_{adj} = .59, β_1 = -.94, p < .000 (see Table 3, model A). General symptoms, as measured by the OQ–10.2 in all sessions, showed to be negatively associated with time (sessions), decreasing on average .44 each session, R^2_{adj} = .57, β_1 = -.44, p < .000 (see Table 3, model B). Chair work resolution stage, as measured by the 'resolution stage mean' of each session, showed to be positively associated with time (sessions), increasing on average .02 (logarithmic scale) each session, R^2_{adj} = .36, β_1 = .02, p = .002 (see Table 3, model C).

4.3. Chair Work as Predictor of Depressive Symptoms

Considering the results of the previous analysis (see Table 3) of the longitudinal progression of depressive symptoms (BDI–II) and of chair work resolution stage ('resolution stage mean'), time (sessions) was included in the subsequent HLM (Raudenbush & Bryk, 2002) analysis of chair work predicting following-session depressive symptoms (see Table 4).

Table 4

Hierarchical Linear Modeling with Chair Work ('resolution stage mean') as predictor of following-session Depressive Symptoms (BDI–II)

Model and Fixed Effects		$Coefficient$	SE	t	p	R^2_{adj}
	Chair Work predicting Depressive Symptoms					
D	Intercept (β_0)	39.92	6.34	6.30	<.000	
	Session (β_1)	-.96	.26	-3.64	.002	.67
	Resolution Stage Mean (β_2)	-5.22	2.40	-2.21	.040	

HLM (Raudenbush & Bryk, 2002) analysis on the chair work predicting depressive symptoms model indicated that chair work resolution stage ('resolution stage mean') was a significant predictor of the decrease in depressive symptoms (BDI–II) in the following session, R^2_{adj} = .67, β_2 = -5.22, p = .040 (see Table 4, model D).

4.4. Chair Work as Predictor of General Symptoms

Considering the results of the previous analysis (see Table 3) of the longitudinal progression of general symptoms (OQ–10.2) and of chair work resolution stage ('resolution stage mean'), time (sessions) was included in the subsequent HLM (Raudenbush & Bryk, 2002) analyses of chair work predicting next-session general symptoms and the reverse model (see Table 5).

Table 5

Hierarchical Linear Modeling with Chair Work ('resolution stage mean') as predictor of next-session General Symptoms (OQ–10.2) and the reverse model

Models and Fixed Effects		$Coefficient$	SE	t	p	R^2_{adj}
	Chair Work predicting General Symptoms					
E	Intercept (β_0)	28.62	2.97	9.62	<.000	
	Session (β_1)	-.20	.16	-1.23	.222	.46
	Resolution Stage Mean (β_2)	-2.30	.96	-2.40	.019	
	General Symptoms predicting Chair Work					
F	Intercept (β_0)	.93	.12	7.53	<.000	
	Session (β_1)	.02	.01	3.05	.003	.35
	OQ–10.2 (β_2)	-.00	.00	-.48	.630	

HLM (Raudenbush & Bryk, 2002) analysis on the chair work predicting general symptoms model indicated that chair work resolution stage ('resolution stage mean') was a highly significant predictor of the decrease in general symptoms (OQ–10.2) in the next session, R^2_{adj} = .46, β_2 = -2.30, p = .019 (see Table 5, model E). However, HLM (Raudenbush & Bryk, 2002) analysis on the general symptoms

predicting chair work model indicated that general symptoms (OQ–10.2) were not a predictor of chair work resolution stage ('resolution stage mean') in the next session, R^2_{adj} = .35, β_2 = -.00, p = .630 (see Table 5, model F).

5. Discussion

The broader purpose of this study was to improve our knowledge on the effects of chair work interventions on client change process in psychotherapy. Specifically, with this study we aimed at clarifying if the process of resolving chair work tasks was associated with symptom reduction diachronically throughout therapy. We sought this objective by exploring the longitudinal relationship between client progression in the resolution of three chair work tasks—two-chair dialogue, two-chair enactment, and empty-chair work—and clinical symptoms in the next session. In our main data analyses we used HLM (Raudenbush & Bryk, 2002) to test the predictive effect of chair work on depressive and general symptoms (see Tables 4 and 5).

Although not the focal point of our study, the descriptive statistics from our sample's chair work analysis bear a few interesting considerations. Two-chair dialogue was found to be the most prevalent chair work task in our sample, with chair work targeting self-evaluation splits becoming the main focus of treatment for most clients. In line with well-established theory and research on the depression phenomena, this finding highlights the role of self-criticism in the onset and maintenance of depression (Blatt, 1974, 2007; Greenberg & Watson, 2006; Kopala-Sibley & Zuroff, 2020; Shahar, 2015; Werner et al., 2016). Another interesting finding, coherent with our expectations, was that most of the time performing chair work tasks was on lower stages of resolution (i.e., stages 2 and 3). This might have occurred since engaging in chair work often starts at these stages and also since stage 3, being the most frequent, aggregates several different facets of the client's emotional experience that are processed at this point. Furthermore, stage 4 already denotes a partial resolution of a given emotional processing difficulty, while stage 6 represents a full resolution. Thus, clinically, it makes sense that clients spend less time performing chair work around these higher stages after reaching a significant degree of resolution on the tasks.

The major finding in our study was that clients' chair work resolution stage was a significant predictor of the session by session decrease in clinical symptoms (see Table 4, model D and Table 5, model E), meaning that performing chair work tasks to resolve conflict splits between parts of the self and unfinished business with significant others was strongly associated with the improvement from depression. Moreover, clients' chair work resolution stage was found to be a better predictor of symptom

progression than time itself (see Table 3, models A and B and Table 5, model E), meaning that the effect of performing chair work tasks surpassed the natural tendency for symptoms to decrease throughout therapy. These results provide empirical support to the theoretical assumption in EFT that targeting specific emotional processing difficulties through chair work is clinically relevant for the treatment of depression (Elliott et al., 2004; Greenberg, 2017b; Greenberg & Goldman, 2019b). This also suggests that conflict splits and unfinished business seem to be somewhat intertwined with the presence of clinical symptoms and depressive states, as is assumed by the clinical theory of this therapeutic model (Greenberg & Watson, 2006; Salgado et al., 2019).

Beyond the main result in our study, our HLM (Raudenbush & Bryk, 2002) analyses require further examination. When modeling general symptoms (OQ–10.2) in a longitudinal model using only time (sessions) as a predictor (see Table 3, model B) this was found to be highly significant (p < .000) with a decreasing tendency, meaning that general symptoms decreased throughout therapy. Nevertheless, when adding clients' chair work resolution stage ('resolution stage mean') of the previous session also as a predictor for the progression of general symptoms (OQ–10.2; see Table 5, model E) the time (session) effect disappeared (p = .222) and the effect of previous-session chair work resolution stage ('resolution stage mean') was found to be highly significant (p = .019). This suggests that the time (session) effect found in the preliminary model (see Table 3, model B) was actually being masked by the effect of clients' chair work resolution stage ('resolution stage mean') in the progression of general symptoms (OQ–10.2; see Table 5, model E). More importantly, higher stages of chair work significantly predicted the next-session decrease in general symptoms (p = .019), with an explained variance of 46% (see Table 5, model E). In the reverse model (see Table 5, model F), however, general symptoms were not found to be a significant predictor of the next-session average resolution stage of chair work (p = .630). Though, in this reverse model (see Table 5, model F), session remained a predictor of the next-session average resolution stage of chair work (p = .003), meaning that clients tended to achieve higher stages of chair work throughout therapy. These results suggest that the relationship between the variables of interest in our study is not bidirectional and do not simply co-occur, supporting the speculation that higher stages of resolution of the chair work tasks lead to the gradual decrease in clinical symptoms.

Our study corroborates the results from the studies of Ellison et al. (2009), of Goldman et al. (2006), and of Greenberg and Watson (1998), which concluded that the addition of chair work interventions was at least partly responsible for the EFT's enhanced efficacy at treatment termination and follow-up. Our findings are also in line with the results from previous studies on the efficacy of treatments with specific chair work tasks, which suggested that these interventions lead to good outcomes in terms

of depression and global symptoms (Stiegler et al., 2018a; Shahar et al., 2012; Greenberg et al., 2008; Paivio & Greenberg, 1995). Finally, our results provide additional empirical support to Greenberg and Webster's (1982) and Greenberg and Malcolm's (2002) early suggestion that the specific client processes depicted in EFT's resolution models of chair work were related to good outcomes at the end of treatment.

6. Conclusion

The results from our study suggest that client performance in chair work may be at least partly responsible for the improvement in clinical symptoms. Resolving emotional processing difficulties such as conflict splits between parts of the self and unfinished business with significant others seems to be a meaningful process variable related to client change process. Chair work seems to be a specific factor of the EFT treatment that contributes to the progressive reduction of clinical symptoms.

As for the clinical implications of this study, it seems that helping clients engage in chair work and fostering their progression through its stages of resolution may contribute to alleviate their clinical symptoms, and also that the intensity of clinical symptoms may not impair clients' ability to progress through the stages of resolution of chair work. In this sense, EFT practitioners should keep in mind that, in spite of the challenges that chair work might present to both themselves and their clients, guiding their clients through such interventions will eventually lead to positive outcomes, even at times when their clients might be struggling the most.

Our study holds several limitations, from which sample size stands out as the most obvious one. Although we have analyzed the full extent of the therapy processes of chair work from 10 clients and resorted to robust statistical analyses to explore its predictive effect, sample size restraints compromise strength and generalizability of our results. Another important consideration is that our study focused solely on three types of chair work tasks, leaving out at least one additional chair work task that although recently developed is commonly encountered in EFT—self-soothing (Sharbanee et al., 2019). As such, the results and the implications drawn from our study must be cautiously regarded in light of the aforementioned considerations.

Future research on the effects of chair work might benefit from analyzing larger samples, including other chair work tasks, and perhaps exploring the relationship of such interventions with other client process variables (e.g., emotional processing). Finally, other studies with experimental manipulations of chair work tasks (e.g., experimental single cases) would allow us to determine with more certainty if the progress along their stages of resolution is directly influencing the improvement in symptoms.

7. References

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CHAIR WORK RESOLUTION PREDICTS DEPTH OF EMOTIONAL PROCESSING IN EMOTION-FOCUSED THERAPY[2]

1. Introduction

Emotion-focused therapy (EFT) advocates that the emotional processing of internal experiences is a key change process in psychotherapy (Elliott et al., 2004; Greenberg, 2010, 2017b; Greenberg & Goldman, 2019a; Greenberg & A. Pascual-Leone, 2006; Greenberg & Watson, 2006). In fact, several empirical studies within the scope of humanistic-experiential approaches have supported this cornerstone of EFT by linking clients' depth of emotional processing to therapeutic outcome (for comprehensive reviews, see Elliott et al., 2013; A. Pascual-Leone et al., 2016; Pos & Choi, 2019; for a recent meta-analysis, see A. Pascual-Leone & Yeryomenko, 2017). As such, over the past decades EFT clinicians and researchers have developed and refined a wide range of therapeutic tasks to promote the emotional processing of several specific client difficulties (Elliott et al., 2004; Greenberg et al., 1993; Greenberg & Watson, 2006). Particularly in EFT for depression, chair work tasks have played a central role in the treatment as they target certain types of emotional processing difficulties closely related to core depressive emotion schemes (Greenberg, 2017b; Greenberg & Goldman, 2019b; Greenberg & Watson, 2006). However, despite its established efficacy in the treatment of depression (Ellison et al., 2009; Goldman et al., 2006; Greenberg & Watson, 1998; Watson et al., 2003) and even its plausible superiority in promoting higher levels of emotional processing (A. Pascual-Leone & Yeryomenko, 2017; Watson & Bedard, 2006), the actual contribution of EFT's therapeutic tasks to clients' depth of emotional processing remains empirically undetermined and largely theoretical. Our aim in this study was to explore if clients' progression in chair work was related to an increase in their emotional processing capability, both at the end of therapy and session-by-session throughout treatment. Results may provide further evidence for the role of EFT's therapeutic tasks and indirectly hint at the internal processes/mechanisms responsible for EFT's efficacy.

1.1. Emotional Processing in Emotion-Focused Therapy

In current humanistic-experiential theory and practice, emotional processing refers to a particularly productive manner of addressing painful emotional experiences in psychotherapy (Foa et al.,

[2] Lourenço, P., Pinheiro, P., Sousa, I., Mendes, I., Salgado, J., & Gonçalves, M. M. (2021). Chair work resolution predicts depth of emotional processing in emotion-focused therapy [Manuscript in preparation].

2006; Greenberg & Safran, 1989; A. Pascual-Leone & Greenberg, 2007; A. Pascual-Leone et al., 2016). The concept encompasses a cognitive-affective continuum of being aware of and attending to a painful emotional experience, arousing and tolerating live contact with its associated emotions, exploring and reflecting on such inner experiences to ascribe sense and derive novel meanings, and transforming maladaptive emotion schemes (Greenberg, 2015; Greenberg & J. Pascual-Leone, 1995; Greenberg & Safran, 1987; Greenberg & Watson, 2006; A. Pascual-Leone & Greenberg, 2007; Pos et al., 2003). Within and beyond humanistic-experiential approaches (e.g., EFT, client-centered therapy, cognitive therapy, cognitive-behavioral therapy, psychodynamic-interpersonal therapy), a vast body of research has systematically shown that higher levels and greater increases of emotional processing during therapy are associated with better outcomes in depression at the end of treatment (Auszra et al., 2013; Castonguay et al., 1996; Goldman et al., 2005; A. Pascual-Leone & Yeryomenko, 2017; P. Pinheiro et al., 2021; Pos et al., 2003, 2009, 2017; Rudkin et al., 2007; Watson & Bedard, 2006; Watson et al., 2011; Whelton, 2004). Moreover, besides predicting pre- to post-therapy depressive symptoms' reduction in a particularly recent study of EFT and cognitive-behavioral therapy for depression, the depth of emotional processing was also found to be a significant predictor of the session-by-session decrease in clinical symptoms (P. Pinheiro et al., 2021).

Emotional processing is unequivocally fundamental in EFT since it mainly regards clinical problems as a byproduct of unprocessed painful internal experiences that stem from maladaptive emotion schemes (Elliott et al., 2004; Greenberg, 2010, 2015, 2017b, 2019b; Greenberg & Watson, 2006; Timulak, 2015; Watson et al., 2007). Emotion schemes are dynamic cognitive-affective structures originated from syntheses of the wide spectrum of elements that compose past lived experiences and which act as a framework for prompt information processing, meaning making, and response production in subsequent situations, resulting in moment-to-moment felt emotional experience and higher order self-organizations (Greenberg, 2010, 2019b; Greenberg & Watson, 2006). Often rooted in traumatic past significant events, maladaptive emotion schemes inhibit adequate processing of current related experiences and subsequently prevent coherent, adaptive emotional responses to situations, therefore generating the associated distress and psychological impairment in which clients become stuck (Goldman, 2017; Greenberg, 2010, 2015, 2017b, 2019b; Greenberg & Watson, 2006). Hence, enduring or recurrent painful internal experiences must be overtly experienced, consciously symbolized, intentionally explored and reflected upon to create new meanings and generate more adaptive emotional responses. Thus, the ultimate goal is accessing and transforming the maladaptive emotion schemes at the core of depression—it is through this cognitive-affective continuum of emotional processing that

maladaptive emotion schemes become accessible and amenable to change (Elliott et al., 2004; Goldman & Greenberg, 2015; Greenberg & Goldman, 2019b; Greenberg & Watson, 2006).

1.2. Facilitating Emotional Processing through Chair Work

EFT proposes to aid clients in the emotional transformation process by guiding them through emotion-evocative therapeutic tasks that address different types of emotional processing problems (e.g., clearing a space for attentional focus difficulty, experiential focusing for unclear feeling, systematic evocative unfolding for problematic reaction point, two-chair dialogue for self-evaluation split, two-chair enactment for self-interruption split, empty-chair work for unfinished business; Elliott et al., 2004; Greenberg et al., 1993; Greenberg & Watson, 2006). Most of these process-experiential tasks were developed through task-analysis of key psychotherapeutic change events, identifying and validating the specific client processes implicated in the successful resolution of each emotional processing difficulty (Greenberg, 1984a, 2007; Rice & Greenberg, 1984). EFT's efficacy in the treatment of depression is assumed to be related with its emotion-evocative therapeutic tasks, presumably because these intentionally target emotional processing problems. Clinical trial studies of EFT for depression actually speculated that its efficacy is largely attributable to its therapeutic tasks (Ellison et al., 2009; Goldman et al., 2006; Greenberg & Watson, 1998; Watson et al., 2003). Likewise, some studies on the predictive role of emotional processing to therapeutic outcomes in different treatment approaches also speculate that EFT's compared enhanced ability to promote clients' capability to process emotional experiences may be due to its therapeutic tasks (A. Pascual-Leone & Yeryomenko, 2017; P. Pinheiro et al., 2021; Watson & Bedard, 2006).

In EFT's treatment of depression, a particular subset of emotion-evocative tasks collectively known as chair work—two-chair dialogue, two-chair enactment, and empty-chair work—have a prominent place in the intervention as they address specific inter- and intrapersonal processes characteristic of depressive states—self-evaluation splits, self-interruption splits, and unfinished business (Elliott et al., 2004; Greenberg et al., 1993; Greenberg & Watson, 2006). These emotional processing difficulties stem from the underlying core depressive emotion schemes that are thought to be formed through early interpersonal significant events of being neglected, abandoned, and/or abused (Elliott et al., 2004; Goldman & Greenberg, 2015; Greenberg, 2019b; Greenberg & Goldman, 2019b; Greenberg & Watson, 2006; Salgado et al., 2019). Taken together, through similar dismantling and additive designs, studies on the effects of using isolated chair work tasks (Greenberg et al., 2008; Paivio & Greenberg, 1995; Shahar et al., 2012; Stiegler et al., 2018a) and change process studies on clients' progress in resolving isolated chair work tasks (Greenberg & Malcolm, 2002; Greenberg & Webster, 1982) suggest that these

interventions lead to better outcomes at the end of their respective treatments. A recent longitudinal study has found that clients' progress throughout EFT treatment in the resolution of chair work tasks significantly predicted the session-by-session decrease in clinical symptoms, concluding that helping clients to progress through the resolution stages of two-chair dialogue, two-chair enactment, and empty-chair work was indeed associated to clinical improvement from depression (Lourenço, Aguiar, et al., 2021).

To the best of our knowledge, despite all the implicit links between EFT's therapeutic tasks and emotional processing in relevant theory and research, only one recent study has attempted to establish an empirical relationship among the two (Stiegler et al., 2018b). In a multi-baseline study of the effects of adding the two-chair dialogue task to the last phase of an ongoing client-centered treatment, Stiegler et al. (2018b) concluded that (although equally effective) the phase in which this particular chair work task was introduced did not present a significantly steeper change trajectory in emotional processing. Albeit its efforts, Stiegler et al.'s (2018b) study never intended to focus on the clients' processes of resolving any of the chair work tasks, but instead on simply adding the two-chair dialogue component to the treatment and investigating its effects on emotional processing. It remains unclear whether the process of resolving chair work tasks has an effect on clients' emotional processing capability. Given its significant role as a process predictor of outcome in psychotherapy, it is paramount to (at the very least) humanistic-experiential therapies to understand how clients' emotional processing is actuated and enhanced through key therapeutic tasks such as chair work.

2. Research Purpose and Design

This longitudinal study examines the effect of clients' progression in chair work resolution on their capability to process emotional experiences. To accomplish this we analyzed all chair work events (two-chair dialogue, two-chair enactment, and empty-chair work) from a sample of 10 EFT clients (160 sessions) and assessed their depth of emotional processing periodically throughout therapy. Such research strategy and design enabled us to test the implicit assumption that reaching higher stages of resolution in the chair work tasks would be longitudinally associated with higher levels of emotional processing in the following session and at therapy termination.

3. Method

3.1. Clients

This study was conducted with 10 randomly drawn clients from the EFT condition in a randomized controlled trial of depression (ISMAI Depression Project; Salgado, 2019). Eligibility for the randomized controlled trial was assessed through the Structured Clinical Interview for the DSM–IV (First et al., 1997; First et al., 1996) and standard self-report measures (e.g., Beck Depression Inventory–II, Outcome Questionnaire–45.2), ensuring the following criteria: diagnostic of mild to moderate Major Depressive Disorder (American Psychiatric Association, 2013) with a Global Assessment of Functioning above 50, absence of relevant medication or concurrent treatment, no risk of suicide, and absence of current or previous diagnostic of bipolar, panic, substance abuse, eating, psychosis, borderline, narcissistic, antisocial, or schizotypal disorders. Enrolled participants agreed on having their therapy sessions video-recorded and were informed regarding quantitative and qualitative research with the collected data.

The 10 clients from this study were Portuguese, mostly female (80%), and their ages ranged from 24 to 48 years (M = 35.50; SD = 8.50). Regarding their marital status, four were married, four were single, and two were divorced. Regarding their educational level, five had a higher degree, four had the 12th grade, and one had the 9th grade. Based on the criteria of reliable and clinically significant change (Jacobson & Truax, 1991; Lambert & Ogles, 2014) for the Beck Depression Inventory–II (A. T. Beck et al., 1996), seven clients were considered as recovered good outcome cases, two clients were considered as improved poor outcome cases, and one client was considered as unchanged poor outcome case.

3.2. Therapists

The therapists (n = 4) of the clients from this study were two female and two male therapists and their ages ranged from 31 to 42 years (M = 34.25; SD = 5.19). Two of the therapists had three clients each and the other two therapists had two clients each. The clinical experience of these therapists ranged from 2 to 19 years (M = 8.25; SD = 7.59) and their experience in EFT ranged from 1 to 4 years (M = 2.50; SD = 1.29). Therapists received training according to the EFT manuals for the randomized clinical trial (Elliott et al., 2004; Greenberg & Watson, 2006) and weekly clinical supervision was conducted.

3.3. Therapy

The 16-session treatment protocol for the randomized controlled trial followed the EFT intervention manuals of Greenberg and Watson (2006) and of Elliott et al. (2004). EFT is a humanistic-experiential treatment that utilizes emotion-evoking therapeutic tasks targeting specific emotional

processing difficulties (e.g., clearing a space, experiential focusing, systematic evocative unfolding, two-chair dialogue, two-chair enactment, and empty-chair work) to access and transform maladaptive emotion schemes (Elliott et al., 2004; Greenberg & Watson, 2006).

3.4. Process Measures

3.4.1. Chair Work Coding System. The Chair Work Coding System (CWCS; Lourenço et al., 2018) is a method of systematic identification of clients' progress in the process of resolving specific emotional processing difficulties through chair work tasks: two-chair dialogue for self-evaluation splits, two-chair enactment for self-interruption splits, and empty-chair work for unfinished business. The coding system is based on Elliott et al.'s (2004) descriptions of clients' processes in the six-stage sequential structures of each chair work task (see Table 6), i.e., the set of client behaviors that compose each stage involved in the successful resolution of each emotional processing difficulty. Therefore, the coding system is a process measure with an interval scale ranging from two (task initiation) to six (task full resolution), where raters identify three types of components: beginning and end delimitations of the chair work event segment, type of task, and resolution stage. Raters enforce the criteria of active chair work in identifying event segments, i.e., plausible contact between parts of the self must be observed in order to be considered as a unit of analysis.

3.4.2. Experiencing Scale. The Experiencing Scale (EXP; Klein et al., 1969, 1986) is a process measure of clients' cognitive and emotional involvement in processing inner experiences, i.e., the extent to which they experience, reflect on, explore and create new meaning from inner experiences and transform their emotions and self-experiences. On a seven-point ordinal rating scale, the EXP levels are indicative of the clients' level of emotional processing (see Table 7; Watson et al., 2007): lower levels (EXP 1 and 2) involve superficial or intellectualized external descriptions of events; intermediate levels (EXP 3 and 4) involve references to emotional reactions or internal processes that clarify the client's inner experience; higher levels involve exploratory reflection on emotional experiences (EXP 5), new meanings and emotional experiences (EXP 6), and application of these emotional changes to other life contexts (EXP 7). The EXP (Klein et al., 1969, 1986) is typically applied to 'emotion episodes' (EEs; Greenberg & Korman, 1993; Korman, 1991), i.e., segments in which the client's discourse involves an emotional response towards a situation or context. The application of the EXP (Klein et al., 1969, 1986) to emotionally-laden content has proven to be a sound, comprehensive method of measuring the cognitive-affective continuum of emotional processing (Hendricks, 2002, 2009; A. Pascual-Leone et al., 2016; A. Pascual-Leone & Yeryomenko, 2017; Pos et al., 2003, 2009). Interrater agreement of the EXP on previous studies ranged between .76 and .91 (Klein et al., 1986).

Table 6

Client processes in the chair work tasks

	TWO-CHAIR DIALOGUE	TWO-CHAIR ENACTMENT	EMPTY-CHAIR WORK
Stage 1	Marker confirmation: *Client describes split in which one aspect of self is critical of, or coercive toward, another aspect. Broadly, client describes two aspects, whether attributed or in somatic form.*	Marker confirmation: *Client engages in or describes how one part interrupts another part.*	Marker confirmation: *Client blames, complains, or expresses hurt or longing in relation to a significant other.*
Stage 2	Initiating two-chair dialogue: *Client clearly expresses criticisms, expectations, or "shoulds" to self in concrete, specific manner.*	Entry: *Client actively enacts own possible self-interruptive process in concrete specific manner.*	Setting up and starting: *Client speaks to imagined other and expresses unresolved feelings (e.g., resentment, hurt).*
Stage 3	Deepening the split: *Primary underlying feelings and needs begin to emerge in response to the criticisms. Critic differentiates values and standards.*	Deepening: *Client contacts and differentiates feelings of passivity and resignation.*	Differentiating meaning and expressing primary emotions: *Client differentiates complaint into underlying primary feelings and experiences and expresses relevant emotions (e.g., sadness, anger, fear, shame) with a high degree of emotional arousal.*
Stage 4	New experiencing and self-assertion: *Client clearly expresses needs and wants associated with a newly experienced feeling.*	Partial resolution: *Client clearly expresses interrupted emotion.*	Expressing and validating unmet needs: *Client experiences unmet needs as valid and expresses them assertively.*
Stage 5	Softening of the critic: *Client genuinely accepts own feelings and needs and may show compassion, concern, and respect for self.*	Self-assertion: *Client clearly expresses need associated with the emotion.*	Shift in representation of other: *Client comes to understand and see other in a new way, either in a more positive light or as a less powerful person who has or had problems of his or her own.*
Stage 6	Negotiation: *Client gains clear understanding of how various feelings, needs, and wishes may be accommodated and how previously antagonistic sides of self may be reconciled.*	Full resolution: *Client feels empowered and envisages or plans new actions in the world in order to meet need.*	Self-affirmation and letting go: *Client affirms self and lets go of unresolved feeling by understanding, forgiving, or holding other accountable.*

Note. Adapted from *Learning Emotion-Focused Therapy: The Process-Experiential Approach to Change* (pp. 223, 239, 246), by R. Elliott, J. C. Watson, R. N. Goldman, and L. S. Greenberg, 2004, American Psychological Association (https://doi.org/10.1037/10725-000). Copyright 2004 by the American Psychological Association.

Table 7

Experiencing Scale (EXP) levels

EXP Level	Description
EXP 1	Clients discuss events, ideas, and interactions with no reference to their own feelings.
EXP 2	Clients refer to others and make reference to the self without expressing emotions.
EXP 3	Clients begin to pepper their narratives with some reference to how they are feeling or reacting.
EXP 4	Clients shift from an external frame of reference to an internal one; they reveal their own subjective worldviews with their feelings, perceptions, and experiences clearly expressed.
EXP 5	Clients begin to examine and explore in a purposeful way their experiences and reflect on their emotional reactions and behavior to try to understand them better.
EXP 6	Clients come to new perspectives about themselves or how they feel about themselves; there is a shift that indicates that clients are now able to reframe their problems or to see themselves or others in new ways.
EXP 7	Clients continually refer to their inner worlds and experiences to process events; there is an ongoing process of in-depth self-understanding that provides new perspectives for solving significant problems.

Note. Adapted from *Case Studies in Emotion-Focused Treatment of Depression: A Comparison of Good and Poor Outcome* (pp. 16–17), by J. C. Watson, R. N. Goldman, and L. S. Greenberg, 2007, American Psychological Association (https://doi.org/10.1037/11586-000). Copyright 2007 by the American Psychological Association.

3.5. Procedures

3.5.1. Process measurement. Process measurement was performed by two separate teams of raters with no common elements, unaware of each other's coding procedures and results with the CWCS (Lourenço et al., 2018) and the EXP (Klein et al., 1969, 1986), and occurred at different moments in time for the purpose of two distinct studies (Lourenço, Aguiar, et al., 2021; P. Pinheiro et al., 2021). Each team of raters was headed by a more experienced principal rater who trained and paired with the other raters, with the first author of this paper heading the CWCS team and the second author of this paper heading the EXP team. Both principal raters were undergoing their Ph.D. in Applied Psychology and all the other raters were concluding their masters' degree in Clinical and Health Psychology. ***Chair work.*** A principal rater with prior training and clinical experience in EFT trained five other raters in the CWCS (Lourenço et al., 2018), ensuing the following sequence: reading and discussion of the coding manual; identification of the type of task and resolution stage presented in previously delimited chair work event segments from the "Emotion-Focused Therapy for Depression with Leslie S. Greenberg" DVD (American Psychological Association, 2007); identification of chair work event segments' beginning and end delimitations, type of task, and resolution stage presented in four to eight sessions from two clients from the randomized controlled trial until the trainee raters met acceptable agreement standards. The entire therapeutic processes of the 10 clients (160 sessions) were analyzed with the CWCS (Lourenço et

al., 2018), resulting in a total of 74 sessions with active chair work events. The pairs of raters analyzed their allocated cases independently session by session with discussion meetings to establish consensus on any discrepancies. Interrater agreement was computed for the five pairs of raters, reaching good to excellent indices on all coding components: percentage of agreement on chair work event segments' delimitation ranged from 69.65% to 81.38% (M = 73.69%), $Cohen's\ \kappa$ (Cohen, 1960; Fleiss et al., 2003; Landis & Koch, 1977) on the type of tasks ranged from .83 to 1.00 (M = .91), and $Intraclass\ Correlation\ Coefficient$ (two-way random-effects model, average measures, absolute agreement; Cicchetti, 1994; McGraw & Wong, 1996; Shrout & Fleiss, 1979) on the resolution stages ranged from .74 to .89 (M = .85). For this study's data analysis, CWCS ratings of in-session chair work event segments' resolution stages were averaged for each of the 74 sessions with active chair work from the 10 clients; this resulted in an averaged chair work resolution stage per session that was calculated accounting for the time spent in each chair work resolution stage within the session (i.e., time-weighted mean), hereinafter referred to as 'resolution stage mean'. ***Emotional processing.*** A principal rater with prior experience in the EXP (Klein et al., 1969, 1986) trained three raters in the EEs (Korman, 1991) and four other raters in the EXP (Klein et al., 1969, 1986). Training procedures followed the same structure on both measures: reading and discussion of the coding manual; coding of excerpts from the manual; coding of sessions from the randomized controlled trial until the trainee raters met acceptable agreement standards. Every fourth session (1, 4, 8, 12, and 16) of the 10 clients (50 sessions) was analyzed following the procedures of the EEs (Korman, 1991) and of the EXP (Klein et al., 1969, 1986). Three pairs of raters independently identified the EEs (Korman, 1991) in randomly assigned sessions and four pair of raters independently rated the highest level of EXP (i.e., EXP peak; Klein et al., 1969, 1986) in those previously identified EEs' segments. Discussion meetings were held between sessions to establish consensus on any discrepancies. The pairs of raters obtained good to excellent agreement indices on both measures: $Cohen's\ \kappa$ (Cohen, 1960; Fleiss et al., 2003; Landis & Koch, 1977) on the EEs ranged from .72 to .91 (M = .82) and $Intraclass\ Correlation\ Coefficient$ (two-way random-effects model, average measures, absolute agreement; Cicchetti, 1994; McGraw & Wong, 1996; Shrout & Fleiss, 1979) on the EXP ranged from .72 to .89 (M = .82). For this study's data analysis, EXP ratings of in-session EEs' segments were averaged for each of the 50 sessions from the 10 clients; this resulted in an averaged EXP peak level per session that was calculated from the EXP peaks rated in the session's varying number of EEs' segments, hereinafter referred to as 'EXP mean peak'.

3.5.2. Data analysis. In our data analysis we used the 'EXP mean peak' as measure of clients' depth of emotional processing every fourth session and the 'resolution stage mean' of each session as a

measure of clients' chair work resolution stage. The variables 'EXP mean peak' and 'resolution stage mean' were considered in the statistical analysis in the logarithmic scale given the distribution of these data in the original scale. With this transformation the variables became with a Normal distribution.

Given the nested nature of our data, with sessions nested within clients, our data analysis approach focused on multilevel mixed-effects models through the use of Hierarchical Linear Modeling (HLM; Raudenbush & Bryk, 2002) with subject-specific random effects. In HLM we model a response variable Y_{ij} measured for subject i at time t_{ij} as a function of time (t_{ij}) and other possible predictors ($predictors_{ij}$). The Equation is assumed as

$$Y_{ij} = \beta_o + \beta_1 * t_{ij} + \beta_2 * predictors_{ij} + U_i + Z_{ij} \quad (2)$$

where U_i is the subject-specific random effect with Normal distribution and variance ν^2 and Z_{ij} is the measurement error with Normal distribution and variance τ^2.

In order to understand the evolution of the variables of interest throughout the therapeutic process, our first step was to compute separate models of their longitudinal progression as a function of time. For this we compute Equation 2 without the component $predictors_{ij}$, only with the effect of time (t_{ij}). For each separate model the response variable Y_{ij} takes the form of 'EXP mean peak' and 'resolution stage mean' (see Table 8).

Afterwards, to test the longitudinal effect of chair work on emotional processing, we computed the same Equation 2 with previous sessions' chair work resolution stage ('resolution stage mean') as $predictors_{ij}$ for the response variable Y_{ij} as depth of emotional processing ('EXP mean peak') at sessions 4, 8, 12, and 16, having also the time t_{ij} effect (e.g., the 'resolution stage mean' from sessions 1 to 3 predicting the 'EXP mean peak' from session 4, the 'resolution stage mean' from sessions 4 to 7 predicting the 'EXP mean peak' from session 8, and so on; see Table 9).

Finally, to test the effect of chair work in client i on the difference in emotional processing from beginning to end of therapy in the same client, we used a simple linear regression of the form

$$ExpMeanPeak(Post - Pre)_i = \beta_0 + \beta_1 * ssResolutionStageMean_i + \epsilon_i \quad (3)$$

where ϵ_i is the measurement error with Normal distribution and variance σ^2 (see Table 10). The subject-specific values for $ssResolutionStageMean_i$ are obtained from the individual estimates of U_i that come from the result of adjusting Equation 2 to the response variable Y_{ij} as 'resolution stage mean' (see Table 8, model G).

All analyses were computed using the nonlinear mixed-effects modeling (nlme) package (version 3.1-142; J. Pinheiro et al., 2019) for R (version 3.6.1; R Core Team, 2019).

4. Results

4.1. Longitudinal Progression of Chair Work and of Emotional Processing

HLM (Raudenbush & Bryk, 2002) analysis of the longitudinal progression of chair work resolution stage ('resolution stage mean') and of depth of emotional processing ('EXP mean peak') indicated that time (sessions) was a significant predictor of both variables throughout treatment (see Table 8).

Table 8

Longitudinal Progression of Chair Work ('resolution stage mean') and of Emotional Processing ('EXP mean peak')

	Models and Fixed Effects	$Coefficient$	SE	t	p	R^2_{adj}
	Session predicting Chair Work					
G	Intercept (β_0)	.87	.07	12.84	<.000	.36
	Session (β_1)	.02	.01	3.16	.002	
	Session predicting Emotional Processing					
H	Intercept (β_0)	1.19	.05	23.38	<.000	.86
	Session (β_1)	.02	.00	8.66	<.000	

Chair work resolution stage, as measured by the 'resolution stage mean' of each session, showed to be positively associated with time (sessions), increasing on average .02 (logarithmic scale) each session, R^2_{adj} = .36, β_1 = .02, p = .002 (see Table 8, model G). Depth of emotional processing, as measured by the 'EXP mean peak' of every fourth session, showed to be positively associated with time (sessions), increasing on average .02 (logarithmic scale) each session, R^2_{adj} = .86, β_1 = .02, p < .000 (see Table 8, model H).

4.2. Chair Work as Predictor of Emotional Processing

Considering the results of the previous analysis (see Table 8) of the longitudinal progression of chair work resolution stage ('resolution stage mean') and of depth of emotional processing ('EXP mean peak'), time (sessions) was included in the subsequent HLM (Raudenbush & Bryk, 2002) analysis of chair work resolution stage predicting following-session depth of emotional processing (see Table 9).

Table 9

Hierarchical Linear Modeling with Chair Work ('resolution stage mean') as predictor of following-session Emotional Processing ('EXP mean peak')

Model and Fixed Effects		$Coefficient$	SE	t	p	R^2_{adj}
	Chair Work predicting Emotional Processing					
I	Intercept (β_0)	1.01	.09	10.88	<.000	
	Session (β_1)	.01	.00	3.10	.006	.87
	Resolution Stage Mean (β_2)	.08	.03	2.46	.024	

HLM (Raudenbush & Bryk, 2002) analysis on the chair work predicting emotional processing model indicated that chair work resolution stage ('resolution stage mean') was a significant predictor of the increase in depth of emotional processing ('EXP mean peak') in the following session, R^2_{adj} = .87, β_2 = .08, p = .024 (see Table 9).

Simple linear regression analysis on the chair work predicting emotional processing pre- to post-therapy difference model indicated that chair work resolution stage ('resolution stage mean') was a significant predictor of the increase in depth of emotional processing ('EXP mean peak') at the end of therapy, R^2_{adj} = .65, β_1 = 3.89, p = .003 (see Table 10).

Table 10

Simple Linear Regression with Subject-Specific Chair Work ('resolution stage mean') as predictor of Emotional Processing ('EXP mean peak') pre- to post-therapy difference

Model		$Coefficient$	SE	t	p	R^2_{adj}
	Chair Work predicting Emotional Processing					
J	Intercept (β_0)	.98	.10	10.21	<.000	.65
	Resolution Stage Mean (β_1)	3.89	.93	4.19	.003	

5. Discussion

This study aimed at providing empirical support for the theoretical assumption that specific humanistic-experiential interventions facilitate the emotional processing of internal experiences. Specifically, we sought to ascertain if the process of resolving chair work tasks was associated with an enhanced capability of emotional processing throughout therapy. To pursue this objective, our research strategy was to explore the longitudinal relationship between client progression in the resolution of three chair work tasks—two-chair dialogue, two-chair enactment, and empty-chair work—and their depth of emotional processing, both diachronically (i.e., in the following session) and synchronically (i.e., in pre-

to post-therapy). To test the predictive effect of chair work on emotional processing we used HLM (Raudenbush & Bryk, 2002) in the session-by-session analysis (see Table 9) and a simple linear regression in the pre- to post-therapy analysis (see Table 10).

Regarding our preliminary HLM (Raudenbush & Bryk, 2002) analyses, when modeling chair work resolution stage ('resolution stage mean') and depth of emotional processing ('EXP mean peak') in longitudinal models using only time (sessions) as a predictor (see Table 8, models G and H) these were found to be highly significant (respectively, p = .002 and p < .000) with increasing tendencies, meaning that both variables increased throughout therapy. Regardless of any possible explanation, we know beforehand that throughout therapy the clients from this study have made progress in resolving several emotional processing difficulties and in processing painful emotional experiences. This alone leads us to infer that at least from the perspective of these process variables (chair work resolution stage and depth of emotional processing) their therapeutic processes seem to have been successful in promoting change.

The major finding in our study was that clients' chair work resolution stage ('resolution stage mean') was a significant predictor of the increase in depth of emotional processing ('EXP mean peak') in the following session throughout therapy and at treatment termination (see Tables 9 and 10). For the clients in our study, (1) reaching higher stages of resolution in the chair work tasks in previous sessions seems to have led to the gradual increase in depth of emotional processing throughout therapy and (2) successfully progressing through the resolution stages of the chair work tasks along therapy seems to have led to gains in terms of their capability to process emotional experiences at the end of therapy. In sum, our clients' performance in chair work was strongly associated with the subsequent enhancement of their emotional processing capability.

An interesting detail in our HLM analyses of the session-by-session prediction of depth of emotional processing ('EXP mean peak') was the slight increase in the explained variance after introducing the chair work resolution stage variable ('resolution stage mean'). The initial model on the longitudinal progression of emotional processing as a function of time (see Table 8, model H) explained 86% of the variance in the response variable and the subsequent model of chair work predicting emotional processing (see Table 9) explained 87% of the variance in the response variable. In either model, the effect of time actually holds in-itself the aggregate effect of any variable with influence on emotional processing that has not been formally accounted for in the model. Since time is a confounding variable that encompasses everything else occurring within therapy, the chair work resolution stage variable introduced in the subsequent model extracts its effect from the pseudo effect of time while still adding to the explained variance in the response variable. In this sense, although minor, the aforementioned

increment in the model explanation confers added reassurance to our results and to the role of chair work tasks in promoting clients' emotional processing capability.

In the simple linear regression analysis (see Table 10), the subject-specific values of chair work resolution stage ('resolution stage mean') were found to predict the increase in clients' depth of emotional processing ('EXP mean peak') from pre- to post-therapy. In other words, the extent of each client's progression in chair work throughout therapy predicted the magnitude of increase in their depth of emotional processing from beginning to end of therapy. Thus, globally, clients who progress more in the resolution of chair work tasks seem to be the ones whose capability to process emotional experiences increases the most at the end of treatment.

At first sight, our results seem to point in a different direction from those of Stiegler et al. (2018b), which did not find any added effect in clients' depth of emotional processing when including a chair work task (i.e., two-chair dialogue) in a client-centered intervention. We argue that the methodological differences between both studies suffice to explain their apparent discrepancies, as we have analyzed the actual effect of clients' performances in the chair work tasks. In our study, as opposed to investigating the effects of providing an intervention with certain therapeutic tasks, the encountered associations with clients' depth of emotional processing are relative to their actual processes of resolving chair work tasks. At another level of analysis of Stiegler et al.'s (2018b) findings, facilitating clients' emotional processing is certainly not an exclusive effect of therapeutic interventions such as chair work.

Altogether, our findings are in line with EFT's theory of practice regarding the effectiveness of emotion-evocative tasks in promoting clients' capability to process emotional experiences (Elliott et al., 2004; Greenberg, 2017b; Greenberg & Goldman, 2019b; Greenberg et al., 1993; Greenberg & Watson, 2006) and corroborate the speculations from previous studies on the role of emotional processing (A. Pascual-Leone & Yeryomenko, 2017; P. Pinheiro et al., 2021; Watson & Bedard, 2006) that process-experiential tasks confer EFT its advantage in achieving higher levels of emotional processing.

Although we did not consider any other emotion-evocative task apart from the chair work tasks, focusing on these particular tasks might as well be representative of what depressed EFT clients typically work on. Chair work tasks address particular emotional processing problems that are among the most common difficulties in cases of depression (Elliott et al., 2004; Greenberg, 2017b, 2019b; Greenberg & Goldman, 2019b; Greenberg & Watson, 2006; Salgado et al., 2019). As such, we are inclined to consider that our results are representative of EFT's treatment of depression and conjecture that similar results would be found by including additional therapeutic tasks.

6. Conclusion

The findings from our study provide empirical support for the effects of emotion-evocative therapeutic tasks—particularly chair work interventions—on clients' emotional processing of painful internal experiences. Resolving self-evaluation splits, self-interruption splits, and unfinished business in a manner consistent with EFT's chair work tasks seems to enhance clients' emotional processing capability. In light of the role of emotional processing to therapeutic outcomes in different approaches, chair work may be a specific therapy ingredient through which this purported common factor is put in motion in EFT for depression.

A possible clinical implication derived from our study is that the impairment in processing painful emotional experiences that is so characteristic of depressive states may be overcome in therapy by guiding clients through emotion-evocative tasks such as chair work. By helping clients in the process of resolving chair work tasks EFT clinicians are concomitantly supporting them in enhancing their capability to become aware, contact, differentiate, and transform difficult internal experiences.

Despite our best efforts, the results and conclusions from our study should be regarded attending to its limitations. Although we resorted to in-depth longitudinal analyses of meaningful process variables (chair work resolution stage and depth of emotional processing) with appropriate statistical models, 10 clients are in no standard a proper representative sample to allow confident generalizability. In this sense, with absolute certainty we may only posit that the results and conclusions from our study are valid for its respective clients and at the very best may be plausible to occur in other samples.

Prospective research efforts on the effects of EFT's therapeutic tasks would profit from focusing on similar in-depth analyses of client processes in more sizeable samples and from including other relevant emotion-evocative tasks (e.g., experiential focusing for unclear feeling, systematic evocative unfolding for problematic reaction point, self-soothing for anguish and familiar despair) to replicate our findings with increased confidence and enhanced generalizability.

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CHAPTER IV

CONCLUSION

To remember, and let go.
Not leaving, no. Moving on.
Christian Shephard

Psychotherapy process–outcome research aims to identify the helpful aspects within client–therapist interaction responsible for positive treatment clinical effects—therapy change processes, client change processes, and change mechanisms (Doss, 2004; Elliott, 2010; Gelo & Manzo, 2015; Hardy & Llewelyn, 2015; Kazdin, 2007, 2009, 2014; Orlinsky et al., 2004). Our empirical studies attempted to echo this logic by focusing on client change processes within clinically meaningful events of chair work—two-chair dialogue, two-chair enactment, and empty-chair work—and their effects on other client change processes and ultimate outcomes in emotion-focused therapy (EFT). Specifically, building on the assumptions about the role of chair work in EFT, our studies sought to fill an empirical gap by demonstrating that the underlying client processes involved in the resolution of chair work tasks effectively lead to positive changes in emotional processing and in clinical symptoms. We accomplished this by implementing a mixed-method research strategy in our studies, combining qualitative and quantitative approaches sequentially, with idiographic data collection (i.e., individual-level) and nomothetic data analysis (i.e., group-level), and accounting for within- and between-client effects using Hierarchical Linear Modeling (HLM; Raudenbush & Bryk, 2002) to test the predictive effect of chair work resolution processes on depth of emotional processing and on intensity of clinical symptoms (general and depressive) throughout therapy in a sample of depressed clients.

Major Conclusions on the Effects of Chair Work

Our research demonstrates that the process of reaching higher stages of resolution in chair work tasks is longitudinally associated with decrease of clinical symptoms in the following session (study 1, Chapter III) and with higher levels of emotional processing in the following session and at therapy termination (study 2, Chapter III). These results are informative of the role of chair work (i.e., therapy change processes) in EFT for depression and, concomitantly, of the importance of addressing conflict splits between parts of the self and unfinished business with significant others (i.e., client change processes) when treating depressive states. Beyond improvement from depression (i.e., ultimate outcome), these results also corroborate that chair works tasks effectively help clients enhance their capability to process emotional experiences (i.e., client change process).

Our empirical studies are more informative about the effects of clients' performances in chair work tasks (i.e., client change processes) than of the implementation of chair work tasks in psychological

treatments (i.e., therapy change processes). The observed associations in our statistical analyses with clinical symptoms and with emotional processing are relative to clients' processes in chair work. It is the process of resolving chair work tasks that is a predictor of the decrease in clinical symptoms and of the increase in depth of emotional processing, and not merely the use of chair work interventions. This is a clear deviation from typical experimental component studies, which compare treatment modalities with and without a certain therapeutic technique, and, in our view, a more intelligible (perhaps also meaningful) way of understanding a therapeutic process. In reference to Doss's distinctions (2004), focusing on *client change processes* (i.e., client resolution stages within chair work) instead of *therapy change processes* (i.e., chair work techniques) is a step closer in the path towards unravelling the relationship between *change mechanisms* (e.g., transformation of maladaptive emotion schemes) and *ultimate outcomes* (e.g., symptom improvement). However, it is clear for us that our research does not address the latter relationship, focusing strictly on the relationship between client change processes and ultimate outcomes. An interesting methodological approach for investigating the whole mediational pathway of the model of psychotherapy change (Doss, 2004) comes from Gómez Penedo et al. (2020), where client change processes and mechanisms associated with long-term outcome are investigated through sequential multilevel structural equation models (Preacher et al., 2010, 2011). Although assessing the output of transformation of maladaptive emotion schemes (i.e., the change mechanism) may prove to be challenging, applying a similar design strategy to the study of client change processes within chair work and its relation to change mechanisms and ultimate outcomes seems promising.

The client processes involved in the chair work tasks we have studied reflect several empirically supported EFT principles of emotional change (e.g., awareness, expression, reflection, and transformation; Greenberg, 2015, 2019a; Greenberg & Watson, 2006) and also put in motion other transversal evidence-based principles of therapeutic change (e.g., active participation, self-understanding, and emotional experiencing and/or deepening; McAleavey et al., 2019), all of which may help frame the direction of our results and provide a complementary explanation for the observed effects of performing chair work. First, progress through the resolution stages of chair work follows a compass of deepening clients' emotional experiencing to become aware of and express different (often conflicted or suppressed) aspects of the self and their tacit (often painful) emotional experiences, so that these may be explored and reflected upon in conscience. This deepening process derives novel understanding of self–self and self–other internal processes, while allowing new, more adaptive emotional states to emerge and transform maladaptive emotion schemes. Transformation occurs through the integration of the newly-formed primary adaptive experiencing in a consolidated self-organization. Second, client active

participation in this emotional transformation sequence denotes engagement with the therapeutic activities of chair work and its healing processes. In a sense, the observed client performances in chair work may be viewed as a proxy measure of adherence to therapy or, in Frank's terms (Frank, 1961; Frank & Frank, 1991), compliance to the *rituals* of EFT. Altogether, in our perspective, the actuation of the abovementioned principles of change through the described emotional transformation sequence provides a coherent rationale for how chair work can contribute to symptom improvement and enhance clients' emotional processing capability.

Our studies suggest that chair work is a crucial piece of EFT's treatment of depression, though surely not the sole change process at play, as we know from EFT theory and research. For instance, EFT treatment is deeply embedded in an empathically attuned relationship (Elliott et al., 2004; Greenberg, 2015, 2017a; Watson, 2019), which by itself as shown to be systematically related to client outcome (for reviews, see Elliott et al., 2011, 2019). In fact, therapist empathy has been indicated as a principle of change in psychotherapy (McAleavey et al., 2019). Moreover, the process of chair work is in itself inextricably interwoven in therapists' empathic understanding and exploration of client experiencing; this interdependency, of course, applies to other factors involved in EFT. Our point here is that the observed effects of chair work resolution client processes in clinical symptoms encompass other salubrious therapy processes and that all of these operate in tandem throughout the dynamically complex psychotherapeutic phenomena.

Based on prior research and on the results observed in our empirical studies, it seems plausible to reinforce the suggestion that psychological treatments for depression ought to address self-directed criticism/censorship and other-directed resentment when treating depression. Perhaps in other treatment modalities, other than EFT, intentionally addressing these processes might have analogous effects on depressive states. For instance, cognitive therapy (A. T. Beck et al., 1979; J. S. Beck, 2021) generically addresses self-criticism through cognitive restructuring techniques to challenge and replace self-critical thoughts, which entails a somewhat different approach from that of EFT (an interesting, yet theoretical, review of client self-criticism in psychotherapy was elaborated by Kannan and Levitt [2013]). In this sense, it would be interesting to identify the therapeutic techniques through which other treatment approaches target these processes, determine similarities and discrepancies with EFT's chair work tasks resolution models, and investigate their comparative efficacy.

Clinical Implications

Psychotherapy research ultimately aims to enhance the efficacy of psychological interventions through the process of understanding how and why psychotherapy works (Gelo et al., 2015). Our empirical studies provided added insight into the client change processes at play in EFT for depression—chair work resolution processes—and a few implications may be drafted for clinical practice, beyond what was already discussed in the empirical studies (Chapter III).

Considering that the statistical phenomenon of reverse causality was found to be absent in the relation between general symptoms and chair work (i.e., symptom intensity did not predict chair work resolution stage), EFT practitioners may rely on facilitating chair work to achieve symptom alleviation even in some severe symptomatic presentations of depression. Helping clients work through conflicts splits between parts of the self and unfinished business with significant others, by guiding their progress in the chair work resolution models outlined by EFT, seems to be a viable path to achieve symptom improvement.

In EFT theory, the ability to fully process emotional experiences is regarded as an important feature of healthy functioning (Greenberg, 2019a, 2019b). Our research suggests that helping clients progress through the resolution stages of chair work has an impact in their ability to process internal experiences. We hypothesize that enhancing clients' capability to process painful emotional experiences through chair work may act as a preventive, helpful strategy that might help them deal with upcoming life situations and internal states in a more adaptive manner.

Working through chair work involves some necessary degree of contact with emotionally difficult states (Goldman & Greenberg, 2015; Greenberg, 2002, 2015). Such close contact with painful emotional experiences is an overarching essential condition for subsequent emotional change (Greenberg, 2017a, 2019a; Greenberg & Goldman, 2019b), one that we have observed while analyzing the therapeutic processes of our sample's clients. In most EFT therapeutic tasks, including chair work, a significant portion of the therapeutic work revolves around accessing, tolerating, and exploring difficult emotions. Our results corroborate that this does not preclude positive treatment outcomes and, quite the opposite, leads to symptom improvement—"the only way out *is* [emphasis added] through" (Hunt, 1998, p. 361; A. Pascual-Leone & Greenberg, 2007, p. 875). In spite of this orienting dictum, placing clients within direct contact with painful feelings is sometimes ambivalent for therapists and most of the times noticeably dreading for clients. Thus, it would be beneficial (to both parties) to explicitly address the inherent difficulties of working through chair work, perhaps during a post-task exploration of the challenges felt by the client. Such metacommunicative act might as well help therapists becoming aware

of client impasses in specific stages of resolution of chair work and inform deliberate efforts to circumvent them.

Limitations and Prospective Research

We began the introduction of this thesis by stating that psychotherapy works. To this symbolic opening sentence, and based on our research, we would add that certain techniques of psychotherapy (i.e., chair work tasks) may work, in highly specified settings (i.e., randomized controlled trials), for a reserved number of clients with homogeneous constellations of symptoms (i.e., mild to moderately depressed). Beyond the fact that it belongs to a research niche, there are several limitations within this thesis that must be made explicit, in order to adequately frame our results and our conclusions about the role of chair work in EFT and its effects on clinical symptoms and emotional processing.

Our studies' sample of 10 clients is undeniably small, and sample size constraints obviously compromise generalizability of results. As a way to minimize such limitation, we resorted to dependable procedures of data collection and of data analysis. A temporal sampling strategy for the process variable "chair work" (i.e., analyzing predetermined sessions) would decrease the amount of time spent collecting data and allow the inclusion of additional clients to our sample. However, the unpredictable nature of occurrence of the process in scrutiny inhibited the adoption of such sampling method; contrary to the course of most process variables in psychotherapy, chair work resolution processes flow from the client's moment-to-moment internal states and are not present in all sessions. One other alternative would have been to employ a different, *macro*-processual observational measure to assess chair work processes and assign a single, global value of resolution for each session. Looking back at the beginning of our research, such possibility was discarded for two reasons of different nature: first and foremost, a macro-processual approach would involve a more subjective level of judgement and such rough estimation would deprive us from the qualitative richness of the in-session evolution of chair work; second, our background as researchers has favored in-depth, micro-analytical perspectives on client change processes and perhaps this past may also have tinted our methodological decisions. Thus, we compromised sample size in favor of process fidelity and an accurate depiction of clients' chair work performances throughout therapy. We will continue our efforts in widening our sample to increase its dependability.

EFT's task resolution models portray seemingly sequential steps in the process of working through emotional processing difficulties. Despite this apparent linearity, client change processes in actual therapy most often develop through back-and-forth movements between resolution stages within a given task and sidetrack movements to alternate tasks—this much is expected and makes clinical sense (Elliott

et al., 2004). For instance, while working through self-evaluative splits in two-chair dialogue, clients are invited to oscillate between the conflicting voices of the experiencing self and of the critic, which may require revisiting lower stages to feed the resolution progress; while at the experiencing self's chair the client may begin to access primary feelings associated to the usual criticisms (stage 3), which often triggers back a harsh response from the critic (stage 2). Moreover, most often there are bridges between an introjected self-critical voice and the resentment felt towards a significant other, which justify that resolution in two-chair dialogue may sometimes be aided by empty-chair work. Such dynamics are evident in Elizabeth's case (Chapter II) and were also observed in most (if not all) cases from our studies' sample. Thus, a seesaw path in the resolution process of chair work tasks, at an in-session level and across sessions, makes clinical sense from an EFT point of view, and it would be interesting to investigate if these irregular patterns have any relation with improvement from depression.

In developing a method for tracking client progress in chair work we have made two important conceptual decisions that were reflected in our coding criteria: task markers (i.e., stages 1) and 'passive chair work' were disregarded from our qualitative analysis. Respectively, the implications of these methodological decisions were that we forfeit the client processes that originate a given chair work event and, perhaps more problematic, we lose an important part of the therapeutic processes that often take place after the more discernable, active enactment in chair work. While ensuring methodological reliability across judges due to the higher subjectivity of post-enactment reflections, this 'active chair work' criteria had the collateral effect of not accounting in our statistical analyses potential chair work full resolutions (i.e., stages 6) that sometimes occur in a mitigated fashion. In retrospective, we should have included these post-task instances of client processes in our research to more faithfully depict their actual progress in resolving conflict splits and unfinished business.

The statistical analyses in our empirical studies have focused on the collective effect of a group of chair work tasks, as opposed to investigating their individual effects on clinical symptoms and on emotional processing. This seems to imply a conceptual framework where resolution stage, regardless of the specific chair work task, is regarded as more meaningful or relevant for positive outcomes—although that is *not* our perspective. Our rationale for analyzing the combined effect of the three separate chair work tasks we have studied was twofold. First, in EFT theory and practice, we found no indication pointing to the relative preponderance in the treatment of depression of one chair work task over the others, and, as we observed in our sample, therapeutic work often involves some degree of interdependency between chair work tasks due to connections amongst the internal processes they address. Second, separate statistical analyses for each chair work task would require a more demanding number of clients, one that

is unattainable with our resources in terms of time and human means. Regardless, separating the individual effects of chair work tasks in a much larger sample of clients would be interesting to follow.

For the purpose of clarity, our empirical study about the predictive effect of chair work on emotional processing should have included the reverse statistical analysis of depth of emotional processing predicting following-session chair work resolution stage, and we will definitely do so before submitting for publication. This study departed from the seemingly straightforward rationale that emotion-evocative tasks facilitate emotional processing of internal experiences, from which we expected that the process of resolving chair work tasks would be associated with an enhanced capability to process emotional experiences. This implies that we viewed emotional processing in two ways: a process through which chair work is actuated, and an outcome in terms of acquired ability to process painful experiences. Such relation between the two variables is probably confounding, and considering causal simultaneity might be more adequate.

At least with regard to conflict splits between part of the self, EFT treatments for depression and anxiety seem to share a common ground, as self-interruptive and self-critical processes are present in this broad diagnostic category (Elliott & Shahar, 2019; Watson et al., 2019). It would be interesting to replicate our studies in a sample of clients with anxiety-related difficulties to determine if client resolution processes in chair work prove to demonstrate similar effects.

Altogether, the results from our empirical studies seem to confer partial validity to EFT's end goal of emotional transformation of depressive schemes through the theoretically proposed path of performing specific emotion-evocative tasks to resolve several types of emotional processing difficulties and enhancing clients' capability to process painful experiences. What our empirical studies completely fail to ascertain are the long-term effects of chair work in terms of relapse prevention and maintenance of treatment gains. Generically, following a psychotherapy treatment for depression, long-term relapse rates are relatively high (Steinert et al., 2014). Although there is some tentative indication that EFT's emotion-evocative interventions may enhance maintenance of treatment gains (Ellison et al., 2009), we still do not know if resolving conflict splits and unfinished business has enduring effects on clients' clinical symptoms and emotional processing capability in the long run. Hence, longitudinal studies with follow-ups up to at least 24 months are needed to start answering these questions.

Final Remarks

The broader purpose of this thesis was to make a contribution of knowledge to the field of EFT. Nonetheless, our research on the effects of chair work does not yield any groundbreaking discovery for

EFT. It is very well established in EFT theory and practice that helping clients working through conflict splits between parts of the self and unfinished business with significant others is relevant for the process of healing depressive states. What it does provide, in our perspective, is (modest) empirical support for these important therapeutic activities—and such is still a necessary matter.

The process of developing a method of tracking client progress in chair work has proven to be challenging and rewarding in equal amounts, and such is also true for the actual process of analyzing our sample. Despite departing from EFT's well-documented chair work tasks' resolution models, operationalizing these comprehensive descriptions of client processes into a practical coding system implied the definition of coding criteria that was adequately balanced in terms of inclusiveness and specificity, while also accounting for reliability concerns. For instance, the assertiveness found in two-chair dialogue for self-evaluation splits (stage 4 – assertion of organismic needs to the critic) and in empty-chair work for unfinished business (stage 4 – assertion of unmet interpersonal needs to the significant other) takes on idiosyncratic manifestations in terms of vocal quality, expressive stance, body language and posture, facial expression, and other non-verbal elements of communication. Beyond this, assertion may flow naturally for some clients more than others and, as such, newly experienced assertiveness may become more meaningful for clients who are typically less assertive. With effect, assertion assumes multiple formats and is context-bound, making the process of its identification a complex task. These nuances also apply for other aspects of client processes within chair work. Thus, coding criteria was necessarily flexible to accommodate idiosyncrasies and dependent on the observer's clinical judgement and overall knowledge of the client. Puzzling as it may have been sometimes, the richness contained in this detailed analysis of the client's moment-to-moment processes of resolving conflict splits and unfinished business allowed us to build faithful portraits of each client's chair work progress throughout therapy, on which our statistical analyses and results relied. Finally, the immersive process of in-depth analysis of the clients from our studies brought clear implications in terms of our clinical sensitivity for the client processes involved in chair work, which became a useful resource for our own clinical practice. In this sense, beyond the attempt to make an empirical contribution to the field, the actual process of studying chair work has contributed to our own individual knowledge as clinical psychologists.

There is a kind of irony in trying to accomplish a Ph.D. through the study of self-critical and self-interruptive processes. This path has been prolific in professional growth as a researcher and as a psychologist, while laden with challenging personal confrontations. In recollecting the earliest steps of struggling to articulate a research project, our initial naïve ambition was to study additional EFT therapeutic tasks we thought were salient in the treatment of depression (e.g., experiential focusing for

unclear feelings, systematic evocative unfolding for problematic reaction points). Letting go of these tasks was probably the earliest unresolved feeling; though, as time would prove, certainly not the only one. As was true to many of our sample's clients in their psychotherapeutic processes, "the only way out [was] through" (Hunt, 1998, p. 361; A. Pascual-Leone & Greenberg, 2007, p. 875).

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