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OBM Integrative and Complementary Medicine

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Original Research

"Seeing Myself Through Someone Else's Eyes": Embodying the Perfect Nurturer in Compassion Focused Therapy

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Academic Editors: Neil Clapton and Syd Hiskey

Special Issue: Compassion Focused Therapy (CFT) – Advances and Innovations

OBM Integrative and Complementary Medicine
2024, volume 9, issue 1
doi:10.21926/obm.icm.2401021

Received: January 29, 2024
Accepted: March 21, 2024
Published: March 27, 2024

Abstract

Compassion-focused chairwork has become a recent focus of empirical investigation. This study extended this area of research by exploring how participants with depression experienced the 'compassionate other' imagery exercise enacted via chairwork methods. Eight individuals from primary care NHS mental health services were interviewed about their experience of the practice. The resultant data were analysed using interpretive phenomenological analysis (IPA). Three group experiential themes were identified: care that feels real, chairwork processes and encountering challenges on the road to discovery. The findings indicate that the intervention has therapeutic utility both as an intervention for cultivating compassion and as means of assessing for and identifying blocks to compassion. The results also suggest that there is potential value in enacting compassion-focused imagery

techniques through chairwork methods, especially for those who have difficulty accessing mental imagery practices. The findings are contextualised within broader theory and literature, and clinical and research implications are discussed.

Keywords
Compassion focused therapy; compassionate other imagery; compassion focused chairwork; chairwork; depression; interpretive phenomenological analysis

1. Introduction

1.1 Compassion Focused Therapy

Compassion focused therapy (CFT) is an integrative, biopsychosocial model of psychotherapy [1]. It combines an evolutionary view of human psychology with affective neuroscience, attachment theory and social mentality theory to provide a framework for integrating compassion into the therapeutic process [2]. CFT defines compassion as: "a sensitivity to suffering in self and others, with a commitment to try to alleviate and prevent it" (p.19) [3]. This definition draws upon findings and theory that suggests that compassion is a motivational state which emerged alongside the evolution of caring behaviour [4]. CFT aims to cultivate compassion through three relational 'flows': from self-to-other, from other-to-self and from self-to-self [3], with each flow thought to confer unique well-being benefits [5]. Systematic reviews suggest that CFT is an effective intervention for a range of clinical presentations [6-8].

CFT was originally developed with and for individuals experiencing elevated levels of self-criticism and shame [2]. Gilbert and Irons [9] conceptualise self-criticism using social mentality theory (SMT). A social mentality is a co-assembly of cognition, emotion, and action potentials that facilitate the formation of interpersonal social roles. Social roles are co-created in pursuit of evolved biosocial goals linked to care giving and receiving, competition and social rank, and alliance formation [3]. Social mentalities originally evolved to coordinate external relationships. However, SMT suggests that higher-order cognition in humans allows social mentalities to play out internally in a self-to-self pattern of relating [10, 11]. Self-criticism, therefore, is thought to represent the internal enactment of a rank-based social mentality based upon the sending and receiving of internally generated social signals [9]. CFT aims to help clients step out of rank-based relating to access care-based social mentalities in their relationships to both themselves and others.

Another central feature of CFT is the three systems model of emotion [12]. CFT combines an evolutionary functional analysis of emotion with affective neuroscience to cluster emotions based on their underlying evolved function [3, 13]. Three interdependent systems are identified, corresponding to threat detection and avoidance, drive-based resource seeking and acquisition, and rest and soothing [12]. In mammals, the soothe system is associated with the experience of care and social safeness. Gilbert [2] highlights that the development of this system is therefore closely linked to one's attachment history [14]. This system plays a crucial role throughout life in downregulating arousal and creating states of calm and contentment [4]. The three systems model suggests that mental health difficulties might result from imbalances in the regulation of these

emotion systems, alongside difficulties accessing the soothe system and associated care-based social mentalities.

The aims of CFT therefore include the re-balancing of these affective systems and the cultivation of a compassionate mindset [2]. CFT recognises, however, that these objectives may be obstructed by various fears, blocks, and resistances (FBRs) to developing compassion [15]. FBRs are processes that inhibit the generation of compassion and might manifest for a range of reasons. For example, some might consider compassion to be a sign of weakness or self-indulgence, whereas others might fear the consequences of 'letting one's guard down' [4]. Gilbert et al. [16] highlight that, because the soothe and attachment system are closely linked, efforts to stimulate the soothe system will naturally bring people into contact with their attachment system, along with the emotional memories stored therein [4, 14]. For those with insecure attachment histories, this might activate aversive emotional memories that make the nurturing of care-based affects and social mentalities challenging. The potential for FBRs to thwart therapeutic efforts has meant that identifying and addressing FBRs are recognised as important components of the therapeutic process [4].

In practice, CFT aims to cultivate a compassionate mindset through compassionate mind training (CMT). CMT utilises a range of techniques, such as breathing exercises and mindfulness practice, in aid of fostering the attributes (e.g., distress tolerance, empathy) and skills (e.g., compassionate thinking, compassionate behaviour) of the compassionate mind [9]. Central to CMT are mental imagery techniques. Imagery involves the retrieval of sensory information stored in memory [17] and is understood to have a powerful influence over physiology and affect [18]. Compassion-focused imagery aims to harness the effect of mental imagery upon physiology and emotion to stimulate the soothing system and support compassionate motivation [2].

One imagery practice utilised in CMT entails imagining a 'compassionate other' (also referred to as 'perfect nurturer') which personifies the core qualities of compassion [19]. This image can take any form (e.g., film character, animal) provided the image is sentient and thus capable of interpersonal communication and understanding [20]. In this exercise, clients are asked to imagine compassionate attributes through their 'ideal compassionate other' [21]. The compassionate other exercise aims to promote access to care-based social mentalities by generating internal signals of care-giving via the image, which stimulate responses associated with care-receiving [9]. This technique therefore aims to tap into different flows of compassion in a single exercise. Moreover, a recent study suggests that this imagery practice might elicit FBRs and memories of attachment/caring experiences and associated grief [22]. The compassionate other exercise might therefore offer a means of identifying FBRs, which can then be addressed by intervention.

CFT also emphasises the use of experiential methods, such as chairwork. Chairwork refers to a group of action-based psychotherapeutic techniques which utilise chairs and movement between chairs for therapeutic ends [23]. Chairwork methods originated in psychodrama [24-26] and have since been incorporated into a broad range of contemporary evidence-based therapies [27-29]. Pugh and Bell [30] have proposed general principles (self-multiplicity, information exchange, and transformation) and processes (separation, animation, and dialogue) which underly the application of chairwork methods across varying conceptual landscapes. Self-multiplicity refers to the notion that the self is made up of multiple and often conflicting parts. According to chairwork theory, self-parts can be separated, by identifying self-parts and locating them in different chairs, and animated, through personification or embodiment. From here, differentiated self-parts can engage in a

dynamic, social-relational style dialogue with the aim of reorganising experience via the exchange of emotionally salient information [31, 32].

There is considerable overlap in the principles of chairwork and the theoretical assumptions of CFT. For example, CFT conceptualises the self as multimodal, comprised of various brain states and patterns that create conflict in relationships with both the self and others [4]. CFT chairwork is unique, however, in its emphasis on building the compassionate self/chair and utilising this aspect of the self to relate to and integrate various strands of experiences [12]. CFT chairwork typically involves enacting and experiencing various social mentalities, with the client switching from rank-based to care-based social mentalities. A single CFT chairwork session can involve various flows of compassion. One might, for example, enact the giving of care in one chair before swapping chairs to experience receiving that care. A range of CFT concepts have been amalgamated with chairwork methods and empirically explored. Findings suggest that compassion-focused chairwork facilitates emotional deepening and expression [33]. It also appears to help clients explore themselves and their emotions with enhanced nuance and granularity [34] and achieve a sense of integration through relating to parts of the self with compassion [35].

Research is yet to explore the impact of a chairwork exercise that invokes the compassionate other imagery practice. The present study aimed to address this gap in the literature by exploring how clients with depression experienced the compassionate other intervention enacted via chairwork methods during a course of CFT treatment. This was investigated through an Interpretive Phenomenological Analysis (IPA) methodological framework. IPA is concerned with exploring the lived experience of personally significant subjective phenomena [36]. IPA is therefore apposite for the study of a novel therapeutic technique. The study chose to focus upon depression. There is a logical consistency in applying CFT to depression as elevated self-criticism and difficulties in generating self-compassion are two factors implicated in the development and maintenance of depression [37, 38], while reducing self-criticism and increasing self-compassion are the therapeutic targets of CFT [4]. Depression is also associated with attachment disturbance, difficulties accessing soothing states and associated FBRs [16]. The compassionate other exercise aims to stimulate care-based social mentalities, activate the soothe system and has been found to elicit FBRs [22]. This exercise may therefore hold promise for this client group by being capable of targeting several processes thought to perpetuate depression [16]. Furthermore, there exists limited research focusing upon specific components of CFT interventions. In exploring a specific component of CFT, this study might offer insights into the compassionate other exercise that allow clinicians to better plan and individualise interventions.

2. Method

2.1 Recruitment and Eligibility

Therapists working in primary care Improving Access to Psychological Therapies (IAPT) services were recruited to become part of the research team. To be eligible for the project, practitioners were required to hold core profession status or be accredited by a therapeutic/professional body (e.g., the British Association of Behavioural and Cognitive Therapies). Participating therapists were also required to have undertaken basic training in CFT and specific training in the compassionate other chairwork intervention via a skills workshop delivered by the authors. The therapist cohort comprised of one male and three females, all of white-British heritage.

Therapists identified potential participants for the study based on the study inclusion and exclusion criteria (see Table 1). Consistent with the IPA paradigm, a purposive sampling approach was employed which aimed to identify participants able to offer insight into the phenomena being studied [39]. A homogonous, rather than representative, sample was therefore recruited, comprised of individuals receiving CFT and the compassionate other intervention as part of their routine treatment package for depression within primary care IAPT services. Eight participants were recruited between June and September 2023 based on the eligibility criteria outlined in Table 1. IPA is an inductive approach and favours smaller samples. This allows for a detailed case-by-case analysis of subjective accounts, producing phenomenologically rich and practically informative findings which remain grounded in participants' personal narratives [40]. Smith et al. [39] and past research [41] indicate that a sample size of eight provides sufficient breadth whilst accommodating the depth of case-by-case analysis that IPA aspires to attain. Therapists provided potential participants with a study participant information sheet and consent forms. The primary researcher attended the IAPT service building to collect signed consent forms. To protect participant confidentiality, personally identifiable information was digitised and stored electronically on password protected data storage software and stored separately to research data. To maximise access to the study and minimise disruption to ongoing interventions, participants were able to complete the compassionate other chairwork exercise through their usual format of therapy engagement (face-to-face in person or face-to-face via video conferencing software). Six participants engaged in the exercise in person; two completed the exercise via video conferencing software.

Table 1 Participant Eligibility Criteria.

Inclusion Criteria	**Exclusion Criteria**
Adults (18 < years)	Not receiving CFT and the compassionate other chairwork intervention as part of standard treatment
Receiving CFT and the compassionate other intervention as part of routine treatment within a primary care IAPT service	Depression not part of presenting problem
Have a 'provisional' diagnosis of Major Depressive Disorder (MDD) at the commencement of therapy as indicated by a score of 10 or above on the Patient Health Questionnaire (PHQ-9) [42]. A score of 10 or above is used as a criterion for the provisional identification of MDD in IAPT services as standard practice [43]	
Sufficiently proficient in speaking and understanding English to partake in an interview	
Able to provide informed consent	

2.2 Intervention

Participants completed the compassionate other chairwork intervention with their usual therapist during a single therapy session within their course of treatment. All participants had undergone CFT psychoeducation and formulation prior to engaging in the exercise. The intervention followed the compassionate other chairwork protocol devised by Bell et al. [44] (see Table 2). The compassionate other chairwork session was audio recorded by the therapist on an encrypted, password protected audio recording device. The first author reviewed the audio recording to confirm that the delivery of the compassionate other chairwork intervention adhered to steps outlined in the protocol. Following the review, audio recordings were deleted immediately to protect participant anonymity. All sessions adhered to the protocol.

Table 2 The Compassionate Other chairwork protocol.

Compassionate Other Chairwork Protocol	
Step 1:	To identify a current problem and consider the type of person/being the client would want to support them with this problem. To clarify the compassionate attributes the compassionate other would have.
Step 2:	The therapist invites the individual to imagine their compassionate other in an additional empty chair.
Step 3:	The therapist invites the individual to change seats and embody the role of their compassionate other.
Step 4:	In the role of the compassionate other, the individual is prompted to focus on the original chair and imagine seeing a version of themselves experiencing difficulties.
Step 5:	In the role of the compassionate other, the individual is supported to generate compassion towards themselves in the empty chair.
Step 6:	The therapist then invites the individual to return to the original chair and experience the care of the compassionate other.
Step 7:	The therapist invites the individual to return to the compassionate other chair to embody the role and offer additional care. This might include working with any FBRs to compassion that might have manifested during step 6.
Step 8:	The therapist invites the individual to change seats and receive the care of the compassionate other. The exercise ends with a debrief and reflection on the individual's experience and learning.

2.3 Participant Characteristics

Eight participants were recruited from primary care IAPT services who met the eligibility criteria. No eligible participants were excluded from the study and the eight included were the first to respond. Participant demographics are summarised in Table 3.

Table 3 Participant characteristics.

Participant Pseudonym	Gender	Age	Ethnicity
Nina	Female	51	White and Asian
Eleanor	Female	34	White-British
Melissa	Female	30	White-British
Suzanne	Female	48	Spanish
Miranda	Female	60	White-British
Dulcie	Female	30	White-British
Chloe	Female	54	White-British
Margaret	Female	62	White-British

Outcome measures were administered at interview to describe the participant cohort on features of clinical relevance to the study. The PHQ-9 [43] was administered to gauge participants' level of depression at the time of interview. To measure aspects of external shame, the Other as Shamer Scale (OAS) [45] was administered. This scale explores expectations of others' judgements of the self. The Forms of Self-Criticising/Attacking and Self-Reassuring Scale (FSCRS) [46] was also used, to explore features of self-criticism and self-attacking which are associated with internal shame.

The overall cohort results on the PHQ-9 (mean = 11.12, SD = 6.52) signified 'moderate depression' [43]. The cohort scored higher on the OAS (mean = 41.75, SD = 19.22) than non-clinical average (mean 20.0, SD = 10.1; Goss et al., 1994). The FSCRS divides into three subscales: Inadequate Self subscale scores (mean = 25.5, SD = 8.48) were similar to clinical average (mean = 26.61, SD = 7.19); Hated Self scores (mean = 6.25, SD = 5.23) were below clinical but above non-clinical average and Reassured Self scores (mean = 14.25, SD = 7.2) were higher than clinical but lower than non-clinical average [47].

2.4 Data Collection

Data was collected via individual interviews with participants conducted by the first author. Five research interviews were carried out face-to-face in-person. The remaining three interviews were conducted face-to-face via video conferencing software. All interviews were conducted within 48-hours of participants completing the exercise to minimise memory decay. This follows previous studies exploring compassion-focused chairwork using an IPA methodology [34]. In accordance with Smith et al. [41], the interview had a semi-structured format which followed the topic guide detailed in Table 4. This offered the flexibility to include additional prompts to promote participant disclosure. Interviews were audio recorded, transcribed verbatim and anonymised by the first author.

Table 4 Research interview topic guide.

Interview Topic Guide with Sample Questions
Introductory questions: Can you tell me about your experience of the exercise?
Questions about giving and receiving compassion: What was it like to receive compassion from your compassionate other?

Questions about using chairs in the exercise: How did you experience moving between chairs to become your compassionate other?
Questions about challenges and benefits: Were there any parts of the exercise that were particularly difficult or challenging?
Questions about overall impression of the exercise: What is your overall impression of the exercise?

2.5 Data Analysis

Consistent with the idiographic spirit of the IPA method, transcripts were analysed on a case-by-case basis following the seven steps outlined in Smith et al. [41]. This involved the re-reading of transcripts for familiarisation. Transcripts were annotated with a view to exploring their content at descriptive, semantic, and conceptual levels of analysis. Informed by exploratory notation, experiential statements were constructed which aimed to capture salient features of each participants' experience. Experiential statements were combined to form personal experiential themes (PETs). Once these stages had been completed for all eight participants, transcripts were analysed more broadly in search of patterns across participant accounts. From this analysis, Group Experiential Themes were abstracted. The resultant findings were written up in narrative form along with illustrative excerpts from the original transcripts. In recognition of the 'double hermeneutic' involved in IPA [48], the first author maintained reflective notes throughout the analytic process. These notes were shared with the research team to monitor the influence of preconceptions upon interpretation. The sixth author also conducted independent analyses on three transcripts which were compared with the first author's analysis. Reflections on the differences and similarities of these analyses were integrated into the analysis and used to refine the ongoing analytic process.

The study was granted ethical approval by the NHS Health Research Authority and Care Research Wales (IRAS Number: 319723; REC Reference: 22/EE/0305) and the University of Manchester.

3. Results

The analysis generated three interrelated Group Experiential Themes: care that feels real, chairwork processes, and encountering challenges on the road to discovery. The themes, and their corresponding sub-themes, are presented in Table 5.

Table 5 Group experiential themes and corresponding sub-themes.

Theme (No. of participants included in the theme).	**Sub-themes**
Care that feels real (7/8)	- Caring for the self through another's eyes - Feeling the caring presence of another
Chairwork processes (7/8)	- Moving between mindsets - Separation and embodiment
Encountering challenges on the road to discovery (8/8)	- Blocks, barriers, and resistance - Drawing meaning from the experience

3.1 Theme 1: Care that Feels Real

3.1.1 Caring for the Self Through Another's Eyes

With one exception, all participants reported experiencing a sense of caring for themselves from another's perspective. After moving chairs, participants had a symbolic experience of "*leaving myself behind*" and "*stepping into the mind of that other person*" (Suzanne). The experience was characterised by the arising of care-based motives and feelings which were directed outwardly towards the original chair in a way that felt like an encounter with another person:

"I had to actually listen and think what I'm going to say to this other person." (Suzanne)

In describing herself as "*this other person*", to whom she is listening and considering how to respond, Suzanne illustrated a feeling of stepping outside a first-person perspective and inhabiting the role of the compassionate other. This allowed Suzanne to speak to herself, still in the original chair, as if in a genuine interpersonal encounter characterised by an external concentration of attention towards "*this other person*". Suzanne also noted experiencing a "*feeling of responsibility"* for the 'other' person, further highlighting the sense of caring for the self from another's perspective. Other participants also noted the significance of the feelings that arose while directing care towards themselves from the perspective of their compassionate other:

"I got a bit emotional at one point, which I felt a bit stupid for, because I'm not actually this person I've chosen… I think it felt a bit emotional, seeing myself through someone else's eyes, in a way, it's just quite sad." (Melissa)

For Melissa, there was something contradictory about the sadness that surfaced while observing herself from the compassionate other's viewpoint. Though aware that the exercise was hypothetical ("*I'm not actually this person I've chosen*"), this understanding seemed to be undermined by the authenticity of the arising emotion. In articulating this tension, Melissa highlighted the way in which the boundary between imagination and reality appeared to blur during the exercise. Miranda also alluded to the authenticity of the experience, which seemed to be driven by deeply held and "*genuinely*" felt emotion:

"*I genuinely did feel the feelings in the exercise. I just wanted to help this other person I was caring for, help them to not be so hard on themselves and to give themselves a future. To understand that it was totally understandable, how they're feeling, and it would be lovely to see them like, you know, happy in the future, and fulfilled and to not feel sad all the time*." *(Miranda)*

Miranda offered a vivid account of the care-giving experience. Her use of the first-person 'I' is suggestive of an authentic sense of immersion in the compassionate other role. The role seemed to be marked by a sincere desire to help "*this other person I was caring for*" and see them flourish, which is inspired by genuine feelings. These reflections depict an experience in which participants related to the self as if the self was 'other', in a care-giving encounter underpinned by genuinely held caring feelings.

3.1.2 Feeling the Caring Presence of Another

In contrast to the experience described above, participants also portrayed a sense of receiving care from their the compassionate other. This experience was not represented in metaphorical terms. Rather, the compassionate other was, according to participants, felt as substantially present in the encounter. For example, Melissa described perceiving a "*comforting presence"* while Margaret reflected "*It felt like someone else was caring for me*". This is striking when considering that the exercise is a one-person role-play. Dulcie elaborated upon the experience of another's presence:

> *"It was like a hug. Like a real person was there giving you that compassion and someone you can genuinely believe. It was almost like someone was holding you." (Dulcie)*

There is a physicality in Dulcie's reflections. She felt as if she was being hugged and held by "*a real person*". Such imagery amplifies the experience of another's presence. It also further illustrates the sense in which the boundary between imagination and reality dissolved during the exercise at an experiential level. By virtue of experiencing another as present, participants felt they could converse with their compassionate other in a social-relational fashion that mirrored real life social interactions:

> *"Receiving it felt very emotional. He was giving me advice, but it was actually me feeling it as he was telling me. When he said "I know you've suffered a lot", the pain was very gripping." (Suzanne)*

Suzanne spoke of "*receiving*" communication via dialogue which is perceived as having originated from an external source ("*he was giving me advice*", "*he said*", "*that person*"). Miranda similarly articulated a sense of being engaged in social dialogue with a substantive other:

> *"I didn't feel like I was being spoken down to or patronised. As I said earlier, I knew that that person who was talking to me, even though it was me as another person, that they cared about how I was feeling. So I was more open to the feedback." (Miranda)*

In concluding that the compassionate other "*cared*" about her feelings, Miranda intimated at having explored the mind and intentions of the compassionate other as one might do in a genuine interpersonal encounter. A similar process might be inferred from Dulcie's words, where she stated that her compassionate other is "*someone you can genuinely believe"*. This further demonstrates the relational nature of the care-receiving experience. Moreover, similarly to Miranda, most participants emphasised the importance of the 'feeling' conveyed via the compassionate other's words, as opposed to focusing exclusively on the semantic content. The perception of a caring non-verbal quality to the words enabled a heightened sense of receptivity ("*I was more open*"), which was emotionally resonant:

> *"Receiving the compassion from my compassionate other was so heart-warming. It made me want to cry." (Nina)*

The reception of care was a profoundly emotional experience for Nina. Care was received as if emanating from the outside and which touched deeply on the inside. Nina, along with several other participants, referred to the 'warmth' ("*heart-warming*") of the experience. Warmth has connotations of comfort and, in interpersonal contexts, tenderness. The culmination of the care-

receiving experience was an ultimate sense of having one's emotional needs met by the compassionate other:

> *"Cared for, calm, looked after, soothed…these are all synonyms aren't they. It was a bit of relief really, as well, I think. And it was just like you could relax and go *sigh*: that's what I needed." (Margaret)*

3.2 Theme 2: Chairwork Process

3.2.1 Moving Between Mindsets

For all participants but one, enacting the compassionate other imagery exercise through chairwork methods enriched the imaginal experience. Physical movement between chairs in particular was highlighted by participants as important, insofar as it facilitated psychological shifting between the self and the compassionate other:

> *"I think if you were sat in the same place it wouldn't have worked as well, for me. I think maybe it was also that the chair was in a different place, so you were looking in a different direction as well, which helps with shifting your mindset or making you feel different, because the things around you are different and you're looking in a different direction and facing a different way." (Melissa)*

Physical movement between chairs brought about a literal change in participants' visual perspective, which appeared to prompt internal shifts in emotion and mindset. Miranda also emphasised the importance of movement between chairs:

> *"Moving between chairs helps, because it helps you to see the difference between who you are and who you are talking to. It helps you to get into that mindset of thinking about what to do next: am I going to be me or [compassionate other]? And moving chairs helped with that shift." (Miranda)*

Miranda indicated that movement offered a means of differentiating between the two roles involved in the role-play. This seemed to allow distinctive mindsets to form, corresponding to the care-giving and care-receiving positions. Dulcie shared a similar view:

> *"When I had said something as the compassionate other, then I had the grounding of putting my hands on the chair and standing up and walking, gives you that ability to think 'I've done this now, now I need to listen to this and what I've said' and you can actually take it in." (Dulcie)*

By bringing attention to the body, physical movement "*grounded*" participants during role transitions. These quotes collectively suggest that movement between chairs came to represent an experiential bridge between the 'self' and the compassionate other, with physical movement corresponding to psychological movement. The process of moving between chairs therefore seemed to give structure and definition to the exercise by facilitating shifts in mindset while delineating the boundary between the care-giving and care-receiving roles.

3.2.2 Separation and Embodiment

The processes of separation and embodiment also enhanced the experience, according to participants. When reflecting on the process of separation, Suzanne said:

> *"Normally, when I am looking at what is there and I'm trying to make sense of what I think or the situation that is in my head, there is no separation. It's all going round like a washing machine, round and round and round, and I get lost in it. But the fact I had to separate myself from it and be someone else looking into it, I found it very useful." (Suzanne)*

When trying to analyse her internal experiences, Suzanne alluded to often finding herself caught in a frustratingly unresolving search for meaning ("*round and round and round*") which leaves her feeling adrift ("*I get lost in it*"). In contrast, through achieving a feeling of separation from her usual sense of self, Suzanne was able to look upon herself from a psychologically distanced, decentred perspective. From this vantage point, Suzanne could perceive more clearly, and thus better analyse, her internal experiences, which allowed her to reach a position of resolution and clarity: "*I went from being lost inside my head, to going there in the other chair and finding what's inside my head*" (Suzanne). Chloe also highlighted the importance of the process of separation. However, for Chloe, this recognition emerged from an inability to gain a separation from the self:

> *"I think maybe I felt too close to me and the sad thing I was dealing with." (Chloe)*

The proximity to the emotion left Chloe struggling amid her sadness and unable to attain a sense of clarity or closure over difficult internal experiences. For others, the feeling of separation represented a separation not from the self per se but from a dominant, and at times problematic, part of the self:

> *"The critic is in the driving seat a lot. It was nice to recognise that I can separate myself from it as well, because it's such an integral part of me that it can sometimes feel impossible." (Melissa)*

Here Melissa indicated that separation allowed her to distance from a part of the self ("*the critic*") that feels so dominating that it often feels "*impossible*" to break free from. Being able to separate from "*the critic*" was thus an empowering revelation for Melissa. It conferred a sense of psychological liberation which allowed her to look upon her problems anew and gain fresh insights regarding the needs underlying her emotional distress. Dulcie likewise benefited from gaining a sense of separation from a dominant part of the self. For Dulcie, separation from an "*overpowering*" self-part allowed a dialogic space to form between the "*anxious self*" and the compassionate other. Within this space, new perspectives and insights took shape.

Separation therefore allowed participants to gain a sense of distance from their usual sense of self and habitual patterns of thought and feeling. The process of embodiment, on the other hand, gave participants an opportunity to inhabit an alternative state of being. This experience was manifest in changes to both internal and external modes of experience:

> *"I didn't cross my legs when I was sat in that chair, but I did in this one. I was more tense when I was sat in my chair." (Melissa)*

> *"I had my compassionate other's way of thinking. It was still me there, but I had my compassionate other's nature, character." (Nina)*

Embodiment seemed to be a unified mind-body experience that produced an immersive sense of shifting character and becoming the 'other': "*I became my compassionate other*" (Nina). An effect of this process was that it seemed to grant participants access to novel patterns of thought. For example, when reflecting on the words she expressed while embodying her compassionate other, Dulcie said:

"*The things I said weren't something I would have thought to have said to myself." (Dulcie)*

The process of embodiment therefore seemed to give a spontaneity to the dialogue between the self and the compassionate other that allowed original ideas to materialise, and which enhanced the sense of being involved in a genuinely interpersonal encounter.

3.3 Theme 3: Encountering Challenges on the Road to Discovery

3.3.1 Blocks, Barriers, and Resistance

While all participants drew some form of value from the experience, the exercise was unanimously experienced as deeply challenging. Obstacles and inner conflict manifested in a range of forms and at various junctures throughout the experience. To begin with, the general concept of the exercise perturbed participants; it appeared "*strange, alien, weird*" (Margaret). This seemed to activate an uncomfortable self-consciousness, with participants feeling "*awkward*", "*silly*" (Chloe), "*daft*" (Nina) and "*stupid*" (Eleanor and Margaret) to begin with. Reflecting on her first impressions of the exercise, Eleanor said:

"Talking to the chair. I mean, I can talk to a wall at home." (Eleanor)

There is a hint of derision in the tone of this statement. It is as though Eleanor felt at first that the exercise was a dubious obstruction to actual therapy. Clients also reported experiencing an initial aversion towards letting go of self-criticism. For some, this aversion arose from a sense of identification with self-criticism, which made it feel innate and inevitable: "*we're mentally wired to self-criticise, aren't we*" (Miranda). For others, while not necessarily innate, the "*critical brain*" nonetheless seemed intent on hijacking the experience:

"Just thinking of the right person was hard. But getting some examples from [therapist] helped with that, because part of my critical brain wanted someone who was a bit more critical and harsher. So it was having to recognise that that's not what I really want." (Melissa)

Melissa noticed an urge to choose "*someone a bit harsher*" as her compassionate other; to do otherwise might have been "*pathetic".* That Melissa feared that being less self-critical might be "*pathetic*" indicates that Melissa perhaps had fears about letting go of self-criticism that were activated during the exercise. Even once participants had established a genuinely compassionate image, the giving and receiving of compassion was for some deeply challenging. While reflecting on giving compassion to her 'self' as the compassionate other, Eleanor said:

"It was like a mental block. I don't know. Because I, when I started talking back to myself, but, I don't know. The things I feel about myself, I couldn't say those things to myself." (Eleanor)

While Margaret stated:

"There was no intonation in my voice. I was just saying: right, this is what you need to hear blah blah blah." (Margaret)

Such reflections suggest that participants struggled to direct compassion towards themselves for a variety of reasons. For some, negative emotion within the self-to-self relationship undermined efforts to generate compassion towards the self. For others, a general lack of familiarity with self-compassion made the caring words feel contrived and hollow. In addition to difficulties in giving care, participants noted an aversion towards receiving care from their compassionate other:

"I don't trust people either. So it's even hard to trust a fake person I've made up in my head." (Chloe)

Chloe also reflected that she had learned to feel most safe when dealing with "*everything on my own*", which caused a disinclination towards accepting the "*whimsical*" and "*sugar coating*" words of the compassionate other. This perhaps suggests that the interpersonal nature of the exercise activated interpersonal fears and associated coping strategies that operate more broadly in participants' lives. Finally, while participants found the emotionally evocative nature of the experience useful in bringing emotion to the surface for conscious processing, some found the emotion overwhelming. This left some participants feeling "*drained*" and "*tired*" (Eleanor) and unable to focus upon the exercise:

"*I just got really emotional, more emotional than I've been in a long time. I just sat in that, so that sort of overshadowed most of it*." (Chloe)

Blocks, barriers, and resistances were therefore a common motif, with procedural, psychological, relational, and emotional obstacles manifesting at various points during the exercise.

3.3.2 Drawing Meaning from the Experience

Despite the challenges outlined above, all participants were able to draw some form of positive meaning from the exercise. In fact, for many, learning and insight came about because, rather than in spite, of blocks, barriers, and resistances:

"It's one thing having it in your head. But to actually say it or try to support yourself or give yourself advice was the hard part." (Miranda)

"I learned that even though I know it in theory, I don't know it in practice. And that's the bit I need to practice." (Melissa)

For Melissa and Miranda, the difficulty they initially experienced when attempting to direct compassion towards themselves drew out a distinction between knowing in "*theory*" that one ought to be self-compassionate and doing this in practice. Chloe likewise found value in encountering difficulty:

"The most impactful part for me was when the resistance came up. When that block came up, rather than the compassion… It's nice to have a refinement of crap, that you need to work on, I guess. As difficult as it was, it's made it more clear that there is something I need to work on: the block that came up." (Chloe)

The activation of blocks illuminated difficulties that participants seemed to intuitively recognise as factors which might thwart therapeutic efforts. Blocks thus appeared to cast a light upon new

therapeutic avenues of which participants were previously unaware. Moreover, bringing blocks to the surface allowed participants to better understand their difficulties with generating self-compassion. As a result, participants were able to relate to themselves with enhanced levels of compassion: "*it made me more aware that it wasn't my fault I find it so difficult*" (Melissa).

For others, a new understanding about the importance of compassion emerged through feeling the benefits of compassion at an experiential level:

> *"It's highlighted to me that I need to do more of it. And that I can do it to myself, and that it does have a powerful impact, because I felt it." (Margaret)*

The experience allowed Margret to feel first-hand the positive "*powerful impact*" of compassion. As a result of the soothing feelings that the exercise elicited, Margaret came to recognise the advantages of approaching herself with kindness, rather than criticism, during moments of difficulty, and resolved to use this learning in the future. By embodying the compassionate other and directing compassion towards the self, Margaret was also able to challenge preconceptions that she was incapable of self-compassion ("*I can do it to myself*").

Finally, participants found transformational value in exploring personal conflicts in the dialogic space between the compassionate other and the self. For Dulcie, by separating and allowing dialogue to flow between the two roles, she experienced an enhanced sense of personal integration: "*as I moved between the two repeatedly, they almost blended together*". Melissa similarly gained a sense of internal integration through the exercise, moving from a position of conceptualising self-criticism and compassion as opponents in conflict ("*you have the critical side and compassion is the opponent*") to an understanding that these experiences are all valid and rooted within a shared history: "*It feels like it can just all be there*" (Melissa).

The exercise was therefore a significant and enlightening experience for participants. It highlighted the importance of compassion, while bringing into consciousness difficulties that had hitherto operated beyond conscious awareness. It also offered an avenue for personal transformation, in prompting the integration of previously fragmented and conflicting elements of internal experience.

4. Discussion

This project is one of a small number of extant studies to investigate the compassionate other imagery exercise. It is also the first to explore the exercise enacted via chairwork methods. An interpretive-phenomenological analysis generated three interrelated group experiential themes: care that feels real, chairwork processes, and encountering challenges on the road to discovery. The results suggest that the exercise offers a range of potential benefits, such as eliciting FBRs and facilitating self-discovery. Findings also highlight the potential value of enacting the exercise via chairwork methods.

The structure of the exercise appeared to allow participants to access, experience and benefit from different care-based social mentalities. For example, through separating from the self and embodying their compassionate other, participants were able to cultivate a sense of caring for themselves as if from another's perspective. This was marked by the presence of care-based motives and feelings which were directed externally in a manner that is characteristic of a care-giving social mentality [49]. Conversely, when in a first-person position, participants felt as though they were receiving care from and being emotionally soothed by 'another'. This description indicates that

participants accessed a care-receiving mentality [50]. Consistent with SMT, this suggests that different social mentalities are associated with unique experiential profiles and can be elicited by self-generated signals of care [9]. The compassionate other chairwork exercise therefore appears to have the potential to facilitate access to care-based mentalities, which is a core aim of CFT [50].

Furthermore, by providing a stage for these different mentalities to play out, the exercise allowed participants to access and experience multiple flows of compassion: self-to-other (care-giving) and other-to-self (care-receiving), while ultimately the client is delivering self-to-self compassion by enacting both care-giving and care-receiving roles. This is significant because evidence suggests that different flows of compassion are differentially related to wellbeing, with fears of compassion for oneself and from others being most significantly associated with poorer mental health [5, 16]. By stimulating multiple flows of compassion, the exercise might be utilised to explore how clients experience each flow (for example, by reflecting with clients on the experience of giving compared to receiving compassion). This might yield clinically pertinent information such as beliefs about and difficulty with giving and/or receiving compassion that can inform formulation and intervention.

Chairwork processes were integral to the experience. As found in previous studies [34], movement between chairs functioned as a means of separating, concretising, and facilitating psychological shifting between roles (and therefore social mentalities). Movement was also pivotal in inducing a sense of separation from a usual first-person perspective. The process of separation is related to the concept of psychological distancing [34]. The literature on psychological distancing broadly suggests that shifting from a psychologically self-immersed (first-person) to self-distanced (observer) perspective can promote adaptive self-reflection and emotion regulation when analysing negative autobiographical experiences [51-53]. The present findings corroborate these assertions, discovering that participants who gained a sense of separation from self were able to scrutinise internal experiences from a self-distanced perspective (‘from the outside’) and draw meaning from these reflections. The contrary was true for participants unable to gain a sense of separation from self. This is significant as reflecting from a self-distanced, compared to a self-immersed, perspective is also associated with improved heart rate variability, which is a physiological marker of psychological health and mind-body connection [54, 55]. Movement was the mechanism by which separation, and thus self-distancing, was achieved. When delivering the intervention, clinicians might therefore ensure the spatial relations between chairs support the process of separation. As separation was seen as fundamental to the experience, clinicians might also simply enquire whether clients have been able to achieve a sense of separation from self and encourage further movement between chairs if not.

The process of separation also allowed participants to dis-identify from dominant aspects of the self. This finding aligns with theories of self-multiplicity which assert that certain self-parts can come to dominate internal organisation [56]. In social mentality theory, this might be formulated as an encapsulation in one specific mentality [50]. By embodying the compassionate other, participants were able to elaborate and occupy an alternative representation of ‘self’ that reconfigured intrapersonal power dynamics, reorganised internal experience and offered a broader repertoire of inner role-formation. This highlights the potential therapeutic value of practices, such as the compassionate other exercise, which explicitly seek to build positive representations of self which might rival more entrenched and readily triggered negative self-representations [19, 57]. It remains unclear, however, whether the benefits of building and embodying a compassionate other endure over time. Future research might explore this by including follow up checkpoints in the design of

the study to ascertain whether the compassionate other representation is internalised and retrieved in challenging moments after completing the exercise.

Much of the transformative impact of the exercise was ascribed by participants to the enactive processes of movement and embodiment. That the body can influence emotion and thinking has been demonstrated in the literature on embodied cognition [58, 59]. The current findings bolster this view, emphasising the possible value in utilising the body to generate novel patterns of thought and feeling. Moreover, two participants (Suzanne and Dulcie) noted that the enactive nature of the practice made the imagery exercise more accessible compared to historic experiences with imagery practices conducted in a traditional one-chair, stationary format. This is pertinent because findings suggest that clients might have trouble in generating a mental image to support the compassionate other exercise and can become self-critical as a consequence [22]. The present results suggest that, through utilising the body, chairwork methods might offer an alternative means of enacting the exercise for those who struggle to engage with purely imaginal forms of intervention.

While participants found the exercise beneficial, they also acknowledged that efforts to engage with the exercise were met with numerous obstacles. As found in previous studies, participants were initially apprehensive about engaging with what they perceived to be an unusual therapeutic task [60]. Clinicians delivering the intervention might therefore anticipate and normalise initial fears while gently encouraging perseverance with the exercise. Furthermore, possibly because of the enactive and interpersonal nature of the exercise, a host of FBRs were brought to the surface during the practice. The identification of and working with FBRs is recognised as a key therapeutic task in CFT [4]. Indeed, although challenging, participants found that becoming aware of FBRs was informative and constructive. It offered insight into personal difficulties and fresh avenues for further therapeutic work. Given that the exercise seemed to so effectively illuminate FBRs, clinicians might view the practice as both an intervention, aimed at cultivating compassion, and as an assessment tool, to identify FBRs for subsequent intervention. Other compassion-focused chairwork studies have drawn a similar conclusion [34].

Overall participants reported gaining benefit and insight from the experience. One interesting discovery was that the exercise revealed to participants a distinction between different levels of 'knowing' regarding the way they relate to themselves. Participants realised that they know 'in theory' that they ought to be self-compassionate but rarely do this in practice. The notion of different layers of knowledge is explored in multi-level theories of cognition. Such theories suggest that information is processed at two levels. The propositional level corresponds to an intellectual knowing, or 'knowing with one's head'. Implicational knowledge corresponds to a more holistic and 'feeling' knowledge, or a 'knowing with one's heart' [61]. Bernard and Teasdale [61] assert that for lasting therapeutic change to occur implicational knowledge systems need to be activated and modified. The exercise, possible because of its multisensory nature [62], seems to have facilitated access to implicational knowledge structures. This might make this exercise particularly useful for clients experiencing the well-known rational-emotive dissociation phenomenon [63]. Future studies might investigate this hypothesis.

In conclusion, this study reports on a compassionate other imagery exercise enacted via chairwork methods. The results highlight the potential value of utilising the technique. Its enactive and embodied nature allowed clients to cultivate compassion in an experiential way that seemed to tap into implicational knowledge structures. It also illuminated a host of FBRs, making these available for intervention. However, the study did not empirically monitor the impact of the exercise

upon symptom presentation. It also did not evaluate the effect of the exercise over an extended period. Future studies might include clinical outcome measures and extend the study over a longer period to ascertain whether the exercise contributes to symptom reduction and if therapeutic gains are sustained over time. Furthermore, the present study exclusively recruited female participants and explored the compassionate other chairwork exercise with clients receiving treatment for depression. As such, it remains unclear how this exercise might be experienced by alternative populations. Future studies might explore how alternative client groups experience this exercise to get a better understanding of its broader clinical application.

Acknowledgments

The authors would like to reiterate our thanks to the participants in the study.

Author Contributions

Dr Bell and Mr Hackley led on initiating the project. Preliminary project plans were reviewed by Professor Brown. Miss Dixon, Mrs Royale and Mr Moss recruited participants, delivered the compassionate other chairwork intervention and audio recorded the sessions. Mr Hackley wrote the initial manuscript, with regular contributions from Dr Bell (primary research supervisor). Professor Brown (secondary research supervisor) proofread and approved the final manuscript. All authors approved the final manuscript.

Funding

The research project was completed as part of Mr Hackley's participation in the University of Manchester's Doctorate in Clinical Psychology (DClinPsy) programme. No other funding was provided.

Competing Interests

The authors have declared that no competing interests exist.

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