Processing emotions in emotion-focused therapy.

Exploring the impact of the two-chair dialogue intervention.

Jan Reidar Stiegler

Thesis for the Degree of Philosophiae Doctor (PhD)
University of Bergen, Norway
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Scientific environment

This dissertation is the result of a collaboration between Institutt for Psykologisk rådgivning AS, the Department of Clinical Psychology, University of Bergen, and Arbeids- og velferdsetaten.

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Summary

An increasing range of approaches to psychotherapy emphasize the importance of unprocessed emotions in explaining the root of psychological problems. These approaches suggest different interventions intended to enhance emotional processing. One such intervention, derived from Emotion-focused Therapy (EFT), is referred to as a two-chair dialogue. This intervention aims to enhance the emotional processing of individuals with regard to destructive self-criticism. More specifically, the intervention is expected to effect the arousal of emotions and help clients attend to and appraise their emotional experiences. The purpose of this dissertation is to investigate and explore the impact of the two-chair dialogue intervention.

Twenty-four clients presenting with destructive self-criticism were recruited from a Norwegian public mental health program, meant for people who are on sick leave due to depression and anxiety, which is the most common mental health difficulties. In this study a multiple baseline design was used. Each client was assigned to a baseline phase comprising either 5, 7, or 9 sessions. For the baseline phase, the therapists were asked to focus on the relationship aspect of EFT, that is, they were required to empathically attune to the clients' emotional experience, provide validation and reassurance for the clients' emotional experience, while complying with the basic Rogerian conditions of empathy, genuineness, and unconditional positive regard. In the second phase, we added a two-chair dialogue intervention for five consecutive sessions.

This dissertation comprises three papers. For paper 1, all clients' sessions were recorded on video and analyzed with the Client Emotional Arousal Scale III and Experiencing Scale. Subsequently, it was investigated whether the phase which included the two-chair dialogue intervention was associated with a higher level of emotional processing in comparison to the baseline phase. Results suggest that the phase containing the two-chair dialogue intervention is associated with significantly more high-arousal episodes than the baseline phase. Experiencing increases

throughout the entire treatment, but not significantly more in the phase including the two-chair dialogue, suggesting that both phases are associated with enhanced emotional processing.

In paper 2, we investigated whether the phase which included the two-chair dialogue intervention was marked by a significantly greater decrease in symptoms compared to the baseline phase. Here, results suggest that adding the two-chair dialogue intervention is associated with a more substantial decrease in depression- and anxiety-related symptoms, in comparison to the baseline phase. A closer analysis of the symptoms of depression indicates that the majority of reduction effected in depressive symptoms is related to the somatic-affective and not the cognitive components of depression. Destructive self-criticism exhibited reduction throughout the treatment. However, this was not significant greater for the phase which included the two-chair dialogue intervention.

In paper 3, the qualitative enquiries indicated three main themes. The first theme, termed as *Talking to a chair: An obstacle to overcome*, refers to the clients' experiences with regard to the intervention as awkward and sometimes difficult to engage in. The second theme, *Heavy, intense, horrendous, and nice* captures the experiences of the intervention as being emotionally intense, physically and mentally draining, painful, but at the same time helpful. The third theme, titled as *Realization: What am I doing to myself?* captures the clients' reports pertaining to the attainment of a better understanding of the way in which they treat themselves. Further, it records the way in which the intervention enhanced their sense of agency.

All of the findings combined suggest that the addition of the two-chair dialogue intervention to the basic Rogerian conditions and empathic attunement to affect, contributes to certain aspects of emotional processing (emotional arousal), and supplements the alleviation of symptoms of anxiety and depression. In addition, the results indicate that productive emotional processing is also facilitated by empathically attuning to the clients' emotional experience, while complying with the

basic Rogerian conditions. Results further indicates that the two-chair dialogue intervention was experienced as being intense, helpful, and difficult to engage in.

List of publications

Paper 1: Stiegler, J. R., Molde, H., & Schanche, E. (Submitted). *Does the two-chair dialogue intervention facilitate processing of emotions more efficiently than basic Rogerian conditions?*

Paper 2: Stiegler, J. R., Molde, H., & Schanche, E. (2017). Does an emotion-focused two-chair dialogue add to the therapeutic effect of the empathic attunement to affect? *Clinical Psychology & Psychotherapy*, 1–10. https://doi.org/10.1002/cpp.2144

Paper 3: Stiegler, J. R., Binder, P. E., Hjeltnes, A., Stige, S. H., & Schanche, E. (in press). "It's heavy, intense, horrendous and nice": Clients' experiences in two-chair dialogues. *Person-centered & Experiential Psychotherapies.*

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Contents

1. Introduction

1.1 Purpose and scope of this dissertation

The purpose of this dissertation is to investigate and explore the impact of a psychotherapeutic intervention designed to facilitate the processing of problematic emotions related to destructive self-criticism of clients with common mental health problems, such as anxiety and depression. The target intervention of this study is termed as the two-chair dialogue and is drawn from Emotion-Focused Therapy (EFT). This is an intervention that aims to structure, clarify, and deal with emotional processes through imaginative and emotionally evocative dialogues between different parts of the self. The objective is to assist the client to clarify and alter the way in which the self-critical part treats the part of the self that undergoes experiencing.

The research project was conducted in the setting of a governmental psychological treatment program (Raskere tilbake). This program aims to prevent the necessity of a long-term sick leave for people on short-term sick leave due to common mental health difficulties. Common mental health problems (anxiety and depression) appear to be a central cause behind work absence (Cornelius, Van der Klink, Groothoff, & Brouwer, 2011; Nieuwenhuijsen, Verbeek, de Boer, Blonk, & van Dijk, 2006; Noordik, Nieuwenhuijsen, Varekamp, van der Klink, & van Dijk, 2011; Nystuen, Hagen, & Herrin, 2001). Therefore, by providing treatment for these common mental health problems, the program aims to strengthen participants' capacity to return to work and reduce the risk of further work absence.

The last three decades have provided us a deeper understanding of our emotional system (Dalgleish, 2004; Damasio, 1998; Ekman & Davidson, 1994; Kagan, 2007; LeDoux, 1996; Panksepp, 2004; Porges, 2011). Due to this development, emotions have attained a more prominent role in psychotherapy-related theory and research. For instance, there is a growing consensus on the fact that excessive negligence or avoidance towards ones' emotions is associated with mental health difficulties

(Barlow, Allen, & Choate, 2004; Castonguay & Hill, 2012; Hayes, Wilson, Gifford, Follette, & Strosahl, 1996). Several approaches to psychotherapy apply interventions that aim to directly enhance clients' ability to get in touch with their emotions and utilize their inherent information (emotional processing). Some of these approaches are Emotion-Focused Therapy (EFT; Greenberg, 2002), Intensive Short-Term Dynamic Psychotherapy (ISTDP; Abbass & Town, 2013), accelerated experiential dynamic psychotherapy (AEDP; Fosha, 2001), affect phobia therapy (APT; Vaillant, 1997) Affect consciousness therapy (Monsen & Monsen, 1999), and memory reconsolidation (Ecker et al., 2012). Further, while in Cognitive Behavioral Therapy (CBT), emotions were originally perceived as being secondary to cognition, they are now being increasingly recognized as key elements in psychotherapeutic change processes (Barlow, Allen, & Choate, 2004; Beck, 1996; Thoma & McKay, 2015). These different approaches appear to reach a converging understanding with regard to emotions as healthy and adaptive processes that facilitate individuals' survival and success in their respective environments. All these approaches suggest that being receptive to one's emotional state allows individuals to better process and get past difficult events in their life. As it has been pointed out by several authors, processing of difficult emotions seem to be a key component of psychotherapeutic change across approaches (Barlow, Allen, & Choate, 2004; Castonguay & Hill, 2012; Elliott, Greenberg, Watson, Timulak, & Freire, 2013; Wampold & Imel, 2015). In each of the above mentioned emotion focused approaches, specific interventions have been developed in order to help clients' process their emotions, thereby regaining the adaptive functions of their emotions. This in turn, is assumed to reduce symptoms of psychological illness. A closer investigation of whether the prescribed interventions in fact do impact clients' therapeutic processes as expected, is called for and will be the main focus of this thesis.

EFT (Greenberg, 2002) constitutes an approach that prescribes interventions explicitly intended to aid clients to handle their unprocessed emotions. A specific intervention developed to enhance emotional processing in EFT is the two-chair dialogue intervention, designed to help clients process difficult emotions related to

destructive self-criticism. Self-criticism can be understood as a negative evaluation of oneself that increases the vulnerability and effect of depression and anxiety (Gilbert & Procter, 2006). In EFT, there is a long-standing research tradition that lays emphasis on the investigation and identification of processes that effect psychotherapeutic change (Elliott, 2010; Watson & McMullen, 2016). In accordance with this tradition, this study will investigate the impact of the two-chair dialogue intervention on emotional processing, symptom reduction, and *how* the interventions' impact the clients' experiences.

1.2 Emotional processing in psychotherapy

Emotion focused psychotherapeutic approaches postulate that being in touch with emotional activation, and being informed by the signals inherent in emotional activation, plays a pivotal part in mental health (Abbass, Town, & Driessen, 2013; Ecker et al., 2012; Fosha, Siegel, & Solomon, 2009; Greenberg, 2002; Monsen & Monsen, 1999; Vaillant, 1997). These approaches understand psychopathology as elicited and maintained by difficulties with experiencing and being informed by ones emotions, often stemming from negative learning experiences with important others. For instance, if a mother is physically abusive to a child, it might make it difficult for the child to deal with the painful emotions related to such an experience. If this painful experience is not somehow dealt with, the difficulties might last into this child's adult life. Emotion focused therapeutic approaches hold childhood as a particularly important and sensitive period for developing healthy or unhealthy relationship to one's own emotions, and therapy is seen as a possibility to process, deal with or change difficult emotional learning experiences from the past (Abbass et al., 2013; Ecker et al., 2012; Fosha et al., 2009; Greenberg, 2002; Monsen & Monsen, 1999; Vaillant, 1997). The assumption that overwhelming and difficult life events during childhood have the potential to hinder healthy adult functioning, has robust support (Anda et al., 2007; Anda et al., 2004; Edwards, Holden, Anda, & Felitti, 2003). A theoretical notion that is similar across emotion focused psychotherapy approaches, is that difficult life events that are not dealt with, can result in

problematic emotional states, or unprocessed emotions. Thus, the notion of emotional processing is important in emotion focused approaches. Emotional processing can be defined as a process whereby abruptions in adaptive functioning of the emotional system is restored after overwhelming events (Foa & Kozak, 1986; Rachman, 2001). Adaptive emotional functioning refers to the ability to allow one's emotions (i.e. to be sufficiently informed and affected) to deal with the situation that elicited the emotion (Greenberg, 1996).

The definition of emotional processing in various emotion focused approaches to psychotherapy appear to contain some similar constituents (Abbass, Town, & Driessen, 2013; Ecker et al., 2012; Fosha, 2001; Greenberg, 2002; Monsen & Monsen, 1999; Vaillant, 1997). For instance, all these approaches invariably involve the activation of emotions during psychotherapy sessions. However, none of the approaches proposes that activation of emotions is sufficient. They all suggest that attention towards one's emotional activation is a vital aspect of emotional processing. Post the state of awareness, various theories diverge in terms of their perception of the way in which emotions effect psychological change. However, they all suggest that the therapist needs to help the client allow rather than reject or ignore the visceral information inherent in the emotional activation. Furthermore, changing how one relates to ones emotions is suggested to have the potential to correct previous negative learning experiences. Pascual-Leone (1991) suggests that relating to ones' emotional experience can lead to an *affective dynamic synthesis*, a process where novel experience changes the person's experience of him- or herself in the world. The adaptive communicative functions of emotions constitute an additional commonality across the various approaches. It refers to the notion of symbolizing and expressing emotions that are part of an individual's awareness.

This thesis investigates two central aspects of emotional processing, both the arousal of emotion, and how the clients attend to and appraise their emotional arousal. The association between the above mentioned assumption that various elements of emotional processing are beneficial for emotional well-being has gained some

empirical support. First, the arousal or activation of emotions has been demonstrated to be associated with a corresponding reduction in symptoms of depression, anxiety, and trauma (Diener & Hilsenroth, 2009; McLean, Asnaani, & Foa, 2015; Missirlian, Toukmanian, Warwar, & Greenberg, 2005; Pos, Paolone, Smith, & Warwar, 2017; Whelton, 2004). This suggests that the activation of emotions can facilitate therapeutic change. Second, there is evidence that the human mind understands emotions through bodily signals that individuals subsequently interpret and symbolize (Craig, 2010). The ability to be aware of emotional signals residing in the body has been demonstrated as necessary in order to experience ones' own emotions (Pollatos, Gramann, & Schandry, 2007; Duschek, Werner, Reyes del Paso, & Schandry, 2015). Not being aware of emotional signals have been negatively linked to symptom severity in fibromyalgia (Duschek, Montoro, & Reyes del Paso, 2017), and positively linked to the ability to read other peoples' emotions (Terasawa, Moriguchi, Tochizawa, & Umeda, 2014). Third, another line of research has demonstrated the importance of accepting and allowing emotions and their accompanying thoughts. For instance, Ford, Lam, John, and Mauss (2017) demonstrated that the acceptance of negative emotions was related to psychological health benefits such as well-being, life satisfaction, and fewer symptoms of anxiety and depression. Further, Campbell-Sills, Barlow, Brown, and Hofmann (2006) demonstrated a relationship between the ability to allow emotions and the degree and length of negative emotional reactions to emotionally aversive material. On the contrary, the degree of experiential avoidance has been linked to the severity of anxiety-related symptoms and physical complaints (Berghoff, Tull, DiLillo, Messman-Moore, & Gratz, 2017). Fourth, the expression of emotions has been exhibited to predict the outcome of psychotherapy (Kramer, Pascual-Leone, Despland, & de Roten, 2015; Whelton, 2004) and promote interpersonal relationships (Graham, Huang, Clark, & Helgeson, 2008; King, 1993). Even the expression of emotions in writing has been depicted to induce certain health benefits (Niles, Haltom, Mulvenna, Lieberman, & Stanton, 2014; Pascual-Leone, Yeryomenko, Morrison, Arnold, & Kramer, 2016; Pennebaker, 1995). However, the expression of emotion in itself might not be sufficient. Research also emphasizes the fact that the

specific ways in which patients attend and symbolize emotional activation is related to the therapeutic outcome of treatment (Auszra, Greenberg, & Herrmann, 2013; Pascual-Leone & Yeryomenko, 2016; Pos, Greenberg, & Warwar, 2009), suggesting that *the way in which* one comprehends and expresses emotions is also important. Conversely, the inability to process emotions is associated, for instance, with increased youth aggression (Roberton, Daffern, & Bucks, 2015), lower marital satisfaction (Lavalekar, Kulkarni, & Jagtap, 2010), and eating disorders (Bydlowski et al., 2005). This increased understanding of the importance of emotional processing has inspired development of interventions that enhance emotional arousal and aids clients' to attend to and appraise their emotional experience in helpful ways.

1.3 Emotion-Focused Therapy

1.3.1 Overview and core concepts

EFT is an evidence based treatment for depression and anxiety (Elliott, Greenberg, Watson, Timulak, & Freire, 2013; Greenberg & Pascual-Leone, 2006). It is grounded in the humanistic tradition of client-centered psychotherapy (Rogers, 1959; Rogers, 1961), Gestalt therapy (Perls, 1969), and focusing psychotherapy (Gendlin, 1962). In EFT, emotions are perceived as core processes in human functioning that are assumed to comprise innate survival functions that aid people in their lives (Greenberg, 2012). Through the automatic appraisal of the internal and external environment, emotions inform the organism via visceral signals about where it stands in relation to its physiological and psychological needs. For instance, if a person is walking on a hiking trail and all of a sudden sees a snake, this person's emotional system rapidly informs them about danger. At the same time, emotions organize and prepare the organism to respond to the situation that elicited the emotional activation (Greenberg & Pascual-Leone, 2001). This means that when the person sees the snake on the trail, their emotional system simultaneously prepares them to stop or jump to the side. Furthermore, it is assumed that sustained emotional suffering and psychopathology develop when emotions are no longer allowed to serve their functions in accordance to their adaptive nature. Using the example with the snake, if

a person is hypervigilant to snakes in surroundings where snakes are rarely found, this might constitute anxiety in a pathological sense. Emotions are assumed to lose their innate adaptive functions when people are emotionally overwhelmed without the necessary support required to deal with a situation. It is assumed that overwhelming experiences are stored in affective-cognitive structures, termed as *emotion schemes* (Greenberg & Paivio, 1997). These schemes can be either adaptive or maladaptive. For instance, if a child experiences abuse, it is likely that this overwhelming childhood experience would develop into a *maladaptive emotion scheme.* This scheme can continue to impact the individual later in life, for instance as hypervigilance to danger or intense anxiety. It is assumed that when a person experiences recurring painful emotions, such as intense fear, they will also develop automatic strategies to avoid these painful emotions. For instance, if a client is in a state of fear, he or she might react to this fear with a protective anger. Such automatic strategies are usually understood as *secondary emotions*. Secondary emotions thus constitute reactions to *primary emotions*. While primary emotions form the persons' immediate reaction to a situation, secondary emotions involve reactions to primary emotions that may be difficult to experience (Greenberg & Paivio, 1997).

EFT further postulates that maladaptive emotion schemes underlie a range of different psychological symptoms, thus suggesting a trans-diagnostic view on psychological difficulties (Elliot et al., 2004). For instance, depression and anxiety is considered to stem from a number of different emotional processing difficulties, such as maladaptive shame, fear or sadness. Further, one kind of maladaptive emotion, for instance maladaptive shame, could result in a number of different symptoms that might constitute different diagnosis (Greenberg, 2002; Greenberg & Pascual-Leone, 2006; Pascual-Leone & Greenberg, 2007). For the study in the present thesis, participants were recruited on the basis of common mental health difficulties, either depression and anxiety. There is research to support that EFT constitutes an effective treatment for both depression (Ellison, Greenberg, Goldman, & Angus, 2009; Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998) and anxiety (Elliott, 2013; Shahar, Bar-Kalifa, & Alon, 2017). When clients present symptoms of

either depression or anxiety, the EFT-therapist typically suggests interventions that are meant to deal with the unprocessed emotions that underlie the client's symptoms of depression or anxiety.

1.3.2 Emotional processing in EFT

Two general principles of emotion processing are postulated in EFT-theory; emotional arousal and experiencing. First, emotions are required to be aroused to a certain level in order to be processed. The notion that EFT increases emotional arousal throughout therapy has empirical support (Pos et al., 2017). It also seems that this increase in arousal is related to better outcome (Missirlian et al., 2005; Pos et al., 2017). Furthermore, it seems that too high or too low levels of arousal are less productive with regard to treatment outcome (Carryer & Greenberg, 2010); further, it seems that emotional arousal is more productive under a good working alliance (Iwakabe et al., 2000; Pos et al., 2003; Pos et al., 2009).

Second, the aroused emotion requires to be attended to and appraised, i.e. experiencing. A number of studies support the notion that experiencing as a processing quality is important. For instance, the manner in which the client experiences emotions appears to mediate the effect of emotional arousal (Auszra et al., 2013; Greenberg, Auszra, & Herrmann, 2007; Pos et al., 2017). Further, Pascual-Leone and Greenberg (2007) demonstrated that good outcomes in EFT were characterized by a shift from a high arousal state and low level of experiencing to lower arousal with higher experiencing. A study by Pos et al. (2003) suggests that EFT is effective in increasing experiencing. Further, experiencing seems to increase during the course of EFT-treatment (Goldman, Greenberg, & Pos, 2005; Pos et al., 2009; Watson & Bedard, 2006; Watson & Greenberg, 1996). A number of studies also suggest that increasing the capacity to experience emotions in a conscious manner is related to good outcomes, both in EFT (Elliott, Greenberg, & Lietaer, 2004; Goldman et al., 2005; Pascual-Leone & Yeryomenko, 2016; Pos et al., 2003; Pos et al., 2009), and in other approaches (Castonguay, Goldfried, Wiser, Raue, &

Hayes, 1996; Pascual-Leone & Yeryomenko, 2016; Silberschatz, Fretter, & Curtis, 1986). It thus seems that EFT is effective in increasing both arousal and experiencing. However, it is less clear whether the specific interventions designed to evoke and process emotions actually accounts for the increase in emotional arousal and experiencing. It is the specific impact of one such intervention that is under scrutiny in this thesis.

In EFT, it is not the arousal and appraisal of any kind og emotions that is assumed to be effective. Psychological symptoms of distress are apprehended as secondary emotional reactions to underlying maladaptive emotion schemes (Greenberg, 2002). Change in EFT is assumed to take place by first shifting from secondary emotions to primary maladaptive emotions (Pascual-Leone &Greenberg, 2002), for instance from secondary anxiety to primary sadness. Then, when the maladaptive scheme is activated and appraised, the emotion scheme is considered to be susceptible to influence and change (Pascual-Leone & Greenberg, 2007). It is also assumed that emotion schemes are most easily transformed or changed by adaptive emotions (Greenberg, 2002). Research supports the notion that moving from secondary emotions to primary emotions is of importance (Herrmann, Greenberg, & Auszra, 2016; Pascual-Leone & Greenberg, 2007), and that adaptive emotions can change maladaptive emotions (Pascual-Leone, 2017; Kramer & Pascual-Leone, 2016; Kramer et al., 2016; Kramer et al., 2015; Pascual-Leone & Greenberg, 2007).

1.3.3 Relationship conditions in EFT: A foundation for change

There are two overarching set of principles and guidelines for the therapist involved in EFT. The first pertains to the therapeutic alliance, particularly the bond and goal components, as described by Bordin (1979), comprising a therapeutic bond, goal and task. In EFT, this is often termed providing relationship conditions (Elliot et al., 2004). The second set of principles pertains to the facilitation of active emotion-focused interventions (Greenberg & Watson, 2006). While these set of principles operate throughout the course of therapy, the first set is assumed to be of particular

importance in the initial phase of therapy, and in case there is a rupture in the alliance. The active emotion-focused interventions are more in use after the formation of a good alliance and until the end of therapy. The intervention that is investigated in this study, the two-chair dialogue intervention, is primarily used in the latter phase.

It is being increasingly recognized across therapeutic approaches that psychotherapeutic change is dependent on the quality of the therapeutic alliance between client and therapist (Horvath, Del Re, Flückiger, & Symonds, 2011; Norcross & Wampold, 2011; Wampold & Imel, 2015). The therapeutic alliance is given particular attention in EFT as a necessary condition for the client to engage in more active emotional processing (Elliott et al., 2004). Research on EFT also suggests that a good therapeutic alliance is associated with better emotional processing (Elliott et al., 2013; Iwakabe, Rogan, & Stalikas, 2000; Missirlian et al., 2005; Pos, Greenberg, Goldman, & Korman, 2003). In the first phase of an EFT-treatment, the therapist is instructed to concentrate on building a safe and trusting relationship by complying to basic Rogerian conditions, that is, being empathic, congruent, and to show unconditional positive regard for the client (Rogers, 1957). In EFT, empathy is further specified as *empathically attune to the clients' emotional experience* as it unfolds (Greenberg & Watson, 2006). In EFT training, a considerable amount of time is spent on learning to use differentiated empathy to serve different purposes in the clients' processes at different times (Elliott, Bohart, Watson, & Greenberg, 2011; Greenberg & Elliott, 1997; Watson, Steckley, & McMullen, 2014). In addition to building a therapeutic bond, empathy is also used in establishing other aspects of the therapeutic alliance (Bordin, 1979), that is, paying attention to the collaboration on the establishment of a goal for the treatment, and obtaining an agreement on the method to reach that goal (Horvath & Greenberg, 1986). Furthermore, an important task throughout the treatment is repairing alliance ruptures (Safran & Greenberg, 1991; Safran & Muran, 2000; Watson & Greenberg, 1998, 2000; Wong & Pos, 2014). This implies that for the EFT-therapist, as for therapists in many approaches, constant and close attention needs to be paid to the state of the therapeutic alliance. The therapist also require to respond accordingly when the bond,

agreement, or task/goal is interrupted (Watson & Greenberg, 1998). The empathic exploration and provision of Rogerian conditions in this treatment phase is assumed to be necessary for the active emotion-focused interventions that comes later to have effect. This phase is also assumed to facilitate psychotherapeutic change in and of itself. However, from an EFT-perspective, psychotherapeutic change is thought to increase and become more substantial in the latter phase, that is, when the active emotion focused interventions are utilized (Elliott, Watson, Goldman, & Greenberg, 2004). The basic assumption in EFT, that active emotion focused interventions will enhance psychotherapeutic change, is being tested in the present thesis.

1.3.4 Markers for utilizing emotionally evocative interventions

When the therapeutic bond and alliance in an EFT-treatment is established, usually assumed to happen within three to five sessions, the therapist starts paying even closer attention to problematic aspects of the clients' emotional processes (Elliott et al., 2004). Here, problematic means that the client displays some behavior or statement that indicates that something of relevance needs attention. In EFT, aspects of the therapeutic process that needs attention is typically called a *marker*. Markers are thus to be understood as process diagnosis that could indicate specific emotional processing difficulties (Greenberg, 2017). When a marker appears, the therapist might suggest to the client a certain task that is designed to lead to an end state where the emotional processing difficulties are no longer present. There are several markers outlined in EFT; each one calls for a separate intervention/task. The studies in this thesis focuses on a specific intervention developed to be used when the client displays markers of destructive self-criticism.

1.3.5 The self-critical marker

In EFT, it is assumed that many clients suffering from anxiety or depression typically display high degree of self-criticism. Self-criticism is specified as a marker for utilizing an emotionally evocative intervention. The two-chair dialogue intervention,

which will be further described in the next chapter, is typically employed when the client displays a marker called a *self-critical split.* The *self-critical split* is, as the name suggests, a state where the client somehow evaluates him- or herself in a critical or negative manner. The goal of the intervention is to help the client gain a more compassionate stance toward him- or herself. Research has revealed a connection between self-criticism and depression (Kopala-Sibley, Zuroff, Hankin, & Abela, 2015; Moroz & Dunkley, 2015; Yamaguchi, Kim, & Akutsu, 2014) and between self-criticism and anxiety (Kopala-Sibley, Zuroff, Russell, & Moskowitz, 2014; Mandel, Dunkley, & Moroz, 2015). Research further suggests that the alleviation of self-criticism alleviates symptoms of distress (Iancu, Bodner, & Ben-Zion, 2014; Kelly, Zuroff, & Shapira, 2009; Leaviss & Uttley, 2015; Shahar et al., 2015).

In EFT, a self-critical marker is perceived as an indication of emotional processing difficulties related to self-criticism. Self-criticism in EFT is assumed to indicate unprocessed, maladaptive shame (Whelton & Greenberg, 2005). In that sense, shame can be said to fuel self-criticism. However, the theory suggests a bi-directional relationship between self-criticism and shame: the activation of maladaptive shame will make it more likely for self-criticism to appear, and criticizing oneself will make it more likely that maladaptive shame will be evoked (Whelton & Greenberg, 2005).

Alluding to the trans-diagnostic aspect of the EFT-theory, one would assume that symptoms of depression and anxiety stem from an underlying difficulty in emotional processing, where one such processing difficulty could be unprocessed maladaptive shame. This unprocessed shame is assumed to often lead to secondary reactions, such as hopelessness, fatigue, depression and anxiety. This further implies that processing the underlying emotional difficulties (in this case maladaptive shame) should alleviate symptoms of depression and anxiety.

1.3.6 The two-chair dialogue intervention

When the *self-critical split* appears, the the two-chair dialogue intervention is utilized in an attempt to access, process, and change maladaptive shame. This intervention involves altering between visualizing and acting as the critical part of the self and the experiencing part of the self. When the client displays a self-critical marker, for instance, by saying, “I’m such a failure. I can’t do anything right in this world”, the therapist prepares the client to work with this by saying something like “It seems like there is this part of you that attacks or criticizes another part of you, and that the criticized part of you is left feeling worse off. Does that fit with how you experience it?” If this makes sense to the client, the therapist introduces another chair and invites the client to move over to this new chair and imagine themselves in the other chair. The client is asked to say and do to the experiencing self what the self-critical part normally does. When the critique has been delivered, the client is invited to again switch chairs and experience the emotional impact of the critique. The goal is to get to the primary maladaptive shame. Primary maladaptive shame is thought to be a response to specific, poignant and painful critique of themselves. Usually this pertains to the hurtful situation or period that created the maladaptive shame. For instance, if the client in the past was repeatedly humiliated by an abusive parent, the self-critical message is thought to resemble the message from the abusive parent. When the self-critic delivers a more poignant critique, the criticized self often experiences maladaptive shame, for instance, as expressed in the following: “I am no good in the eyes of others.” When primary maladaptive shame is evoked, it is also hypothesized to be susceptible to change. The therapist attempts to get the client in contact with the emotional or psychological need that is related to the maladaptive shame, for instance, validation or self-assertion. If the process is successful, theory suggests that the client will experience more adaptive emotions, activated through the realization and experiencing of pain with regard to the unmet need. The assumption is that the adaptive emotion that follows the maladaptive emotion has the potential to alter or reorganize the maladaptive emotion, thus changing the maladaptive emotion scheme that was created as a result of the humiliation received from the abusive parent.

1.4 Aim of the study

The aim of this dissertation is to investigate and explore the impact of a psychotherapeutic intervention, the two-chair dialogue intervention, designed to better help clients with mental health difficulties to process problematic emotions related to destructive self-criticism. The two-chair dialogue intervention is assumed to facilitate emotional processes and outcome more than the provision of basic Rogerian conditions and the therapist empathic attuning to the clients' emotions and experience. By adding the two-chair dialogue intervention to these basic conditions, we wanted to investigate the following research questions: 1) is there an enhancement of the the clients' emotional processing; 2) is there an improvement of symptomatic outcome; and 3) how do clients experience this emotion-focused intervention. The dissertation employs both quantitative and qualitative research methods to investigate these aims: coding of video recordings as process measures (paper 1), self-report instruments as outcome measures (paper 2), and qualitative interviews as a mean of obtaining in-depth knowledge with regard to the clients' reported experiences (paper 3).

1.4.1 Aims, research question, and hypothesis for paper 1

The aim of paper 1 was to evaluate whether a change in the clients' emotional processing occurred when the two-chair dialogue was added to basic Rogerian conditions and empathic attunement to affect. The Client Emotional Arousal Scale III (Warwar & Greenberg, 1999) was used to code the clients' level of emotional arousal. The Experiencing Scale (Klein, Kiesler, & Coughlan, 1969) was used to code the clients ability to attend to and appraise their emotional arousal. These two vital aspects of emotional processing were coded both for sessions where the therapist solely focused on providing basic Rogerian conditions and empathic attunement to affect, and for sessions where the therapist also utilized the two-chair dialogue intervention. The research question for paper 1 was as follows: is adding the two-chair dialogue intervention associated with enhanced emotional processing, that is,

does the intervention a) lead to increased emotional arousal, and b) help the clients to better attend to and appraise their emotional experience? In line with the EFT-model, we hypothesized that adding the two-chair dialogue intervention would lead to increased emotional arousal and to increased quality of emotional experiencing.

1.4.2 Aims, research question and hypothesis for paper 2

The aim of paper 2 was to investigate whether adding the two-chair dialogue intervention had an enhanced effect on the clients' symptoms in comparison to solely providing basic Rogerian conditions and empathically attune to the clients experience. The research question for paper 2 was as follows: is adding the two-chair dialogue intervention associated with a reduction in symptoms, that is, is the intervention associated with a greater reduction in symptoms of (a) anxiety, (b) depression, and (c) self-criticism compared to when the therapist solely focuses primarily on providing basic Rogerian conditions and empathically attuning to the clients' affect? We hypothesized that the addition of the two-chair dialogue would lead to a significantly greater decrease in self-reported symptoms of anxiety, depression, and self-criticism.

1.4.3 Aims and research question for paper 3

The aim of paper 3 was to explore the clients' experiences of working with the two-chair dialogue intervention. We conducted in-depth qualitative interviews with 18 clients after they completed EFT therapy. The research question for paper 3 was as follows: How do self-critical clients suffering from anxiety and depression experience the impact of the two-chair dialogue intervention during EFT treatment?

2. Method

2.1 Research design

In order to test our hypotheses, we chose a multiple baseline design. In this design, a baseline is first established, and then, the intervention in question is added at different times for different clients. By adding the interventions at different times, one is better able to control for time as a factor. If the dependent variable only changes when the intervention is added, the hypothesis that alteration of conditions explains the change is strengthened (Kazdin, 2011). We chose this design as it seems suitable for the investigation of specific components in psychotherapy. The treatment thus consisted of two phases. In the first phase (baseline phase), therapists were asked to adhere to relationship conditions as prescribed in EFT: empathically attune to the clients' emotional experience, validate and reassure the clients' emotional experience, as well as follow the basic Rogerian principles, which are empathy, genuineness, and unconditional positive regard. In the second phase (the active component phase), we added the two-chair dialogue intervention as outlined by Greenberg and Watson (2006) for five consecutive sessions. In the instructions to the therapist, it was highlighted that the only intended difference between the first and second phase was the two-chair dialogue in the second phase.

As prescribed for multiple baseline designs, different lengths for the baseline phases of different clients were selected (Kazdin, 2011). Clients were assigned to a baseline phase that consisted of either five, seven, or nine sessions. This design allowed us to investigate whether the trajectory of the clients' self-reported symptoms changed if, and only if, we introduced the two-chair dialogue intervention. In this way, we could infer with increased certainty that any change on the dependent variable would be caused due to the added component, and the clients function as their own control.

The lengths of the baseline conditions (five, seven, and nine) were chosen for two main reasons. First, from a methodological standpoint, the length of the baseline

needs to be at least 5 sessions in order to stabilize the baseline period (Kazdin, 2011). Also, from a clinical perspective, five sessions as the minimum intervention period allows the development of a good working alliance (Horvath & Greenberg, 1994). The difference between the different baseline conditions (five, seven, and nine) was determined in order to make the phases significantly different, but still similar to one another. We chose the length of the active component phase to be five sessions, as we assessed this as necessary and sufficient to observe a tendency in the clients' change trajectory. Further we assessed that five sessions would suffice to provide the clients' adequate experience of the intervention for the investigation of their experiences through qualitative interviews.

2.2 Participants

All participants in this study were recruited from a low threshold, mental health treatment program in Norway. The treatment program, called Return to Work (Raskere Tilbake), is intended for adults with common mental health issues who are on paid sick leave due to their mental health issues, typically anxiety or depression. The intention of the program is to prevent long-term sick leave. The typical user of this program was referred to the program due to anxiety difficulties or mild to moderate level of depression. The program is a short-term one, with a maximum time frame of 18 weeks. Anyone who is on sick leave was eligible for referral by their general practitioner, and they would have to undergo a clinical intake interview. Exclusion criteria from the program were serious mental health issues, lack of motivation to attend treatment, or active substance abuse. The treatment was delivered in a private clinic, but was covered and administered by the Norwegian national social services (nav).

In the 6-week recruitment period spread over February and March 2015, 98 people were referred to the program. Sixty-four of those referred were eligible for treatment. Out of the 64, 36 agreed to participate in the study. During the intake interview, participants were informed that participation in the research program implied that

their sessions would have to be video recorded for analysis by research assistants at the University of Bergen. Nearly everyone who declined to take part gave the reason that they did not want their sessions video recorded and viewed by others. The 36 individuals who agreed to participate were subjected to further screening by the main researcher. Inclusion criteria were met by 24 clients who subsequently participated in the project. During treatment, three clients dropped out of the treatment program. Two of those who dropped out did not give a reason for it. One reported symptomatic improvement and thus lack of motivation to continue treatment. Out of the 21 who participated, 15 were women. All were native Norwegians, one with an Asian background. The age span was 20–63 years, with a mean of 38.2 years. Five participants reported not receiving any higher education; the rest reported a span of two to four years of higher education. All participants were employed full time. Seven participants reported not being in a long-term relationship. Five had no children. Six of the participants had previously received treatment for common mental health issues.

Inclusion criteria for this study were symptoms in the clinical range on depression or anxiety. We utilized BDI-II (Beck, Steer, & Brown, 1996) and BAI (Beck et al., 1988) for the screening. Also, as the intervention being investigated was targeted at self-criticism, we only recruited participants who showed a moderate to high level of self-criticism. We measured self-criticism with a subscale from the Forms of Self-Criticizing/Attacking & Self-Reassuring Scale (FSCRS; Gilbert et al., 2004). Based on previous research on this scale (Baião, Gilbert, McEwan, & Carvalho, 2015), cut-off was set to 22 or above on the subscale Inadequate Self. The FSCRS also contains two other subscales. These are Hated Self and Reassured Self. The Hated Self subscale measures an even more malign form of self-criticism, while the Reassured Self subscale measures the resilience shown with regard to self-criticism more than self-criticism (Gilbert, Clarke, Hempel, Miles, & Irons, 2004). Exclusion criteria were effectively the same as not being eligible for treatment in the Return to Work program, in addition to a score below 22 on the subscale Inadequate Self of the FSCRS.

For paper 1, data from process measures was retrieved for 20 clients. The reason due to which there were 20 rather than 21 clients (as was the case in paper 2), was that a number of recordings from one of the client's sessions did not have any audio. For paper 2, self-report data from all 21 clients was utilized in the analysis. For paper 3, 18 clients were interviewed and thus provided data for the qualitative analysis. Three out of the 21 clients declined to take part in the interview. Reasons for abstention were not obtained.

2.3 Therapists

Six therapists provided the treatment. All six were clinical psychologists who had five to thirteen years of clinical experience (mean 9.2 years). Four of the therapists were female, while two were male. The therapists had a minimum of 300 hours of EFT training over at least 3 years. In addition, they all had minimum 20 hours of supervision on videotaped practice. During the EFT training, there was a great emphasis on basic Rogerian conditions considered as necessary conditions for change to occur in EFT. There was also a major focus on the application of differentiated empathic attunement to affect. Thus, all therapists were trained both in the application of differentiated empathy, alliance building, genuineness, and presence, as well as the two-chair dialogue intervention.

2.4 Data collection procedure

2.4.1 Data collection procedure for paper 1

For this paper, we wanted to study the clients' emotional processes and the way in which these were impacted by adding the two-chair dialogue to basic Rogerian conditions and empathic attunement to affect. Data consisted of ratings of the clients' emotional processes. All clients' sessions were video recorded and stored for analysis. We employed two scales to analyze the recordings: The Client Emotional Arousal Scale III (Warwar & Greenberg, 1999), to measure the clients' degree of

emotional arousal, and The Experiencing Scale (Klein et al., 1969), to measure the clients' ability to attend to and appraise the emotional experience (see instruments and measures provided in the subsequent sections for details).

Thirty-one undergraduate psychology students from the psychology program at the University of Bergen were instructed with regard to the rating of sessions with these two scales. The students were trained to observe and rate emotional processes in psychotherapy, using The Client Emotional Arousal Scale III (Warwar & Greenberg, 1999), and The Experiencing Scale (Klein et al., 1969). The training comprised 21 hours of both didactics and practical exercises in which the students practiced rating on a separate set of video recordings of EFT sessions. Before they were allowed to start rating the material in the present study, the students were tested against a gold standard to ensure reliability (ICC > 0,6). The gold standard was established by expert raters from York University in Toronto, Canada. Average reliability against the gold standard for arousal was observed at ICC = 0.70 and for experiencing at ICC = 0.78.

All sessions were divided into two-minute segments. With The Observer® XT software, each segment was rated with the application of both scales. The raters were divided into pairs, and the raters in each pair rated 2/3 of all sessions for one client. This secured a 1/3 overlap of session ratings within each pair that rendered the calculation of interrater reliability possible. ICC-scores for the Client Emotional Arousal Scale III averaged at 0.8 (SD = 0.12), ranging from 0.48 – 0.97. For the Experiencing Scale, the ICC-scores averaged at 0.82 (SD = 0.09), ranging between 0.52 – 0.92.

Additionally, to ensure that the raters indeed rated the same emotion category (sadness, anger, fear, shame, positive emotions, fused anger/sadness, or fused fear/sadness); they were instructed to specify the category of emotions before rating the episode with the two scales. Emotion episodes were coded based on action tendencies, the description of an action tendency, or descriptions of an emotional

reaction (Warwar & Greenberg, 1999). If there was disagreement on emotion category within a pair, we used the rating of the rater who had combined highest interrater reliability on The Experiencing Scale and the Client Emotional Arousal Scale III, compared to the gold standard.

For segments in which the two raters diverged in their rating, we utilized the average of the two values. If one rater recorded 'no data' and the other rater gave a rating, we employed the value from the later rater. The data from the rating of each 2-minute segments were calculated in two different ways. First, we employed the peak from each scale per session. Further, as both scales were considered to observe a clinically significant shift when the client moved to a 4-minute segment, we were interested in the number of segments per session that were above 3 on both scales. Thus, each session consisted of two values: peak and the number of segments above 4.

Ratings were completed over a period of 7 months. During this period, interrater reliability was evaluated to detect any drifting in the ratings, that is, divergence from the co-rater who rated the same sessions. In cases where such a tendency was observed, the main researcher met the raters who showed this drift and reiterated the instructions before resuming further rating.

2.4.2 Data collection procedure for paper 2

For paper 2, we collected data through self-report measures in order to monitor the intervention's impact on symptoms. In addition, we measured the clients' perception of the therapeutic alliance for the purpose of adherence. All clients who consent to participate in this study were asked to arrive 30 minutes before each session in order to complete the self-report measures. We employed the following measures: the Beck Depression Inventory-II (BDI-II; Beck, Steer, & Brown, 1996), Beck Anxiety Inventory (BAI; Beck, Epstein, Brown, & Steer, 1988), Forms of Self-Criticizing/Attacking & Self-Reassuring Scale (FSCRS; Gilbert et al., 2004) and Working Alliance Inventory – Short Version, Patient (WAI-S-P; Tracey &

Kokotovic, 1989). See instruments and measures below for details of these measures. The clients provided the measures on paper to fill out. The responses were later plotted into an excel file by a research assistant with the application of procedures to minimize plotting errors.

Any missing data was managed in the following manner: single items on each instrument were plotted by replacing the missing scores with the subjects' mean score on the subscale/scale. This was done for 3.99% of all possible items. In cases where more than 50% of the items on a subscale/scale were missing, the last observation carried forward (LOCF) was utilized. If this was not possible, the last observation carried backward (LOCB) was applied. LOCF and LOCB were applied in 3.05% of all possible scores. This rather conservative procedure was applied, since the total amount of missing data was insubstantial.

2.4.3 Data collection procedure for paper 3

The qualitative interviews were conducted by four researchers and clinical psychologists who were associated with the research project. None of them were involved in the treatment of the clients or the rating of the material. Two of them were familiar with EFT, two of them were not. Data was obtained between August and September 2015, about two months after the completion of the treatment. The lead researcher did not conduct any interviews. All interviews were audio recorded and then transcribed by a team of graduate students. The instructions for the graduate students were to transcribe the material verbatim. Further, they were asked to add short parenthetical notes about poignant non-verbal aspects. The interview guide is described under instruments and measures below.

2.5 Instruments and measures

2.5.1 Process rating scales for paper 1

The Client Emotional Arousal Scale III (Warwar & Greenberg, 1999)

The Client Emotional Arousal Scale III is used to assess the degree of emotional arousal. Using this scale, raters assess the emotional arousal based on the degree of activation by analyzing the clients' voice quality and body language. Voice quality refers to the accentuation pattern, pace, contours, and speech disruption. Body language refers to the facial expressions and the bodily action tendencies that are typically associated with emotional arousal, such as the trembling of lips when one is on the verge of tears or the clenching of the fists when one is angry. The scale ranges from 1–7, where 1 is no expression of emotion and 7 is extremely intense expression of emotion. Level 4 is assumed to be a clinically productive level of arousal, while level 7 is assumed to be too intense. Emotional arousal, as measured by The Client Emotional Arousal Scale III, has been associated with good outcome in prior research (Missirlian et al., 2005; Pos et al., 2017; Pos et al., 2009).

The Experiencing Scale (Klein et al., 1969)

The Experiencing Scale is designed to evaluate the clients' ability to stay in contact with and make meaning of their internal experience during therapy. It was originally designed to rate the transcribed material, and the manual aids the coder to analyze the clients' ability to verbalize their experience. It focuses on the manner of the verbalizing rather than on the content. The goal is to assess the clients' ability to process and integrate the content of their own emotional state. The scale indicates seven different levels of involvement with the clients' inner experience. At level 1, the client is objective and intellectual; there is no indication of personal significance of what is being told. At level 2 and 3, the client starts to refer to themselves and to their inner world, but it is still not their inner voice that speaks. At level 4, the client speaks about their emotional experience using an internal referent, for instance, by talking about their feelings in great detail, while at level 5, they shift to questioning

their experiences, transcending beyond their existent knowledge. For example, the client might narrate a problem that carries emotional value. Level 6 pertains to a level where the client's starts to talk about newly realized feelings about the problem that was posed, whereas level 7 constitutes a level where newly realized feelings span the other aspects of the clients' life. Enhancement in the quality of experiencing as measured according to this scale has previously been found to correlate with good outcome in psychotherapy (McLeod, 1997; Pascual-Leone & Yeryomenko, 2016; Pos et al., 2017; Pos et al., 2003; Stiles, Shapiro, & Elliott, 1986).

2.5.2 Self-report measures for paper 2

The Beck Depression Inventory-II (Beck et al., 1996)

The Beck Depression Inventory-II (BDI-II) is a 21-item self-report instrument meant aiming to measure the severity of depressive symptoms. The respondents are given four options for each item. Each option describes a particular degree of a depressive symptom, and the respondents are asked to circle the most fitting option. So far, BDI-II has demonstrated good discriminant and convergent validity as well as good test-retest reliability (Beck et al., 1996). In the present study, Cronbach's alpha was calculated before the treatment (0.84), after baseline (0.94), and after the treatment (0.93). The mean score for the BDI total, ranging from 13 to 50, was 24.21 (SD = 9.69). A factor analysis of BDI-II suggests two subscales – a subscale composed of items measuring how depression affects the cognitive domain, and a subscale measuring how depression affects the somatic-affetive domain of human functioning (Steer, Ball, Ranieri, & Beck, 1999). After a calculation, it was found that for the somatic subscale, the mean score was 15.05 (SD = 6.02), ranging from 8 to 31. On the cognitive subscale, the mean score was 8.4 (SD = 4.38), ranging from 3 to 19.

The Beck Anxiety Inventory (Beck et al., 1988)

The Beck Anxiety Inventory (BAI) is a commonly used self-report instrument containing 21 items. BAI is used to quantify the symptoms of anxiety. The

respondents are asked to indicate the degree to which each item fit their experience of their symptom/s using a Likert scale ranging from 0 to 3. BAI has demonstrated a high internal consistency (Beck et al., 1988). In the present study, Cronbach's alpha before treatment was measured at 0.92. It was 0.96 after baseline, and 0.96 after the completion of the treatment. The mean score for the participants was 26.02 (SD = 13.89), ranging from 5 to 52.

The Forms of Self-Criticizing/Attacking & Self-Reassuring Scale (Gilbert et al., 2004)

The Forms of Self-Criticizing/Attacking & Self-Reassuring Scale (FSCRS) is a self-report instrument designed to measure the degree of self-criticism. Each item comprises a statement about the respondents' thoughts and feelings. The respondents are asked to mark themselves on a 5-point Likert scale from 0 (not at all like me) to 4 (extremely like me). A factor analysis of this instrument suggests three subscales – the Inadequate Self, the Hated Self, and the Reassured Self. FSCRS has demonstrated good internal consistency and is congruent with other measurement scales of self-criticism (Gilbert et al., 2004). The Norwegian version of FSCRS was translated and back translated by Norwegian psychologists (Stiegler, Schanche, Vøllestad, & Nielsen, 2015), who were fluent in both Norwegian and English. Cronbach's alpha was calculated before the treatment was 0.89, 0.90 after baseline, and 0.90 after the treatment. For this study, we were interested in the subscale Inadequate Self. This was due to the fact that the subscale Hated Self did not seem clinically relevant for this population, and Reassured Self seemed to measure the resilience to self-criticism rather than self-criticism. For the Inadequate Self subscale, the mean score was calculated at 25.24 (SD = 7.42), ranging from 8 to 36.

The Working Alliance Inventory – Short Version, Patient (Tracey & Kokotovic, 1989)

WAI – Short Version, Patient (WAI-S-P), is a 12-item self-report measurement scale deployed to assess the clients' experience of the working alliance. The scale is based on the working alliance inventory (Horvath & Greenberg, 1986), which measures the

therapeutic alliance as conceptualized by Bordin (1979). Thus, the scale takes into consideration three aspects of the alliance: the therapist-patient bond, – agreement on the goal, and agreement on the task, and the therapist-patient bond (1979). The WAI-S-P contains four questions for each dimension. The scale has shown acceptable psychometric qualities (Hanson, Curry, & Bandalos, 2002; Tracey & Kokotovic, 1989). After the completion of the first session, Cronbach's alpha was 0.81. It increased to 0.83 after baseline and lowered to 0.71 post treatment. The mean score on WAI was measured at 60.56 (SD = 11.57), ranging from 43 to 82.

2.5.3 Qualitative interview for paper 3

The approach employed by us for developing and conducting the interviews was a hermeneutic-phenomenological approach to thematic analysis (Binder, Holgersen, & Moltu, 2012). The epistemological assumptions made during the study were thus hermeneutic-phenomenological, indicating that we intended to interpret (hermeneutical) and explore the participants' lived experiences (phenomenological). In a hermeneutic-phenomenological approach, it is assumed that the researchers will inevitably influence the interview process, and subsequently, the clients' experience. On account of the unavoidability of influence, an important part of the research process is for the researcher to become aware of this influence. It is assumed that co-construction of the meaning will be done by the client and the researcher in a dialectical fashion. The clients' utterances will be interpreted by a researcher who already possesses an understanding of the phenomenon referred to by the client. This pre-understanding will influence the researchers' further investigation, the interview process, and thus, the drawn meanings of the clients' further utterances. In a hermeneutic-phenomenological approach, this is not perceived as an error; it is considered to be a necessary step that contributes to the process of understanding. However, if the researcher assumes to be ignorant or has extensive blind spots regarding this pre-understanding, it may prove to be a potential source of prejudice and bias. Therefore, the researchers putting this approach into practice need to be

aware of their role as interpreters of meaning. It is advisable for them to be as reflexive with respect to their role as possible (Finlay, 2002).

The interview guide had a broader focus than what strictly pertained to the research question in this study. The larger qualitative study focused on several issues – the clients' motivation for seeking help; their experiences of the treatment as a whole; their relationship with the therapist; and the clients' experiences of working with the two-chair dialogue intervention. The interview was initiated with an open question about the clients' experience with regard to their experiences with psychotherapy. If the clients' themselves did not approach the topic of the two-chair dialogue intervention, the interviewer focused in on that segment of the treatment with a question such as, "At some point, you performed exercises where you used the chairs to work with individual topics. Did you notice that?" In the interview guide, there were follow up questions concerning the participant's perceived aim with the intervention, their experience of the impact on their process, and their perception of its influence on their work on their presented issue. The interview guide always suggested starting with an open question, and if an open exploration did not yield information relevant to the research question, more specific questions were utilized. A translated version of the interview guide can be found in appendix of paper 3.

2.6 Data analyses

2.6.1 Quantitative analyses for paper 1

In paper 1, we concentrated on the following:
1) Investigating whether the phase containing the two-chair dialogue manifested a higher number of high-arousal and high-experiencing episodes compared to the phase containing only basic Rogerian conditions. In order to compare the phases on high-arousal and high-experiencing episodes, each episode was given a dummy score of "1" or "2", where 1 indicated an arousal/experiencing level from 1 to 3, and 2 stood for an arousal/experiencing level from 4 to 7. Using an ANOVA, we compared the number of high and low arousal/experiencing episodes in the two phases.

2) Investigating whether the clients' change trajectory for arousal and experiencing changed after the two-chair dialogue was added to the basic Rogerian conditions. In order to model the clients' change trajectory for arousal and experiencing, the mean growth rates within the group were compared during two different time periods. The variation across individuals not being the primary focus, no person moderators were included. As we were mainly interested in the group average, in the analysis, we allowed the intercept to vary across individuals (random), while the slope trajectory was fixed. R version 3.4.0 (The R foundation for statistical computing, 2017) was used to analyze the hierarchical linear growth models. Using linear tests, the trajectories of the two phases were compared to see if they differed significantly from each other. All residuals were normal distributed. The details with respect to equations and specific statistical procedures can be found in paper 1.

2.6.2 Quantitative analyses for paper 2

In paper 2, we were interested in investigating whether the change trajectory of the clients' symptoms altered after adding the two-chair dialogue. This was done by comparing the mean growth rates within the group during two different time periods. As in the case of paper 1, the interest was not in the variation across individuals; therefore, no person moderators were included in our models. We allowed the intercept to vary (random), while the trajectory across individuals remained constant (fixed). In this paper a multivariate two-level hierarchical linear growth model was chosen due to low sample size and the fact that we were mainly interested in the group averages. We used R version 3.4.0 (The R foundation for statistical computing, 2017) to analyze the hierarchical linear growth models. A restricted maximum likelihood estimator (REML) was used. After investigating the trajectories in each phase, the baseline trajectory was compared to the treatment trajectory to see if they differed significantly from each other. The residuals were inspected for normality, and no violation of the distributional assumptions of the models was found. The

details concerning the equations and specific statistical procedures can be found in paper 2.

2.6.3 Qualitative analyses for paper 3

The data was analyzed using a thematic analysis, as outlined by Braun and Clarke (2006). The analyses were conducted in accordance with the following procedures: 1) All five researchers read all the transcripts in order to familiarize themselves with the material at hand; 2) The first author closely examined the material and identified units of meaning relevant to the research question, using NVivo 11 (QSR International, 2015) computer software. More specifically, only parts of the interview material directly or indirectly related to the experiences pertaining to the use of the two-chair dialogue intervention were investigated here; 3) Based on these units of meaning, the first author suggested tentative themes under which the units of meaning could be classified; 4) With these tentative themes in mind, all five authors reread the transcripts to facilitate the addition or redefinition of the possible themes; 5) The first author rearranged the units of meaning under the newly agreed upon themes. All references of the participants to their experience with the two-chair dialogue were assigned to one of the themes; 6) This new sorting was brought back to the research team for a consensual discussion and final agreement on the themes, descriptions, and sorting of units.

2.7 Reflexivity

Reflexivity can be understood as a tool or a process by means of which researchers engage in critical self-reflection about the possible influences of their own preconceptions and subjective perspectives on the research (Finlay, 2002). In the hermeneutical-phenomenological approach, as employed in paper 3, the researcher will unavoidably influence the data collection, the analysis, and the interpretation (Binder, Holgersen, & Moltu, 2012; Finlay, 2002). It is therefore of prime importance

to aspire to be transparent by reflecting on how the researchers' preconceptions and perspectives might have influenced the research process. Wilkinson (1988) differentiated between personal, functional and disciplinary reflexivity. I will comment on my role as a researcher in this project using these three forms of reflexivity. Personal reflexivity refers to how ones' personal interests, concerns, and identity as a construct influence the research project in foreseen and unforeseen ways. I got introduced to EFT in 2008, a few years into my career as a psychologist. EFT as an approach to psychotherapeutic change caught my attention at once, particularly due to the immediate and thorough access it provided to my own emotional processes. Since then, I have invested my time and energy into the implementation of this method of practicing psychotherapy in Norway. I have been extensively trained over several years by leading experts in EFT and I now conduct training sessions for Norwegian psychologists. I have also written a book and several articles on the same subject. EFT is gaining national interest across Norway. Thus, the chosen topic for this project was based on an already required enthusiasm with regard to this approach. When I commenced this research project, I tried to be openly reflective about the fact that I was enthusiastic and invested with respect to EFT as an approach to psychotherapy. It has also been of big help for me to be able to discuss my preconceptions and blind spots with my supervisors and colleagues. However, researcher allegiance is of concern when one is doing research on a topic with which one is personally involved. Both during the qualitative and the quantitative undertaking of the project, I have had the fortune of being aided by colleagues and co-researchers who, themselves not being invested in EFT, were able to ensure a more neutral perspective on the different aspects of the research project.

Although functional reflexivity is closely connected with personal reflexivity, the focus remains more on the role as a researcher and on the shaping, influence, and understanding of the research project by the researchers' preconceptions. For the qualitative interviews, we chose to use interviewers other than me as the main researcher. This step was taken to ensure that my preconceptions would not influence what was being shared by the participants. Still, I took lead in the analysis of the

transcribed interviews, and it is inevitable that my preconceptions interfered in some way with the analysis and understanding of the participants' utterances. As pointed out under "Researchers' Reflexivity" in paper 3, our research team for this paper included researchers who were unfamiliar with EFT, thus increasing the prospects of a reduced impact of the researchers' allegiance. In addition, I played the role of both the main researcher and a therapist in this project. My team and I tried to deal with this possibly confounding factor by adherence measures. Moreover, my particular awareness of intervening in accordance with the treatment protocol aided in the reduction of the impact of my preconceptions as mentioned earlier.
In disciplinary reflexivity, "… we explicate our stance towards theory, method and psychology – political, epistemological and theoretical" (Gough, 2017, p. 311). Before the commencement of this research project, I was already influenced by EFT theory, its epistemological stance, and its view on research. Regarding psychological and epistemological theory, I advocated a non-reductionist view of the individual's experience of emotions as a core element in human functioning and change, a stance that is reflected by the chosen methodology and theoretical framework in the articles.

2.8 Ethical considerations

The study was approved by the Norwegian Regional Committees for Medical and Health Research Ethics. Written informed consent was obtained from all participants prior to their participation in the study. We considered there to be particular ethical considerations regarding the recruitment, data collection, and the probable impact of the design on the treatment received by the clients. In addition, considerations and measures had to be taken regarding the storage of sensitive material that could not be listed in a journal. Except for the fact that clients' were receiving psychological treatment, which in itself can prove stressful for its recipients, we did not consider there to be particular strains on people, the community or the environment.

Those who were initially excluded for the treatment program were not informed about the research project and were therefore not affected. Regarding the recruitment

beyond the existing participants of the treatment program, all those who were initially considered eligible for the project were subjected to an extra assessment. This put additional strain on the participants, irrespective of the results of the assessment. Also, for those declared not eligible, their disappointment at the exclusion might have proved stressful. Most importantly, those who were present for the assessment but weren't eligible for the project still received the treatment in the program they had originally signed up for.

For the purpose of data collection, all clients in the research project had to fill out forms or measures before each session. This meant that the clients spent an additional 30 minutes per session, which laid an extra load on them. Additionally, all sessions were video recorded and later analyzed by research assistants at the University of Bergen. This was considered to be an extra strain or was at least proved uncomfortable for many participants. Particularly since the clients were already preselected on the basis of their self-critical nature, it is likely that having the sessions recorded was unpleasant for them. Therefore, we considered it to be of particular importance to thoroughly inform the participants of this potential stressor and also made sure they were aware of their right to withdraw their consent to partake in the project. In an interesting turn of events, several participants reported in the qualitative interviews that filling out forms before each session was helpful for them to monitor their own change process. Also, some reported that contributing to research felt rewarding.

In order to preserve the sensitive material, all self-report measures were given a unique ID that could not be linked to the clients' names. Also, the forms were locked away in a cabinet immediately after the clients had filled them out. Thus, the question of storage of sensitive material pertained solely to the video recordings of the sessions. We consulted the data protection services made available by the government to get cues on the storage of the said recordings. We complied with the recommendations and stored the data on secure servers that were on a closed network without access to the internet. A backup of the data was stored on an encrypted hard

disk that was locked away in a secured safe behind locked doors in the location where the therapy sessions were held.

The rating of the video material was processed in a closed and secured room video laboratory at the University of Bergen. All the research assistants responsible for the rating had to sign a confidentiality agreement and were carefully informed about how to ensure maximum confidentiality. For instance, they were informed to refrain from discussing any of the recordings except with their rating partner and only in the laboratory were the rating was done. Furthermore, they were instructed not to allow anyone who was not a rater into the laboratory, even those raters who were not recording at the moment. In accordance with the approval from the Norwegian Regional Committees for Medical and Health Research Ethics, the data was deleted at the end of the project period.

3. Results

3.1 Summary of paper 1

In this paper, we conducted a careful study of two aspects of the clients' emotional processing (arousal and experiencing). More specifically, we investigated whether the two-chair dialogue intervention was associated with an increase in the clients' emotional arousal and experiencing in comparison to a therapeutic condition where the therapist solely empathically attuned to the clients' emotional experience while complying with the basic Rogerian conditions of empathy, genuineness, and unconditional positive regard. After a careful comparison, it was found that emotional arousal was high throughout both phases and that the second phase contained a significantly higher number of high-arousal episodes as compared to the first phase. However, when we investigated the clients' change trajectory using Hierarchical Linear Modelling, a significant difference between the phases was not found. The results, therefore, remain somewhat unclear. Concerning experiencing, we found a significant increase throughout the treatment. Contrary to our hypothesis, the increase was not significant larger in the phase containing the two-chair dialogue. The working alliance, as measured with WAI-S-P, was considerable and stable throughout both phases. To summarize, the two-chair dialogue has been confirmed to be an emotionally evocative intervention, more so than Rogerian conditions and empathic attunement to affect. However, the increase in arousal was smaller than expected. Although experiencing increases throughout treatment, the results indicate that the two-chair dialogue does not increase experiencing significantly more than Rogerian conditions and empathic attunement to affect.

3.2 Summary of paper 2

In this paper, we investigated whether the two-chair dialogue intervention was associated with more symptomatic change in comparison to a therapeutic condition where the therapist solely empathically attuned to the clients' emotional experience

while complying with the basic Rogerian conditions of empathy, genuineness, and unconditional positive regard. The results revealed a significantly greater drop in the symptoms of anxiety and depression after the two-chair dialogue intervention was introduced. Looking more closely at the subscales of the measure of depression (BDI-II) – the somatic-affective and the cognitive subscale – we found that only the somatic-affective subscale showed significant changes, thus accounting for the major drop in depressive symptoms. The tendency of self-criticism also showed a significant drop after the two-chair dialogue intervention was introduced. However, contrary to our hypothesis, the drop in self-criticism in the latter phase did not significantly differ from the trajectory of self-criticism during the baseline phase. The working alliance, as measured with WAI-S-P, was considerable and stable throughout both phases.

3.3 Summary of paper 3

A detailed analysis of the qualitative interviews was formulated, which suggests that there are three main themes that encapsulate the clients' experiences with the two-chair dialogue intervention. The first main theme, *Talking to a chair: An obstacle to overcome*, captures the clients' reluctance to partake in the task. Three subcategories were constructed to capture the different kinds of reluctance to engaging in the task. First, there were *feelings of embarrassment* or *awkwardness,* reported by almost all participants. The second subcategory was termed *Anxiety about performing,* and was also reported by almost all participants. This was mostly talked about as the fear of not being able to perform the tasks in the correct manner. The final subcategory for the first theme was called *Letting go of control*. This explored many of the participants' experience of engaging in the activities in spite of their reluctance. Our second main theme, *It's heavy, intense, horrendous, and nice,* describes the clients' experiences with the two-chair dialogue intervention as emotionally evocative in a way that was both painful and helpful. We suggested four subcategories for this theme. The first one, *Physically demanding,* was about many of the participants' experiences of exhaustion during or after sessions. The second subcategory, termed

Intensity of experience, pertained to the clear and painful reception of their emotions by the participants. The third subcategory was called *Useful/Productive.* This subcategory ranged from the participants description of "helpful pain" to experiencing the work during the intervention as more real. Some experiences of the intervention were also described as too intense, leaving the client seeking more time at the end of sessions to make sense of the evoked emotions. Thus, the fourth subcategory was termed *Too overwhelmed*.

Our third main theme was named *Realization: What am I doing to myself?* This theme was aimed at capturing the clients' descriptions of how they had established a new understanding of the fact that they were actively treating themselves in a particular manner. The theme was divided into three subcategories. The first subcategory was called *Doing something to myself,* as most of the participants perceived the intervention as something that was being "done" to the self rather than simply "talked about". The second subcategory for the third theme was termed *Agency*. Most participants talked about how they somehow realized that they were active agents when it came to working on their own experiences. Finally, the subcategory *Realization* pertained to the reported experiences of most participants with respect to the realization of their harsh treatment of themselves .

4. Discussion

The aim of this dissertation was to investigate and explore the impact of a psychotherapeutic intervention – the two-chair dialogue intervention – designed to help clients with mental health conditions to process problematic emotions related to destructive self-criticism in a more effective manner. The research involved investigating the impact of the intervention with the help of three main questions. The first research question focused on how the two-chair dialogue intervention impacted the clients' emotional processes as observed by trained raters. These ratings were compared to the readings when the therapist was empathically attuning to the client and providing basic Rogerian conditions without the use of the two-chair dialogue intervention. The second research question pertained to the effect of the two-chair dialogue intervention on the clients' self-reported symptoms of depression, anxiety, and self-criticism in comparison to the baseline phase. The third research question was aimed at understanding how the clients' experienced the two-chair dialogue intervention. The discussion in this paper consists of studied comparisons of the findings associated with the different research questions.

4.1 General findings

The following are the main findings from the three papers with regard to adding the two-chair dialogue intervention to basic Rogerian conditions and empathic attunement to affect (baseline phase):

1. The phase where the two-chair dialogue intervention was added is associated with a high number of high-arousal episodes in comparison with the baseline phase. The phase with the two-chair dialogue also showed a significant substantial increase in experiencing, albeit not significantly more than solely the baseline phase.
2. The phase where the two-chair dialogue intervention was added is associated with a greater reduction of symptoms of anxiety and depression in comparison with the baseline phase. The reduction in depressive symptoms seems to be mainly somatic-affective symptoms, not cognitive symptoms. The two-chair

dialogue intervention is also effective in reducing the tendency of self-criticism, albeit not significantly more than solely the baseline phase.

3. The two-chair dialogue intervention is perceived by many of the clients as both challenging and helpful. It aids in the creation of a different understanding of how the clients' treat themselves. For research question 3, no explicit comparison was done with the baseline phase.

The main findings from each of the three separate studies are discussed in the respective papers 1, 2 and 3. In the following, a comparison of the findings from the three different papers will be discussed. When comparing the results from different papers, there are a several interesting findings with important implications that help in understanding the impact of the two-chair dialogue intervention: First, there is a possible discrepancy between the significant reduction in self-reported symptoms, while the change in emotional arousal and experience is less clear. Second, a similar finding is that the baseline phase seemed to consist of emotional processing that was comparable to the second phase, involving a generally high arousal with an increase in experiencing but no significant change in symptoms. Third, the emotional intensity and the pain that most clients reported from using the two-chair dialogue intervention did not coincide with the fact that there was only a slight increase in arousal for this phase. Finally, on one hand, many clients reported quite aversive emotional experiences related to both going into and working with the intervention (painful, draining, intense), and on the other hand, they reported a reduction in their former symptoms. These comparisons will be discussed below.

4.2 Change in symptoms, not as much in process measures

The clients' self-reported reduction of the symptoms was significant after the introduction of the two-chair dialogue intervention, while the change in the process measures was less clear. Although not explicitly tested in this research project, it was an underlying assumption that the symptoms would be reduced as a result of

improved emotional processing. However, analyses shows that the symptoms were reduced in the phase were the two-chair dialogue was used, but there was no clear improvement in the emotional processing. There are two main possibilities that can account for such a discrepancy. One of them is that the observer ratings did not accurately pick up the client's emotional processes, for instance, due to lack of sensitivity in the rating scales or systematic rating errors. However, concerning sensitivity, since both scales have previously been found to detect the changes in the clients' processes (Boritz, Angus, Monette, Hollis-Walker, & Warwar, 2011; Missirlian et al., 2005; Pascual-Leone & Yeryomenko, 2016; Pos et al., 2017; Pos et al., 2003; Watson & Bedard, 2006), it is not likely that the scales lack sensitivity for detecting the processes in question. On the other hand, concerning systematic rating errors, it is would be possible that there were rating errors due to the lack of proper training of the raters, thereby leading to inaccurate rating. However, for this study, all raters had to show good interrater reliability with the pre-set "gold standard". The gold standard was set by two expert raters who developed the Client Emotional Arousal Scale III and who were highly familiar with the Experiencing Scale. Also, interrater reliability remained decent throughout the rating procedures. Therefore, if both these observations are taken into consideration, it is unlikely that these findings were a result of inaccurate measures or rating procedures.

Another major explanation could be that the reduction in symptoms was due to other processes than those identified by the Client Emotional Arousal Scale III and the Experiencing Scale, indicating that the change in symptoms could be better explained by other processes than arousal and experiencing. Previous research on EFT has related both arousal (Carryer & Greenberg, 2010; Missirlian et al., 2005; Pascual-Leone et al., 2016; Pos et al., 2017; Watson, 1996) and experiencing (Clarke & Greenberg, 1986; Greenberg & Clarke, 1979; Hendricks, 2009; Pascual-Leone & Yeryomenko, 2016; Pos et al., 2003) to symptom outcome. However, some of those studies were conducted on a larger sample size. It is possible that this study lacked the power to detect subtle but clinically relevant changes in the clients' processes. It is also possible that looking solely at arousal and experiencing is not a sufficiently

nuanced investigation. For instance, neither arousal or experiencing completely captures whether the client is particularly aware of visceral signals, whether they are accepting of such signals, or whether the expression relates to the most pertinent signals. Still, one could argue that experiencing is not possible without these processing constituents.

EFT theory suggests that adaptive emotional processing is characterized by more than arousal and experiencing. Two other aspects are also highly relevant. First, productive emotional processing is characterized by processing primary emotions, not secondary emotions (Greenberg & Paivio, 1997). Also, it is assumed that productive emotional processing happens in a specific sequence, where the client moves from secondary emotions, via primary maladaptive emotions, to adaptive emotions (Pascual-Leone & Greenberg, 2007). Although this sequencing does not happen in a linear fashion, research supports the notion of this kind of emotional processing sequence in a two-steps-forward, one-step-back-manner (Pascual-Leone, 2009). It is therefore possible that the analysis in this study was not fine-grained enough, or high-powered enough, to pick up other important emotional processes that would have given a clearer picture of the changes that occurred in the clients' processes.

As mentioned in the introduction, prior research has suggested elements in emotion processing that span across approaches, such as awareness of emotional signals, acceptance/allowance of emotions, and verbal expression of emotions. Even though the Experiencing Scale can be said to detect some of these elements, perhaps even more specific scales are needed to identify such data. Furthermore, if this assumption is right – that emotional processing comprises different elements – it might also be the case that different clients have different specific processing difficulties during therapy. For instance, one client might struggle with the awareness of bodily signals, while another might have a hard time with verbal symbolization of emotions. The results from both paper 1 and paper 2 suggest that the clients undergo varied changes as a result of the same intervention. There is a possibility that a better understanding

of the clients' emotional processing difficulty during therapy could help the therapist adjust the interventions to the clients' needs in more effective ways.

Another possible ground for the decrease in symptoms, without an equally clear increase in processing quality, might be different mechanisms than those specified in EFT. Other approaches suggest different change mechanisms than EFT, and it is possible that the reduction in symptoms could be better explained by other mechanisms. For instance, in classical cognitive therapy, one is interested in challenging the client's dysfunctional believes (Beck, 1979), and in the more recently developed meta-cognitive therapy, the focus is on helping the clients modify the manner in which they relate to their own thoughts (Wells et al., 2009). It is possible that the two-chair dialogue intervention, where the clients express their thoughts and feelings about themselves loudly to themselves before responding to them, might impact both their dysfunctional believes and their manner of relating to their own cognitions. From the qualitative interviews, some of the clients' highlighted the importance of realizing how they were treating themselves. This might indicate a change in the cognitive or meta-cognitive components.

It might also be the case that attentional processes, as suggested in both meta-cognitive approaches and mindfulness-based approaches, could explain the abatement in the symptoms. A common assumption in these approaches, is that training in attentional exercises (through becoming aware of ones' own thoughts and feelings and relating to them in less reactive and rigid ways) can lead to an enhancement in the ability to recognize and decenter from depressogenic processes. This might lead to a new meta-awareness and increased ability to treat one-self more compassionately and less harshly (van der Velden et al., 2015). It could be that such meta-cognitive mechanisms are active in the explanation of symptomatic change in the two-chair dialogue. For instance, it is possible that the process in this the two-chair intervention helps the client evoke depressogenic processes and decenter by viewing the process from another chair, thereby making it easier for the client to get in touch with a more compassionate perspective and empathy for the self.

4.3 Good processing in the baseline phase, but no change in symptoms

The rating of the clients' processes during the baseline phase, consisting of a generally high degree of arousal and an increase in experiencing throughout the phase, indicated good emotional processing. This means that the conditions during this phase (basic Rogerian conditions and attunement to affect) contributes to emotional arousal and contributes to helping the client to explore this arousal. Apart from a higher number of high-arousal episodes, no significant difference in emotional processing during the comparison of the two phases was found. Still, there was not a significant reduction of symptoms in the baseline phase, while in the phase which included the two-chair dialogue, a significant drop in the symptoms was observed. Apart from assumptions about the lack of reliability and validity of the measures, which is discussed in a later section, there are other possible explanations for this finding. One explanation is that the lack of abatement in symptoms in the baseline phase might simply be due to the fact that this was the initial phase. Methodologically, this is attempted to be dealt with by employing various lengths of baseline. No statistical differences were observed between the clients who had 5, 7 or 9 sessions of baseline treatment when the second phase of treatment was initiated, making it less likely that a lack of change in symptoms in the first phase was simply due to it being the former of the two. Nevertheless, it is possible that the emotional processing seen in the baseline phase somehow contributed to the change processes in the second phase. This would be in line with what is suggested in the EFT manual (Elliot et al., 2004) with regard to ensuring a safe therapeutic relationship before moving to the active processing. Perhaps, creating safety, finding a meaningful goal to work towards, and being empathically understood in this process involves an elevated emotional arousal and increase in experiencing, albeit not sufficient to cause much symptomatic change. If so, the two-chair dialogue, if combined with a safe therapeutic relationship, can be said to add to or accelerate the effect of the treatment. There might have been important process elements in place during the first phase, but only when other process elements were added during the second phase was the effect substantial enough to cause a significant drop in the symptoms of anxiety and

depression. Particularly, it seems like adding the two-chair dialogue contributed to a significant change on somatic-affective symptoms of depression and symptoms of anxiety. These findings coincide with EFT-theory, suggesting that although basic Rogerian conditions are necessary, the change processes can be further enhanced by facilitating emotional processing in a more direct manner. However, self-criticism and cognitive symptoms of depression are not as much affected by adding this intervention. It is possible that cognitive and self-critical elements require more time to change, but it is also possible that an even stronger focus on meaning making could accelerate changes in cognitive and self-critical elements.

4.4 Emotional intensity and pain, but not as much arousal

When asked about their experiences with the two-chair dialogue, almost all clients highlighted that the work was emotionally intense, either describing it as painful but useful, physically draining, or as too intense. Although the qualitative interviews did not explicitly focus on comparing the two-chair dialogue with the first treatment phase, most clients initiated a comparison by talking about an increase in emotional intensity after the introduction of the two-chair dialogue in therapy. Even though not explicitly tested in this project, we expected that the clients' experience of emotional intensity would also be detected by the Client Emotional Arousal Scale III. This was, however, not the case. A possible explanation for this discrepancy is that experiencing emotional intensity is not assumed to be identical to emotional arousal. Rating emotional arousal requires the rater to read the clients' external cues, typically their voice quality, body language, or facial expressions. Emotions, and thus emotional intensity, is, however, a subjective phenomenon that may not be directly perspicuous for an observer (Merleau-Ponty, 1969). This implies that objective ratings provide a data that is different from qualitative data, even when the same phenomenon is being studied. While objective ratings have the advantage of picking up cues that are not necessarily obvious to the client, qualitative interviews can provide researchers with data that cannot be observed by a rater. These two methods

of investigations can therefore supplement each other in the study of emotional qualities.

Another possibility is that the clients' experience of emotional intensity involves something more than just arousal. For instance, it is not unlikely that a moderate arousal with high awareness is experienced as more intense than high arousal with low awareness. Similarly, it is possible that emotional experiences are more intense if coupled with a congruent verbal expression. Yet another explanation suggests that the clients' referrals to emotional intensity might have been about a few, short-lasting moments or episodes rather than a general increase in emotional arousal. If so, this coincides with the fact that there were only a few more high-arousal episodes in the phase with the two-chair dialogue intervention, but an increase is not observed in the clients' arousal trajectories. It also coincides with the fact that episodes are often better remembered during activation of emotion (Labar, 2015). Again, a more nuanced or high-powered investigation might be needed to explore these postulations.

4.5 Emotionally awkward, painful and draining, but it reduces symptoms

Although not necessarily a discrepancy, it is interesting that most of the clients reported their experiences with the two-chair dialogue as awkward, emotionally painful, and intense, and at the same time, their self-reported symptoms subsided. At first sight, it might look like an oxymoron that aversive emotional experiences could coincide with a reduction in the symptoms of distress. However, this change, and thus symptom reduction, can also be seen as a result of processing painful emotions, as proposed in EFT theory. In EFT, one assumes that change, and thus the reduction in symptoms, is a result of processing painful emotions. More specifically, it is assumed that the client needs to activate and get in touch with maladaptive emotions in order to process and change them. As mentioned earlier, maladaptive emotions are assumed to stem from emotional injuries sustained in the past. Change, as proposed in EFT, therefore inevitably involves emotional pain and intense experiences, as this

assumedly makes previously learned emotional patterns more readily available for new correction and change.

The fact that the emotions, which the therapist is trying to help the client get in contact with, are painful might also shed light on the clients' reported experiences of hesitation or awkwardness about initial engagement in the intervention. Both in EFT and in other approaches working explicitly with emotional change processes, it is hypothesized that the clients often avoid painful emotions, even though it is therapeutic to get in touch with them (Abbass et al., 2013; Fosha, 2001; Greenberg, 2002; Monsen & Monsen, 1999; Vaillant, 1997). Thus, when the therapist suggests interventions that the client knows will involve emotional pain, it is reasonable to expect hesitation or reluctance on part of the clients. It might also be the case that overcoming this reluctance is crucial for change to occur. Reversely, not engaging in the interventions or not being able to overcome the reluctance might be associated with lack of change.

Even so, one could expect the access to emotional pain to lead to increased symptoms. For instance, it would be reasonable to expect that getting in touch with maladaptive shame that stems from experiences of being bullied or humiliated could lead to a temporary increase in symptoms indicating depression. This might of course be the case for some clients, but for this sample, working with the two-chair dialogue and experiencing it as intense and painful was at the same time associated with a decrease in symptoms. It is noteworthy that it was the symptoms of anxiety and somatic-affective aspects of depression that showed significant reduction. To a great extent, both these scales refer to psychological elements that imply bodily arousal. One interpretation of the fact that bodily arousal decreased while clients experienced more emotional pain is that avoiding painful emotions increases bodily arousal, while allowing or being receptive to painful emotions leads to a decrease in bodily arousal. This is in accordance with an increasing amount of research suggesting that staying in touch with ones emotions is related to mental health (Berghoff et al., 2017; Campbell-Sills et al., 2006; Duschek et al., 2017; Duschek et al., 2015; Ford et al.,

2017; Graham et al., 2008; Lavalekar et al., 2010; Niles et al., 2014; Roberton et al., 2015).

4.6 Methodological issues

4.6.1 Reliability

For paper 1, we used two observer rating scales. The raters were tested both against gold standard (needed to prove ICC > 0.6) and against their rating partner during the actual rating of material. ICC scores for the Client Emotional Arousal Scale III averaged at 0.8 (SD = 0.12), ranging from 0.48–0.97. For the Experiencing Scale, the ICC-scores averaged at 0.82 (SD = 0.09) and varied from 0.52–0.92. For paper 2, only well-known measures with good psychometric properties were employed. The FSCRS was translated from English to Norwegian, but internal consistency seemed to be good for the translated version, with Cronbach's alpha measured before treatment 0.89, that after baseline 0.90, and the value measured after treatment 0.90. Thus, no major reliability issues were encountered.

4.6.2 Validity and generalizability

In order to make inferences about internal validity in experimental designs, one has to show covariation between the dependent and the independent variables, prove that the change on the dependent variable comes after an alteration of the independent variable, and keep other conditions in the experiment stable (Shaughnessy, Zechmeister, & Zechmeister, 2009). Usually, a randomized controlled trial is used to ensure high internal validity in experimental designs. For the purpose of deducing whether the use of the two-chair dialogue intervention increased emotional processing and reduced symptoms, a multiple baseline design was applied (Kazdin, 2011). There are advantages and disadvantages with this design when it comes to internal validity. For instance, with the use of multiple lengths of baseline, one can alter the independent variable at different times and see if the dependent variable changes solely with change in the independent variable. This establishes whether there is a covariation and whether the dependent variable changes after the

independent variable. However, as this design has always changed the independent variable in a certain order – first the Rogerian conditions and then the two-chair dialogue – it is less clear whether the dependent variable changes due to the altering of the independent variable or due to passing of time. This could have been dealt with by altering the sequence in which the different conditions were administered or by taking into consideration one group where the dependent variable did not change. Several possibilities were considered for the same. The first option was eliminated due to ethical reasons, where introducing emotionally evocative interventions before establishing a relationship that felt safe could have had adverse effects on the clients. The second option, having a group where the dependent variable did not change, was rejected due to cost-benefit assessments. It is believed that using three different baselines, where the longest baseline was almost twice as long as the shortest, should suffice to draw inferences about whether the alteration of the independent variable co-varied and preceded a significant change on the dependent variable (Kazdin, 2011). Also, the chosen design ensured that all the clients received the intervention that was assumed to be beneficial.

External validity refers to the degree that findings from a study can be applied to individuals, settings or contexts that are not confined to the research setting (Shaughnessy et al., 2009). There are several aspects of external validity. First, if the setting in which the data was collected is similar to the setting in which the findings are meant to be generalized to, the external validity increases. In this study, the setting is naturalistic, indicating that the phenomenon in question is studied in the same setting as the one it is meant to be generalized to. However, a possible threat to the external validity in this project is the fact that the independent variable was subjected to experimental manipulation during treatment. After the assigned baseline period, the therapists were instructed to apply an intervention for five consecutive sessions. This is dissimilar to how EFT usually works, thus affecting the external validity. Normally, the therapist applies interventions based on the client's process markers and not on the number of passed sessions. This manipulation of the independent variable might have confounded both the therapists' and the clients'

processes. However, in a bargain between the external validity and sufficient manipulation of the independent variable, we chose to instruct the therapists to apply the intervention irrespective of the presence of a marker. This gave us the opportunity to test our research question by increasing the frequency of the intervention we wanted to investigate, but also at the expense of external validity, and thus possibly the degree of generalizability.

Another aspect of external validity that pertains to all three papers has to do with whether the clients in the study are representative to the population that might seek this kind of treatment. There are two major aspects about this population that might have an impact on the generalizability of the findings. First, a rather small sample size was used. Small sample sizes increase the risk of a sample that is non-representative to the general population. Also, the clients in this sample were not formally diagnosed, as the treatment program in which they took part did not require a formal diagnosis, thus making it more difficult to know for whom the findings might apply. However, the results could be generalized to the problem area of destructive self-criticism, regardless of formal diagnosis.

For paper 3, we used a qualitative methodology. Although quantitative methods try to rule out individual differences in order to find a mean value for a population, in our qualitative analysis in paper 3, we were interested in both the broad diversity of the participants' experiences and the commonality across the sample. This provided us with a possibility to comprehend our quantitative findings in a broader sense. Qualitative research should be evaluated with criteria that are appropriate for this method of investigation rather than according to the criteria developed for quantitative methods (Smith, Flowers, & Larkin, 2009). Stige, Malterud, & Midtgarden (2009) have suggested seven criteria to be used in evaluating qualitative methodologies. These are Engagement, Processing, Interpretation, Critique, Usefulness, Relevance and Ethics. The first three criteria are connected with the various forms of reflexivity in the research process. *Engagement* refers to the fact that the researcher in qualitative methods needs to be aware of the fact that he or she

interacts with the subject of investigation with preconceptions. In this study, it is particularly important to note that the main researcher was involved and engaged in a clinic that teaches EFT to other clinicians. Researcher allegiance thus becomes an issue. Partly, this was dealt with by employing co-researchers who were not involved in EFT and by excluding the main researcher from conducting interviews with the participants. The criterion *Processing, interpretation,* and *critique* has to do with the fact that the qualitative researcher is initiating, planning, analyzing, and interpreting the material in question and that this is being done with a preunderstanding. In this study, this was dealt with by aspiring to be reflexive regarding the context of the study, on the researchers possible preconceptions, and on how the analysis was conducted. For details, see the *Method* section and the *Researchers reflexivity* in paper 3. *Usefulness* is about "the impact of the qualitative study in relation to real-world problems in various ways" (p. 1511), while *Relevance* is about "how the study contributes to development of the involved discipline(s) or interdisciplinary field" (p. 1511). These two criteria are discussed under the section *Implications for clinical practice* and in the *Discussion,* where we compare the findings drawn from the qualitative and the quantitative studies. The final criterion, *Ethics*, encourages qualitative researchers to be highly aware of how their research impacts the participants, the population for which the study applies, and for the community at large. For this project, these concerns are covered under the section *Ethical considerations*.

4.7 Limitations and suggestions for future research

Methodologically, there are some limitations to the generalizability of the findings. Mainly, this has to do with low sample size and the manipulation of the therapeutic conditions. A larger sample size with a marker based application of the intervention would have improved generalizability. That is, studying the two-chair dialogue intervention when it naturally appeared in a treatment, rather than imposing the intervention regardless of markers. Also, to rule out the possibility that results were due to the sequence in which the interventions were administered – Rogerian

conditions, then the two-chair dialogue – one group of clients could have received Rogerian conditions throughout both phases.

A more nuanced investigation of emotional processes could have provided a clearer image of the discrepancy between the drop in symptoms and the rather small alteration in the emotional processing. Future research could investigate both the quality of emotional arousal (secondary/primary, adaptive/maladaptive) and the sequence in which the processing occurs. This would expound the work of other researchers (Auszra et al., 2013; Greenberg et al., 2007; Herrmann et al., 2016; Pascual-Leone, 2009; Pascual-Leone, Gillespie, Orr, & Harrington, 2015; Pascual-Leone et al., 2016). In addition, future research could take into account the clients' processing style or processing ability when starting therapy. By doing this, more can be learnt about how specific processing difficulties can be understood and overcome.

Future research could also look into the discrepancy between the clients' reports of emotional intensity and how it fits with emotional arousal. As the clients' reporting in this study is based on the interviews that took place weeks after the intervention, it might not have captured the nuances of the very moments that were intense and painful. As time passes, the recollection becomes more general and holistic. It is possible that investigating the clients' experiences right after the session would allow for a comparison of the qualitative experience and the observer rated process. For instance, one could use Interpersonal Process Recall (Elliot, 2010), where after the session, the researcher shows the client the taped session, stops the tape at points of interest, and questions the client about their experience.

In this study, we did not enquire into or measure the clients' process between sessions. It is plausible that emotional processing is either enhanced or hindered by what transpires between the sessions. For instance, some clients might need relational support to continue their processing of difficult emotions between sessions, while others might need distractions or help to step out of this process for optimal processing. Also, life circumstances or incidents that occur between sessions might

be crucial for the clients' ability to deal with the processes brought up in therapy. Between-session aspects could be included as possible mediators or moderator for the outcome.

4.8 Implications for clinical practice

Results from this study suggest that adding the two-chair dialogue to basic Rogerian conditions and empathic attunement to affect is an effective method for abating the symptoms of common mental health conditions. Both the Rogerian conditions alone and the addition of the two-chair dialogue help the client to activate, make sense of, and symbolize their emotions in a meaningful manner. However, the addition of the two-chair dialogue is associated with increased high-arousal episodes. As it is important that the clients engage actively in the suggested interventions, clinicians using this method should pay special attention to the fact that the intervention might be considered as awkward or at least view it as an obstacle that has to be overcome. It is likely that many clients will benefit from therapy in overcoming their tendency to avoid confrontations with painful emotions. It is plausible that this intervention provides a structure to overcome experiential avoidance, but the threat that is embedded within an experiential approach toward emotional pain means that the therapist should empathize and support the client during this particular part of the process. As the intervention is emotionally intense and most likely brings to the surface painful emotions, special attention should be paid to the working alliance and the clients' feelings of safety, not only in the initial engagement, but throughout the process. Also, it seems like the evocativeness of the intervention leads some clients to feel confused or concerned after the sessions. When therapists are successful in helping clients get in touch with intense emotions through two-chair dialogue interventions, they should save some time at the end of sessions to help the clients make sense of their experiences during the intervention and provide a meaningful framework for understanding how these experiences may be relevant to address the client's current problems. In addition, therapists should help the clients become better aware of what they might need right after the session and how to take care of

themselves between sessions in the best possible manner. This is particularly important, since it is possible that some clients are in too fragile a state to utilize and make sense of this intervention. A good assessment of the client's existing ability to utilize emotionally evocative interventions becomes important. Finally, as the intervention seems particularly effective on symptoms that involve bodily arousal, therapists could also help the clients prepare for this by providing proper psychoeducation about the impact of the intervention.

It is also noteworthy that the program from which the participants were recruited was aimed at reducing the need for sick leave. It is a possibility that for some participants, using these emotionally evocative techniques might lead to a temporary increase in distress and a decrease in their ability to function at the work place. In such cases, the therapists should assess the client's need for balancing emotional processing with functioning at work. It might also be of importance to strengthen the client's repertoire for dealing with increased distress between multiple sessions.

5. Conclusion

The aim of this dissertation was to investigate and explore the impact of a psychotherapeutic intervention – the two-chair dialogue intervention – designed to help clients with common mental health difficulties to process problematic emotions related to destructive self-criticism in a more effective manner. The research project investigated the impact of adding the two-chair dialogue intervention to basic Rogerian conditions and empathic attunement to affect on the following: 1) the clients' emotional processing (arousal and experiencing), 2) the clients' symptoms of anxiety, depression and self-criticism, and their 3) experience of using the two-chair dialogue intervention. The participants were all selected due to the fact that they displayed destructive self-criticism and showed symptoms of anxiety and depression. For the purpose of answering research question 1 and 2, we utilized a multiple baseline design. This allowed us to introduce the two-chair dialogue intervention at different times. In the first phase, the therapist focused on alliance building, empathic attunement to affect, and therapeutic presence and genuineness. In the second phase, the two-chair dialogue intervention was added to these conditions. We then investigate whether the intervention had a significant impact on the quality of the clients' emotional processing and on their symptom levels.

In paper 1, we found that emotional arousal was high throughout both phases and that the second phase contained a significantly higher number of high-arousal episodes as compared to the first phase. The clients' depth of experience increased throughout both phases. However, contrary to our expectations, adding the two-chair dialogue to the basic Rogerian conditions did not lead to a significant increase in experiencing. Emotional processing in the second phase thus showed a smaller alteration than what we had expected, perhaps due to an already substantial processing quality in the first phase. This indicates that both the phase with basic Rogerian conditions and the phase were the two-chair dialogue was added, contributes positively to clients ability to activate, attend to and appraise their emotions.

In paper 2, we found that the clients' symptoms of anxiety and depression were significantly reduced. Taking a close look at the symptoms of depression, we deduced that it was particularly the somatic-affective components that accounted for this change. Contrary to our expectations, destructive self-criticism was not reduced significantly more after adding the two-chair dialogue. However, destructive self-criticism was reduced throughout the entire treatment, indicating that the basic Rogerian conditions in the baseline phase were as effective in reducing symptoms as the phase with the two-chair dialogue.

Paper 3 explored the clients' experiences with the two-chair dialogue. Their experiences were captured in three main themes that were named; *Talking to a chair: An obstacle to overcome; Heavy, intense, horrendous, and nice; and Realization - What am I doing to myself?* It thus seems like the clients found it difficult to overcome the awkwardness of talking to oneself in an empty chair. However, once they were engaged in the intervention, it was perceived as an emotionally intense, draining, but also helpful experience. They also reported that using the intervention changed the manner in which they understood or related to certain parts of themselves, for instance, by realizing the harshness of their self-criticism.

The findings in this dissertation suggest that the two-chair dialogue intervention is an effective way of helping self-critical clients become less anxious and less depressed. It is less clear how the intervention impacts clients' emotional processes, but the clients' emotional arousal and depth of experience throughout the entire therapy process suggests that both basic Rogerian conditions and the two-chair dialogue intervention were effective in helping clients' process painful and distressing emotions. A more nuanced investigation of the clients' emotional processes during this intervention seems required. A better understanding of how different clients might need somewhat different process facilitation at different times, might also lead to a more detailed guideline for the therapists to help clients process difficult emotions using the two-chair dialogue intervention.

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Paper I

Stiegler, J. R., Molde, H., & Schanche, E. (Submitted). *Does the two-chair dialogue intervention facilitate processing of emotions more efficiently than basic Rogerian conditions?*

Does the two-chair dialogue intervention facilitate processing of emotions more efficiently than basic Rogerian conditions?

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Abstract

Processing of difficult emotions is assumed to be of importance in therapeutic change. In this study we examined whether the use of a two chair dialogue as used in Emotion-Focused Therapy (EFT), was associated with a change in emotional processing, comprising emotional arousal and emotional experiencing. In a multiple baseline design, 20 clients in treatment for depression or anxiety first received 5, 7 or 9 weekly sessions of baseline treatment resembling basic Rogerian conditions. In the second phase, the two-chair dialogue intervention was added for 5 consecutive sessions. All sessions where rated using The Client Emotional Arousal Scale III and The Experiencing Scale. Analysis indicated that there was a significantly higher number of high-arousal episodes in the active component phase, but the individual clients' change trajectory was not significantly steeper in the second phase. Experiencing increased continuously throughout both phases of treatment. However, the change trajectory after introducing the two-chair dialogue was not significantly steeper than for the baseline phase. These findings suggest that both the two-chair dialogue and basic Rogerian condition, is effective in facilitating emotional processing. The two-chair dialogue is confirmed as an emotionally evocative intervention. Implications and limitations are discussed.

Keywords:

emotional processing, Emotion-Focused Therapy, emotional arousal, experiencing, two-chair dialogue

Introduction

There is an increasing amount of support for the notion that emotional processing is an important trans-diagnostic change mechanism in psychotherapy (Campbell-Sills & Barlow, 2007; Castonguay & Hill, 2012; Diener, Hilsenroth, & Weinberger, 2007; Kramer, Pascual-Leone, Despland, & de Roten, 2015; Town, Salvadori, Falkenström, Bradley, & Hardy, 2017; Whelton, 2004). Emotional processing is often defined as comprising the following components; activating emotions, becoming aware of emotions, allowing emotions and symbolizing emotions (Coughlin Della Selva, 2006; Foa & Kozak, 1986; Greenberg, 2012; Monsen & Monsen, 1999). Within several psychotherapeutic theories there is a prevailing view that problematic life events has the potential to hinder healthy emotional processing, and thereby creating enduring symptoms of psychological distress (Abbass & Town, 2013; Barlow, Allen, & Choate, 2004; Fosha, 2001; Greenberg, 2002; Thoma & McKay, 2015). Different theoretical approaches specify interventions that are meant to help clients overcome difficulties in processing emotions. It is of interest to figure out whether such emotionally focused interventions are successful in facilitating emotional processes in accordance with what is theoretically expected.

Emotion-Focused Therapy (EFT) is one psychotherapeutic approach where emotional processing is assumed to be the one of the main mechanism of change (Greenberg & Watson, 2006a). EFT-theory suggests several necessary steps in a successful therapeutic change process. Firstly, emotional processing can only be facilitated within a safe therapeutic alliance where the therapist empathically explores and validates the client's process. When such conditions are provided, particularly two basic aspects of emotional processing are considered to be of particular importance for emotional change to occur. Firstly, emotions needs to be aroused, and secondly the client needs to experience the arousal in an attentive manner that leads to an adaptive appraisal of the emotion (Greenberg & Bolger, 2001; Greenberg & Watson, 2006b). For the purpose of this study, an attentive and adaptive appraisal of an emotion will be referred to as experiencing (Gendlin, 1962). Furthermore, it is assumed within EFT that emotional processing happens in a nonlinear manner, moving between productive and unproductive emotion states (Pascual-Leone, 2009), towards a gradually less distressing state (Pascual-Leone & Greenberg, 2007). Such emotional processing can be enhanced by specific interventions designed for this purpose (Greenberg & Paivio, 1997).

A few studies have investigated emotional arousal in the course of EFT. In a study by Missirlian, Toukmanian, Warwar, and Greenberg (2005) results indicated that emotional arousal during the middle phase of psychotherapy was of particular importance. Another study suggested that emotions needs to be aroused for about 25 % of the time, and that both too much and too little arousal is less productive (Carryer & Greenberg, 2010). One example of a productive effect of emotional arousal is its contributions in resolving relational injuries (Greenberg & Malcolm, 2002). The importance of emotional arousal has also been found in other approaches to psychotherapy (Diener & Hilsenroth, 2009; McLean, Asnaani, & Foa, 2015; Whelton, 2004). However, a couple of other studies suggests that it is not emotional arousal in itself, but rather the productive nature of this arousal, that is of importance (Auszra, Greenberg, & Herrmann, 2013; Greenberg, Auszra, & Herrmann, 2007). In addition to emotional arousal, the way in which clients appraise their emotions is also thought to be of central importance in EFT (Angus & Greenberg, 2011). The manner of appraisal is commonly measured with The Experiencing Scale (Klein, Kiesler, & Coughlan, 1969). In line with previous research on the importance of experiencing (Hendricks, 2009), a recent meta-analysis by Pascual-Leone and Yeryomenko (2016) concludes that experiencing is an important predictor of psychotherapeutic outcome, regardless of psychotherapeutic approach.

One central EFT-intervention that is designed to increase emotional arousal and deepen experiencing, is a technique called the two-chair dialogue. This intervention is thought to be of particular help when clients display problematic ways of treating themselves, such as being self-critical (Shahar et al., 2012; Watson & Greenberg, 1996). The two-chair dialogue is an imaginative technique where the goal is to help the clients resolve emotional conflicts that are contributing to self-criticism and feelings of being inadequate. This is done by introducing two chairs which represent different parts of the client´s own self. In one chair, the client is asked to criticize him or herself, and the goal is to activate and arouse maladaptive feelings related to the criticism (most often shame). In the experiencing chair, the therapist tries to help the client become aware of the aroused maladaptive emotion, and to symbolize and express the emotional arousal. Then, the therapist tries to facilitate adaptive emotions (for instance anger) in order to transform the maladaptive emotion. This sequencing of emotional processes, from global distress to more differentiated use of emotions, has been demonstrated as effective processing of emotional difficulties (Pascual-Leone & Greenberg, 2007).

Emotional processing, in the form of emotional arousal and experiencing, is assumed to be the central route to facilitating change in EFT. In training of EFT-therapists, much focusing is therefore given to master the two-chair dialogue intervention. Both EFT in general (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998; Paivio & Greenberg, 1995; Paivio, Jarry, Chagigiorgis, Hall, & Ralston, 2010) and the two-chair dialogue in particular (Greenberg & Dompierre, 1981; Greenberg & Webster, 1982; Stiegler, Schanche, & Molde, 2017) has previously been shown to reduce symptoms of distress, more so than empathic attunement to affect as a specific psychotherapeutic method. Greenberg and Clarke (1979) found that the two-chair dialogue was associated with higher degrees of experiencing compared to empathic responses from the counselor. In comparing the two-chair dialogue to a cognitive-behavioral counseling intervention, the two-chair dialogue was also favored when it came to making difficult decisions (Clarke & Greenberg, 1986). The two-chair dialogue intervention has also been proven effective in enhancing self-compassion (Sager & Sherry, 2005). In a study by Bohart (1977) chair work was associated with reduction of anger, hostility and aggression. There is a need to further investigate if and how the two-chair dialogue effects emotional processing in a psychotherapeutic setting. Studies have yet not been conducted to investigate whether the two-chair dialogue in itself actually facilitates emotional arousal and experiencing more so than an approach solely based on basic Rogerian conditions.

Hypothesis

In the present study, we wanted to explore whether the two-chair dialogue intervention was associated with two central aspects of emotional processing, that is, emotional arousal, and the clients' ability to attentively appraise such arousal, ie experiencing. We expected that adding the two-chair dialogue to a baseline of therapy based on basic Rogerian conditions would result in a significantly higher level of clients' arousal and experiencing. More specifically our hypotheses were that the active component phase where the therapist utilized the two-chair dialogue intervention would;

1. lead to an increase in high-arousal episodes, and lead to a steeper growth curve in the clients' measured arousal, and
2. lead to an increase in high-experiencing episodes, and lead to a steeper growth curve in the clients' measured experiencing.

Method

Procedures

In order to investigate whether the two-chair dialogue had an impact on clients emotional processing, a multiple baseline design was utilized. This design allows us to administer the specified intervention at different times for different clients. Thus, we could investigate whether clients emotional processing changed when – and only when – the intervention was introduced. If so, the change is more likely to be attributed to the intervention (Kazdin, 2011). The treatments were thus comprised of two phases for each client. In the first phase, 1/3 of the clients received 5 sessions, 1/3 got 7 sessions and 1/3 got 9 sessions. In the latter phase all clients got 5 sessions. This means that the clients in this study got either 10, 12 or 14 sessions. This allowed us to compare emotional processes between the two phases by 1) counting the number of episodes with high level of arousal and experiencing, and 2) investigating and comparing the clients' change trajectory within both phases. First, each client went through a baseline phase consisting of basic Rogerian conditions with an added specific focus on empathically attuning to affect. All though these conditions are thought to be effective in alleviating distress, it is assumed within EFT that the two-chair dialogue will provide a more effective structure for processing emotions. Therefore, in the baseline phase, the therapists were instructed not to use chair-work interventions. Clients where assigned to baseline-lengths of either 5, 7 or 9 sessions. Then, in the second active component phase, the therapists were instructed to use the two-chair dialogue for five consecutive sessions. The therapist instruction for the two-chair dialogue was in line with Greenberg and Watson (2006a). However, in EFT one uses these interventions when the therapist assesses that the client is in a self-critical state. This was not the case for this study. Instead, the clients were selected on the base of being highly self-critical. So that in the second phase, the therapist introduced the theme of self-criticism and suggested working on the self-criticism using the two-chair dialogue. Thus, the initiation of the intervention was different from what is usually prescribed in EFT. For further details about procedures, see (REMOVED FOR ANONYMOUS PEER REVIEW) for details.

Informed consent was obtained from all individual participants included in the study. The study was preapproved by the (REMOVED FOR ANONYMOUS PEER REVIEW).

Participants

Twenty-four clients were recruited from a (REMOVED FOR ANONYMOUS PEER REVIEW) public treatment program called Return to Work (RTW). The RTW-program is a time limited treatment program (maximum 18 weeks) for people who are on sick leave due to common mental health issues, such as depression and anxiety. People with severe mental health issues are not referred to the program, nor are people who are out of work. Those referred are screened using a clinical interview. An experienced clinical psychologist screens interviews those referred in order to rule out severe psychopathology, severe substance abuse or people who are not motivated for an intensive short-term treatment. In addition to being eligible for treatment in the program, the recruited participants for this study also had to have symptoms in the clinical range on either depression or anxiety as measured by BDI-II (Beck, Steer, & Brown, 1996) and BAI (Beck et al., 1988). Also, they had to be moderate to high on self-criticism, since the two-chair dialogue is directed at different forms of self-criticism, self-blame or self-attack. We used the subscale *Inadequate Self* from The Forms of Self-Criticising/attacking & Self-Reassuring Scale (Gilbert, Clarke, Hempel, Miles, & Irons, 2004) to screen for self-criticism. Exclusion criteria were 1) not eligible for treatment in the RTW-program, 2) not symptoms of anxiety or depression within the clinical range, and 3) cut off below 23 on the subscale *Inadequate Self* . This cut of was based on an established cut of in previous study on the FSCRS scale (Baião, Gilbert, McEwan, & Carvalho, 2015).

Ninety-eight people were referred to RTW by their GP's during the 6 weeks of recruitment. Sixty-four were considered eligible for treatment, out of which 36 agreed to take part in the study. Of those who declined, most gave the reason that they were uncomfortable with having their sessions video-recorded. As taping of therapy sessions in [removed] is still quite uncommon, the number of clients who declined was not surprisingly high. Thirty-six were further screened and 24 met the inclusion criteria for the study and were enrolled in the study. Three clients dropped out (2 clients abruptly ended treatment, 1 client reported feeling better and was therefore not motivated), and for one client the recordings were without sound due to technical issues. Thus, 20 treatments were recorded, 14 women and 6 men. Age ranged from 20-63, with a mean of 38.

Therapists and Therapist Training

Six clinical psychologists provided the treatment. The therapists had 5-13 years of experience (mean, 9,2). Two therapists were male, 4 were female. They had minimum 300 hours of

training over minimum three years, and at minimum 20 hours of supervision with an experienced EFT trainer. The training in EFT involves fundamental Rogerian conditions as well as specific training on attunement to affect and active interventions like the two-chair dialogue intervention. Thus, both phases of treatment consisted of conditions in which the therapists were sufficiently trained.

Process Measures

The Client Emotional Arousal Scale III (Warwar & Greenberg, 1999) is a scale used to assess the degree of the clients' emotional arousal. On a scale from 1 – 7, where 1 is no expression of emotion and 7 is extremely intense expression, raters assess the emotional arousal based on degree of activation by analyzing the clients' voice quality and body language. Voice quality refers to accentuation pattern, pace, contours and speech disruption. Body language refers to emotional facial expressions and bodily action tendencies typically associated with emotional activation. At level 4, it is assumed that the client reaches a clinically significant level of arousal. Increase in emotional arousal as measured by The Client Emotional Arousal Scale III has formerly been associated with good outcome (Missirlian et al., 2005; Pos, Greenberg, & Warwar, 2009).

The Experiencing Scale (Klein et al., 1969) is a scale designed to evaluate to what degree the client is able to stay in touch with and symbolize their internal experience in psychotherapy. By analyzing how the client verbalize their experience, the manner rather than the content, one can derive the clients' ability to process and integrate the content of the emotional state. The scale describes 7 levels of involvement with inner experience, where 1 is objective and intellectual, and 7 is a shift to being in touch with and exploring the emotional experience rather than talking *about* experience through an external description of events. High experiencing also comprises a new understanding of oneself. At level 1, the client speaks about something abstract or not directly relevant to their experience. At level 2/3, the client starts to refer to their inner world, but not speak from their internal world. At level 4, the client speaks about his emotional experience. Level 5-7 describes different levels of talking about their inner experience in a fresh and explorative manner. The Experiencing Scale assumes a clinically significant productive shift once the client reaches level 4. Here, the client shifts to start talking *from* his fluid experience rather than talking *about* his experience as an external description of events. Increase in experiencing as measured by this scale has

formerly been related to good outcome in psychotherapy (McLeod, 1997; Pascual-Leone & Yeryomenko, 2016; Pos, Greenberg, Goldman, & Korman, 2003; Stiles, Shapiro, & Elliott, 1986).

Ratings

To rate the video-recorded material, 31 undergraduate psychology students were recruited from the psychology program at [removed]. The students received 21 hours of training in how to observe and rate emotional processes in psychotherapy, using The Client Emotional Arousal Scale III (Warwar & Greenberg, 1999), and The Experiencing Scale (Klein et al., 1969). The training consisted of both didactics and practical exercises where they rated tapes of therapeutic processes. Each rater had to show acceptable interrater reliability (ICC > 0,61) (Shrout & Fleiss, 1979) set against a gold standard, before they were allowed to start coding the material. The gold standard was set by the developers of the Client Emotional Arousal Scale (Warwar & Greenberg, 1999). The rating of the material was conducted in a recently established rating laboratory at [removed]. Using the The Observer® XT software, all sessions were divided into two-minute segments, and each segment was rated using both scales. In order to ensure that raters rated the same emotion category, they were instructed to first specify which category of emotions where being rated (sadness, anger, fear, shame, positive emotions, fused anger/sadness or fused fear/sadness). Raters were asked to code emotion episodes based on action tendencies, words describing an action tendency or words describing an emotional reaction (Warwar & Greenberg, 1999). If the raters disagreed on emotion category, we used the rating from the rater who was closest to the gold standard. Interrater reliability for the participating students was acceptable (average ICC for arousal was 0.70, and for experiencing 0,78).

For each client, two raters coded 2/3 of all sessions, making sure there was a 1/3 overlap to account for interrater reliability. ICC-scores for The Client Emotional Arousal Scale III averaged at 0.8 (SD=0,12), ranging from 0,48 – 0,97. For The Experiencing Scale, the ICC-scores averaged at 0.82 (SD=0,09) and varied from 0,52 – 0,92. The rating of the material was done over a period of 7 months. During this period the main researcher checked interrater reliability in order to prevent the raters from drifting, that is, diverging from the fellow student whom rated overlapping sessions. If there was a tendency to drift, the main researcher met with the raters in question and helped them adjust for further rating. For all segments where

the raters diverged, the average of the two values was used. In cases where one rater had 'no data' and the other rater had a rating, a decision was made to use the value from the one who did rate the segment.

For each of the measures, we were interested in clinically relevant changes in the processing of emotions. We therefore used two ways of calculating both experiencing and arousal. First, we wanted to see if peak arousal and peak experiencing changed from before till after the two-chair dialogue was introduced. Secondly, as both scales have a clinically relevant change at level 4, we wanted to see if there was an increase in segments where clients reached a 4 or above after the two-chair dialogue was introduced.

Adherence

In order to make sure therapists adhered to prescribed treatment in the two different phases, the following measures were taken; video recordings from both phases were randomly chosen for inspection; the Working Alliance Inventory, short version, for patients (WAI-S-P) was administered before each session detect differences in the alliance between phases; therapists completed a questionnaire after each session where they could report deviances. A few deviations were recorded; two clients had 6 rather than 7 sessions in the baseline phase. In two sessions, two different clients did not engage in the two-chair dialogue as the therapist chose to focus on the clients' more pressing matters. Deviations where handled as missing data. See (REMOVED FOR ANONYMOUS PEER REVIEW) for details.

Statistical Analyses

Two separate tests were applied to detect differences between the phases. First, we compared number of high arousal/high experiencing episodes in the two different phases using all the clients as a group. In order to test whether the phase containing the two-chair dialogue was associated with more frequent high-arousal and high-experiencing episodes, we performed analysis using dummy scores where level 1-3 of arousal/experiencing was scored "1", and level 4-7 was scored "2". We then ran an ANOVA.

Secondly, we wanted to compare the clients' change trajectory in the two different phases. These statistical analysis was conducted using R (Team, 2016). In the analysis, measurement occasions (time) were nested within individuals. In order to investigate whether the rate of

change in the trajectory was significant in either the baseline phase or the active component phase for the dependent variables arousal or experiencing, we analyzed a multivariate two-level piecewise hierarchical linear growth model. This allowed us to compare growth rates during two different time periods. Using a multivariate model with two related outcomes, the power is increased in comparison with the use of two independent univariate models (Baldwin, Imel, Braithwaite & Atkins, 2014). Furthermore, as we were not interested in between individual variation in effects, no person moderators at Level 2 were included in as predictors. In the multivariate model, the values for arousal and experiencing are combined into a single dependent variable, Y_{hij}, where h indexes the specific outcome variable. Setting up the model, we used two indicator variables, d_j and q_j, where d_j =1 for arousal and 0 for experiencing, and q_j = 1 for experiencing and 0 for arousal. Thus, for both outcomes. Hence, for each outcome, within subject change over time at Level 1 was modeled by the equation $Yti = \beta 0i + \beta 1iX1ti + \beta 2iX2ti + eti$. $\beta 0$ is the intercept or initial status pre-treatment. $\beta 1i + \beta 2i$ represent the growth rate (slope) in the relationship conditions alone (baseline phase) and the active component phase, respectively. Fixed effects are a mean value or constant for all participants (group average), while random effects are scores varying across participants (or individual deviations from a fixed effect). Using linear tests, the slope of the baseline was tested against the slope of the active component phase, in order to test if they were significantly different from each other. Due to the low sample size, only random intercept, fixed slope models was applied, using a restricted maximum likelihood estimator (REML). The model building procedure followed the one described by (Baldwin, Imel, Braithwaite & Atkins, 2014).

Fitting the models, the level-1 residuals were inspected for normality (e.g. using qq-plots). All residuals were normal distributed. Hence, the distributional assumptions of the models seem to be fulfilled.

Results

Table 1 shows mean and mode values for experiencing and arousal.

Comparison of the two phases revealed a significant difference score for Arousal ($M(1) = -0.34$, $SD=0.027$; $M(2)= 0.25$, $SD=0.018$, $F=11.9$, $p < .05$), but not for Experiencing. Thus, comparing segments in the two phases, analysis suggests that there are significantly more

segments with high arousal in the active component phase compared to the baseline phase, but not so for experiencing. It thus looks like both phases are effective facilitating emotional processing.

The multivariate model presented is a random intercept, fixed slope model, meaning that the baseline score were free to vary across the participants, while the slope is a mean average estimate. For the dependent variable "arousal 4 or above", the random intercept in the model was 8.32 (SE=0.98), with a nonsignificant fixed slope for the baseline phase ($\beta 1i = 0.26$, $p > .05$) and also a nonsignificant fixed slope for the active component phase ($\beta 1i = 0.11$, $p > 0.05$).

For the dependent variable "Experiencing 4 or above", the random intercept was 12.9 (SE=1.19), with a significant fixed slope for the baseline phase ($\beta 1i = 0.52$, $p < 0.001$) and also a significant fixed slope for the active component phase ($\beta 1i = 0.94$, $p < 0.001$). Testing the baseline slope versus the active component phase slope for Experiencing 4+, the difference was nonsignificant (diff= -0.40, $p = 0.25$). See table 2 for details.

For the dependent variable "arousal peak", the random intercept in model was 4.82 (SE=0.17), with a nonsignificant fixed slope for the baseline phase ($\beta 1i = 0.03$, $p > .05$), and also a nonsignificant fixed slope for the active component phase ($\beta 1i = 0.011$, $p > 0.05$). For the dependent variable "experiencing peak", the random intercept in model was 5.09 (SE=0.13), with a significant fixed slope for the baseline phase ($\beta 1i = 0.07$, $p < 0.001$) and also a significant fixed slope for the active component phase ($\beta 1i = 0.13$, $p < 0.007$). Testing the baseline slope versus the active component phase slope for Experiencing peak, the difference was nonsignificant (diff= -0.058, $p = 0.27$). See table 3 for details.

We also modelled the change in WAI-S-P for adherence purposes. For the bond component of WAI-S-P we found a nonsignificant fixed slope for the baseline phase ($\beta 1i = -.05$, $p > .05$) and for the active component phase ($\beta 2i = .18$, $p > .05$). This was also the case when we only used time as a predictor for change ($\beta 1i = .06$, $p > .05$).

Discussion

The present study investigated whether a two-chair dialogue intervention contributed to a higher level of emotional processing than therapy comprising fundamental Rogerian conditions. More specifically, we investigated whether the two-chair intervention was associated with an increase in emotional arousal and experiencing. Regarding our first hypothesis, results indicate that the phase with the two-chair dialogue intervention was associated with more frequent high-arousal episodes then what was seen in the baseline phase. This implies that the two-chair dialogue intervention might be more emotionally evocative than fundamental Rogerian conditions. However, comparing the change trajectory for peak and mean arousal in each phase, no significant increase was found after introducing the two-chair dialogue. Also, within each phase, emotional arousal did not significantly increase. Our first hypothesis was therefore only partially supported by the fact that there were more episodes with high arousal, but results suggest caution in attributing the change in arousal to the intervention.

As the two-chair dialogue work intervention is assumed to be emotionally evocative (Paivio & Greenberg, 1995), we were somewhat surprised not to see a clearer increase in clients' arousal after introducing the two-chair dialogue intervention. One possible explanation is that the basic Rogerian conditions in the baseline phase proved to be more efficient in producing emotional arousal than expected. In the baseline phase, the therapists were instructed to empathically attune to the clients affect in an accepting and caring manner. As table 1 suggests, the mean level of arousal in the baseline phase was already moderately elevated at 3,27. After introducing the two-chair dialogue, the mean level of arousal rose to 3,54. At level 3, arousal is considered to be mild and in a manner where the client allows the arousal with restriction. A level 4, is considered a moderate arousal that is somewhat restricted (Warwar & Greenberg, 1999). Thus, there was a substantial amount of high arousal (4 or higher) throughout both phases. For the clients in this study, the conditions constituting the baseline phase, seems to have been sufficient to facilitate emotional processes. This finding is in line with previous research suggesting that being empathically understood by a therapist is associated with productive processes in psychotherapy (Elliott, Bohart, Watson, & Greenberg, 2011; Watson, Steckley, & McMullen, 2014). In light of the evocative nature of the baseline phase, the design might have lacked sufficient power to detect possible differences in arousal between the two phases.

It is also possible that a clearer detection of differences between the phases would require a more finely tuned analysis of the emotional processes. Theoretically, it is assumed that clients do not have to stay in high emotional arousal for very long in order to process emotions. A study by Kramer et al. (2015) suggests that even very short episodes of emotional arousal might have significant clinical value. Based on findings by Carryer and Greenberg (2010), it might not be necessary with a large increase in amount of high arousal in order to produce significant clinical change. For this study, this assumption is supported by the fact that there were more frequent high-arousal segments during the active component phase. Also, the clients in this study did show a significant decrease in symptoms after the introduction of the two-chair dialogue intervention (Stiegler et al., 2017), suggesting that the therapeutic processes might have changed with the intervention. It is therefore possible that a rather small increase in high-arousal segments might have been of clinical significance. However, it is also possible that the increased number of high arousal episodes could be due to the fact that this phase came at a later stage in the treatment, making clients more prone to allow emotional expression.

Regarding our second hypothesis, we found that the active component phase was not associated with more frequent high-experiencing segments than the baseline phase. Also, comparing the clients' change trajectory in each phase, we did not find a significant steeper trajectory after introducing the chair work. However, the growth curve for level of experiencing increased throughout both phases. This suggests that therapy based on both basic Rogerian conditions and an addition of the two-chair dialogue intervention, were successful in increasing the clients' ability to experience and appraise their emotions in an attentive manner. As the baseline phase proved to be as effective in increasing experiencing, it might be the case that this study lacked power to detect a change in the clients' trajectories after introducing the two-chair dialogue intervention. Previous research has previously demonstrated that this intervention is effective in furthering emotional processing (Goldman et al., 2006; Greenberg, 1980; Greenberg & Clarke, 1979; Greenberg & Dompierre, 1981; Greenberg & Watson, 1998; Paivio & Greenberg, 1995; Pos & Greenberg, 2012).

The results in the present study suggest that both therapy based on basic Rogerian conditions (empathic attunement to affect) and therapy adding the two-chair dialogue intervention to these conditions, helps clients to explore and make sense of their experience. It is not surprising to see that empathically attuning to affect within a good therapeutic alliance can

enhance emotional processing. This is in line with theories that point to the importance of being empathically understood in order to help the clients explore and make sense of their inner processes (Barrett-Lennard, 1997; Rogers, 1961; Watson et al., 2014). Also, there is an increasing amount of research stressing the importance of empathic attunement within a good alliance when it comes to producing psychotherapeutic change (Bohart, Elliott, Greenberg, & Watson, 2002; Castonguay, Constantino, & Holtforth, 2006; Elliott, Greenberg, Watson, Timulak, & Freire, 2013; Horvath & Symonds, 1991; Watson et al., 2014). However, it is also possible that the results are due to a type II error. When the conditions in the two phases was compared as entire treatments, results favored the condition with active chair-work. The artificiality that the design imposed on the treatment, while retaining internal validity, might have impacted the very process that was being studied.

Even though the findings in our study does not support our hypothesis, the second phase lead to an increase in experiencing across sessions, albeit not significantly more than in the first phase. Also, the second phase had more frequent high-arousal episodes. This suggests that the two-chair dialogue intervention is a useful tool for this aspect of emotional processing. The two-chair dialogue intervention invites clients to do or say to themselves explicitly what is habitually being done on the inside. This externalizing of an intrinsic process has the potential to help clients become aware of what they do to influence their emotional reactions. For instance, the clients can become more aware of how they criticizes themselves and the effect of this critique. By overtly expressing self-criticism the clients can also discover in a novel manner how they contribute to feelings of shame and inadequacy. This is in line with the intention of this Gestalt-derived intervention (Perls, 1969). On a similar note, it could be that the resolution of an internal conflict between different parts of the self leads to deeper experiencing, as suggested in a study by (Greenberg, 1980). The two-chair dialogue might also provide a more useful narrative structure, where one part of the self, acts and responds to another part of the self. Instead of simply feeling bad, the clients might discover that their feelings are consequences of a repetitive sequence of actions. Furthermore, realizing that one is an active agent, might render the client accessible to explore experience.

A possible confounding factor in this study is the artificiality of instructing the therapists to not intervene in a certain manner for the first phase, and instruct them to use only one particular intervention in the second phase. First of all, it excludes other relevant interventions that might have been beneficial for the clients' processes. Secondly, the instructions might

have impacted the therapists presence and intuition. Finally, it violates the assumption in EFT that it is beneficial for the client to be in a particular state that matches the different interventions. Taken together, this might have impacted the clients' emotional processes and thus impacted results.

Conclusion

In a multiple-baseline design where the clients received a treatment consisting of two phases, a two-chair dialogue intervention was associated with a significantly larger number high-arousal episodes, compared to a treatment phase consisting of basic Rogerian conditions with an emphasis on empathic attunement to the clients' emotional processes. However, when we comparing the individual clients' change trajectory in the two phases, there was not a significant difference between them. Clients' depth of experiencing increased in both phases, but not significantly more in the phase with the two-chair dialogue. Findings also suggests that both therapy based on basic Rogerian conditions, and therapy adding a two-chair dialogue to these basic conditions, enhances emotional processing.

Limitations and further research

This study has investigated the specific effect of a two-chair dialogue intervention on emotional processing (arousal and experiencing). It seems like the two-chair dialogue might have a potential to produce more frequent episodes of high arousal, but results does not support that the intervention leads to a change in the clients trajectories for neither arousal nor experiencing. It is therefore uncertainty as to whether the increase in emotional arousal across sessions can be attributed to the intervention or to being the latter phase in the treatment. Larger studies with more nuanced analysis of emotional processes in the two phases are needed in order to make a more robust conclusion. It would also be of importance to investigate the clients' experience of processing emotions within the framework of the two-chair dialogue intervention, for instance via in-depth interviews of clients who has taken part in this intervention. As the two phases also are assumed to diverge in the therapists' degree of directedness, future investigations should include this as a potential mediating variable. With a larger sample size, the same design could also include a broader specter of EFT-interventions, reducing the potentially confounding factor of artificiality in restricting the therapists in this phase of treatment. Also, to get a more nuanced picture, one could also investigate whether various emotions have higher arousal or experiencing associated with

them. For instance, in the two-chair dialogue, one would expect more maladaptive shame to occur, followed by adaptive anger or compassion. One could therefore investigate whether the two-chair dialogue was associated with an increase in high-arousal episodes involving shame, anger, and compassion.

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Table 1

Mean and Mode values for Arousal and Experiencing

	Baseline	Two-chair
AROUSAL MEAN	3,27	3,54
AROUSAL MODE	3	3
EXPERIENCING MEAN	3,05	3,82
EXPERIENCING MODE	3	4

Table 2

A multivariate multilevel model of Arousal and Experiencing, 4 or above.

Arousal 4+ & Experiencing 4+	Estimates (SE)
Fixed effects	
Intercept arousal	8.32 (0.98) **
Intercept experiencing	12.9 (1.19) **
Baseline arousal	0.26 (0.16)
Baseline Experiencing	0.52 (0.16)*
Treatment arousal	0.11 (0.24)
Treatment experiencing	0.94 (0.24)**
Random effects (variance components)	
Intercept arousal	3.03
Intercept experinecing	4.29
Residuals	4.81
Correlations	
Ar(1) Phi	0.24
Model summary LL	 -1454
# parameters	6

* p<.05

** p<.001

Table 3

A multivariate multilevel model of Arousal and Experiencing, peak

Arousal peak & Experiencing peak	Estimates (SE)
Fixed effects	
Intercept arousal	4.82 (0.17)**
Intercept experiencing	5.09 (0.13)**
Baseline arousal	0.03 (0.02)
Baseline Experiencing	0.07 (0.02)*
Active component phase arousal	0.011 (0.04)
Active component phase experiencing	0.13 (0.04)**
Random effects (variance components)	
Intercept arousal	0.60
Intercept experinecing	0.40
Residuals	0.72
Model summary LL	-572
# parameters	6

* p<.05

** p<.001

Paper II

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WILEY

RESEARCH ARTICLE

Does an emotion-focused two-chair dialogue add to the therapeutic effect of the empathic attunement to affect?

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Abstract

An increasing amount of research suggests that it is beneficial to work explicitly with emotions in psychotherapy. Emotion-focused therapy (EFT) utilizes interventions that are thought to enhance the evocativeness of emotional processing and facilitate explorations of new meaning. The purpose of this study was to examine the effect of such an intervention on therapeutic outcome. The intervention, a two-chair dialogue drawn from emotion-focused therapy, was added to the treatment conditions that consisted of empathically following the clients' emotional processes. The treatment comprised 2 phases. Using a multiple baseline design, 21 self-critical clients (15 women and 6 men) with clinically significant symptoms of depression and/or anxiety first received 5, 7, or 9 sessions of a baseline treatment focused on alliance building, empathic attunement to affect, and therapeutic presence and genuineness. A two-chair dialogue intervention was then added for 5 sessions. The symptoms were measured before each session using Beck's Depression Inventory, Beck's Anxiety Index, and Forms of Self-Criticizing/Attacking and Self-Reassuring Scale. An analysis using Hierarchical Linear Modelling revealed that the phase with the two-chair dialogue had a larger impact on symptoms of anxiety and depression when compared to the baseline phase. On BDI-II, there was a greater impact on somatic-affective components than cognitive components. Self-criticism was reduced when we used time as a predictor for both phases but not significantly more after introducing the intervention. The results corroborate that the two-chair dialogue intervention is associated with change beyond what is shown when relationship conditions alone are being provided. Implications and limitations are discussed.

KEYWORDS

emotion-focused therapy, multiple baseline design, two-chair dialogue

1 | INTRODUCTION

An increasing amount of research suggests that working with emotions is central in alleviating the symptoms of psychological distress (Foa, Huppert, & Cahill, 2006; Pos, Greenberg, Goldman, & Korman, 2003; Whelton, 2004). Various ways of processing problematic emotions are also thought to be a central mechanism of change across psychotherapeutic approaches (Castonguay & Hill, 2012; Diener, Hilsenroth, & Weinberger, 2007; Norcross & Wampold, 2011). In addition, several theories and suggested methods, such as intensive short-term dynamic psychotherapy (Abbass, Town, & Driessen, 2013), accelerated experiential dynamic psychotherapy (Fosha, 2001), emotion-focused therapy (Greenberg, 2002), affect phobia therapy (Vaillant, 1997), and affect consciousness therapy (Monsen & Monsen, 1999), have been developed with the specific aim of helping clients process their emotions.

A common basic assumption in the humanistic approaches to psychotherapy is that psychotherapeutic change, including emotional change, occurs only when the therapist is successful in providing the conditions for growth (Elliott, Watson, Goldman, & Greenberg, 2004; Rogers, 1961). For instance, client-centred therapy (CCT) cultivates the art of following the clients' process with precise empathy, genuineness, unconditional positive regard, nonjudgmental attitude, and a deep dedication to foster the clients' potential to grow within such

Public Health Significance Statement: This study supports the use of a specific intervention within the framework of emotion-focused therapy. We found that facilitating a dialogue between a critical part and a criticized part of one's self can be more effective than merely being empathically understood by a psychotherapist.

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a therapeutic environment (Cain, 2010). These conditions have previously proven to be effective in producing psychotherapeutic change (Elliott, Greenberg, Watson, Timulak, & Freire, 2013). There is also vast empirical evidence for the necessity of a good therapeutic bond across most psychotherapeutic approaches (Norcross & Wampold, 2011; Wampold & Imel, 2015). In emotion-focused therapy (EFT), which is rooted in the humanistic traditions, it is assumed that emotional processing can be further enhanced if the therapist utilizes specific emotion-focused interventions (Greenberg & Watson, 1998). Thus, emotional processing in EFT is considered to be facilitated both by empathically attuning to the clients' emotions (following component) and by therapist-initiated interventions (leading components) such as the two-chair dialogue. When compared to CCT, two previous studies have favoured EFT as more effective than CCT for depressed clients (Goldman, Greenberg, & Angus, 2006; Greenberg & Watson, 1998). Also, particularly in the investigations of the two-chair dialogue (Greenberg & Dompierre, 1981; Greenberg & Webster, 1982), the results suggest that this intervention reduces symptoms of distress and more so than empathic reflection alone. Furthermore, Greenberg and Clarke (1979) found that the two-chair dialogue was associated with better emotional processing. The two-chair dialogue has also been favoured over a cognitive behavioural counselling intervention in overcoming difficult relational decisions (Clarke & Greenberg, 1986). However, it is valuable to investigate whether specific interventions might be associated with increased effects of treatment, and more research is needed to further investigate such hypothesis.

The two-chair dialogue is one of the central interventions that differentiate CCT from EFT. The two-chair dialogue intervention is an imaginative dialogue between different parts of the clients' self—a criticizing self and a criticized self. When the client criticizes himself in the session, the therapist invites the client to do so in an imaginative dialogue wherein two chairs are used to access the different parts of the self. First, the client criticizes himself explicitly, for instance by telling himself what a failure he is. Then, he changes chairs and focuses on how it feels to be criticized. The critique often activates maladaptive emotions, especially shame. The goal is for the criticized self to assert itself against the critique with anger. Such assertive anger is thought to potentially transform the maladaptive shame, thus contributing to a positive change in the clients' experience of themselves (Greenberg, 2011) and reducing the symptoms of depression and anxiety.

The two-chair dialogue in EFT is specifically designed to be employed when clients display destructive self-criticism. Self-criticism is a transdiagnostic phenomenon that is associated with a range of psychological disorders, including depression (Kopala-Sibley, Zuroff, Hankin, & Abela, 2015; Moroz & Dunkley, 2015; Yamaguchi, Kim, & Akutsu, 2014) and anxiety (Kopala-Sibley, Zuroff, Russell, & Moskowitz, 2014; Mandel, Dunkley, & Moroz, 2015). Conversely, reducing self-criticism is associated with a reduction in the symptoms of different kinds of psychological distress (Iancu, Bodner, & Ben-Zion, 2014; Kelly, Zuroff, & Shapira, 2009; Leaviss & Uttley, 2015; Moroz & Dunkley, 2015; Shahar et al., 2015). The previous studies suggest that such imaginative dialogues are an effective way of dealing with the maladaptive emotions that underlie conditions such as depression, anxiety, and self-criticism (Goldman et al., 2006; Pascual-Leone & Greenberg, 2007).

1.1 | Hypotheses

In this study, we aimed to investigate the effect on the clients' outcome when EFT therapists utilized the two-chair dialogue interventions in the treatment. We hypothesized that the two-chair dialogue intervention that is aimed at activating and changing emotions would lead to a greater reduction in the symptoms of (a) anxiety, (b) depression, and (c) self-criticism than relationship conditions alone, wherein the therapist focuses primarily on empathically attuning to the clients' emotions.

2 | METHOD

2.1 | Procedures

To test our hypotheses, we used an additive component design (Borkovec, 1990) consisting of two different phases. In the first phase (baseline phase), the therapists were instructed not to utilize chair-work interventions, but only to adhere to the relationship conditions as prescribed in EFT. The prescriptions comprise empathically attuning to the clients' emotional experience, validating and reassuring the clients' emotional state, and following the basic humanistic principles for building and maintaining the therapeutic relationships, namely, empathy, genuineness, and unconditional positive regard. In the second phase (the active component phase), the therapists utilized the two-chair dialogue intervention as prescribed by Greenberg and Watson (2006). Thus, the only intended difference between the phases was the addition of the two-chair dialogue in the second phase. The active component phase with the two-chair dialogue intervention lasted five sessions and was added at different points in time for the different clients. This constitutes a multiple baseline design, which allowed us to investigate whether the trajectory of the clients' self-reported symptoms changed when, and only when, the two-chair dialogue was added. The multiple baseline design also enables each client to function as their own control. This is done by dividing the treatment into two phases for each client and by using different lengths of baseline treatment, allowing us to infer that the change in the dependent variable would be due to the added component (Kazdin, 2011). The number of sessions offered in the baseline treatment varied across clients in order to control for the effect of time. The clients were assigned to conditions of either five, seven, or nine sessions with baseline treatment. The lengths of the baseline conditions (five, seven, and nine) were chosen due to two main reasons. First, it is assumed from a clinical perspective that the first few sessions are necessary to establish a working alliance (Horvath & Greenberg, 1994). Second, from a methodological standpoint, the length of the baseline needs to be at least five sessions in order to stabilize the baseline period (Kazdin, 2011). After the baseline period, each client received five sessions that involved a two-chair dialogue intervention. The reason for choosing five sessions in the active component part is that the symptoms are not expected to change immediately after an intervention. Also, five sessions of the two-chair dialogue intervention would be sufficient to stabilize the phase in order to see a linear change in the trajectory of symptoms.

2.2 | Participants

In the study, 24 participants were recruited from a Norwegian public treatment programme called *Return to Work* (RTW). RTW is a low-threshold treatment offered to people who are on paid sick leave due to common mental health difficulties, which typically are mild to moderate depression or anxiety. All the clients being considered for the treatment in this programme must have been referred by their general practitioner, and all those who are referred are screened through a clinical interview conducted by an experienced clinical psychologist. To be eligible for the treatment, the participant needs to meet the criteria for common mental health difficulties as assessed in the intake interview. They need to be on sick leave due to the common mental disorder and be motivated to receive psychotherapeutic treatment over a maximum period of 18 weeks. People who have serious mental health issues or lost their jobs or lack of motivation for treatment are not included in the programme.

The inclusion criteria for enrolment in this study were symptoms in the clinical range on either depression or anxiety as measured by BDI-II (Beck, Steer, & Brown, 1996) and BAI (Beck, Epstein, Brown, & Steer, 1988). In addition, only participants who were moderate to high on self-criticism were included, as the intervention in question is targeted at self-criticism. Self-criticism was measured by the Forms of Self-Criticizing/Attacking and Self-Reassuring Scale (FSCRS; Gilbert, Clarke, Hempel, Miles, & Irons, 2004) and the cut-off was set to 22 or above on the subscale *inadequate self*, based on the previous research on this scale (Baião, Gilbert, McEwan, & Carvalho, 2015). The other two subscales from the FSCRS were excluded as inclusion measures because the *hated self* subscale might pertain to more serious mental health issues (Baiao et al., 2015), and the *reassured self* subscale seems to measure the resilience to self-criticism more than self-criticism in itself (Gilbert et al., 2004). The exclusion criteria were effectively the same as those of the RTW programme and were low in the case of self-criticism (below 22 on the subscale inadequate self of the FSCRS).

A total of 98 people, out of which 64 were eligible for the treatment, were referred to the programme in the 6-week recruitment period. Out of these 64, 36 agreed to participate in the present study and signed consent forms. The main reason provided by all the people who declined to participate in the study was the fact that the therapy sessions would be videotaped. Taping of therapy sessions is relatively uncommon in Norway, and so the number of people who declined was not surprising. The 36 who agreed to participate were contacted for further screening. Twenty four met the inclusion criteria for the study and thus subsequently enrolled in it. Three clients dropped out of the programme, two did not report a reason, and one reported improvement and was not motivated to continue. All the 21 clients who completed were Caucasians, comprising 15 women and 6 men. Their ages ranged from 20–63 years, with a mean of 38.2 years. The participants had an average of 2–4 years of education, and five participants were uneducated. Seven participants were not in a long-term relationship, and five were childless. Out of the 21 clients, 6 had previously received treatment for depression or anxiety. Furthermore, as the programme was for people on sick leave, all participants were employed full time.

The study was preapproved by the Norwegian Regional Committees for Medical and Health Research Ethics.

2.3 | Therapists and therapist training

Six therapists provided the treatment, all of whom were clinical psychologists with 5–13 years of experience (mean 9.2 years). Two of the therapists were male and 4 were female. All 6 therapists had at least 3 years of EFT training (minimum 300 hr) and additional supervision (minimum 20 hr) with an experienced EFT trainer. In the EFT training, there is a large focus on the fundamental humanistic principles that are regarded as necessary for change to occur. Thus, in addition to being trained in specific active interventions (like the two-chair dialogue intervention), all the therapists had had extensive training in the use of differentiated empathy and alliance building in accordance with CCT.

2.4 | Measures

2.4.1 | The Forms of Self-Criticizing/Attacking and Self-Reassuring Scale (Gilbert et al., 2004)

The FSCRS is a self-report questionnaire that is designed to measure self-criticism. The respondents are asked to respond on a 5-point Likert scale from 0 (*not at all like me*) to 4 (*extremely like me*) based on the degree to which the statement on each item resembles their own thoughts and feelings. A factor analysis has identified three factors: inadequate self, hated self, and reassured self. The FSCRS has been found to show good internal consistency and is congruent with other measures of self-criticism (Baiao et al., 2015; Gilbert et al., 2004). The Norwegian version (Stiegler, Schanche, Vøllestad, & Nielsen, 2015) was translated and back translated by Norwegian psychologists who were fluent in both Norwegian and English. Cronbach's alpha was calculated before treatment (0.89), after baseline (0.90), and after treatment (0.90). For this study, we were mainly interested in the subscale inadequate self. For this subscale, the mean score was 25.24 (SD = 7.42), ranging from 8 to 36.

2.4.2 | The Beck depression inventory-II (Beck et al., 1996)

BDI-II is a commonly used 21-item self-report instrument that measures the severity of depressive symptoms. For each item, respondents are given four options that describe the degree of a depressive symptom and are asked to circle the most fitting option. BDI-II has shown good discriminant and convergent validity and good test–retest reliability (Beck et al., 1996). Cronbach's alpha was calculated before treatment (0.84), after baseline (0.94), and after treatment (0.93). The analysis of BDI-II suggests two clinically relevant subscales —a cognitive subscale and a somatic-affective subscale (Steer, Ball, Ranieri, & Beck, 1999). The mean score for the BDI total was 24.21 (SD = 9.69), ranging from 13 to 50. For the somatic subscale, the mean score was 15.05 (SD = 6.02), ranging from 8 to 31. The score on the cognitive subscale was 8.4 (SD = 4.38), ranging from 3 to 19.

2.4.3 | The Beck anxiety inventory (Beck et al., 1988)

BAI is a 21-item, commonly used self-report instrument that is employed to quantify the symptoms of anxiety. The respondents are asked to respond to each item on a Likert scale from 0 to 3, indicating to what degree the statement fits their experience of the symptom. BAI has demonstrated high internal consistency (Beck et al., 1988).

Cronbach's alpha was calculated before treatment (0.92), after baseline (0.96), and after treatment (0.96). The mean score on this scale was 26.02 (SD = 13.89), ranging from 5 to 52.

2.4.4 | The working alliance inventory—Short version patient (Tracey & Kokotovic, 1989)

WAI-S-P is a 12-item self-report measure administered to the patient in order to assess the clients' experience of the working alliance. It is based on the working alliance inventory (Horvath & Greenberg, 1986), which is a measure of the therapeutic alliance as conceptualized by Bordin (1979). Bordin stated that the alliance consists of three elements: agreement on goal, agreement on task, and the therapist–patient bond (Bordin, 1979). The WAI-S-P has four questions for each of these dimensions of the alliance, and the WAI-S-P has shown decent psychometric properties (Hanson, Curry, & Bandalos, 2002; Tracey & Kokotovic, 1989). Cronbach's alpha was calculated after the first session (0.81), after baseline (0.829), and after treatment (0.71). The mean score on the WAI for the 21 subjects was 60.56 (SD = 11.57), ranging from 43 to 82.

2.5 | Adherence

Three measures were taken to ensure adherence to both the phases of treatment: (a) for each client, two video recordings from each phase was checked to ensure that the therapists did not deviate from the protocol for each of the two phases; (b) the WAI was administered to the clients after each session to ensure that there was no systematic difference in the alliance between the phases; (c) the therapists wrote and completed a questionnaire after each session, describing what they did and reporting any deviance from the treatment protocol for that particular phase. The following deviations from protocol were registered: Two clients received a shorter baseline period than they were prescribed (eight instead of nine sessions), and two clients had one session each where they were supposed to do chair work, but where the therapist assessed that more pressing matters had to be handled. All these deviations were handled as missing data (see next section).

2.6 | Missing data

The missing data on single items were handled by replacing the scores with the subjects' mean on the subscale/scale. This was done for 3.99% of the total items possible. If more than 50% of the items on a subscale/scale were missing, it was not calculated. In those cases, the last observation carried forward was used if possible, else the last observation carried backward. Last observation carried forward and last observation carried backward were used in 3.05% of all the possible scores. We chose these conservative procedures for handling missing data as the overall level of missing data was minor.

2.7 | Statistical analyses

R version 3.4.0 (The R foundation for statistical computing, 2017) was applied in the statistical analysis. Fixed effects are a mean value or constant for all participants (group average), whereas random effects are scores varying across participants (like individual deviations from a fixed effect). In our models, the measurement occasions (time) are referred to as Level 1, nested within individuals (Level 2). As we were not interested in the variation in the effects across individuals, no Level 2 predictors or person moderators were included in our models. To investigate whether the rate of change ("slope") in the self-reported symptoms was significant in either the baseline or the treatment phase, we analyzed several two-level piecewise (two-phase) hierarchical linear growth models. This allowed us to compare the growth rates during two different time periods. Hence, individual change within subject growth over time (Level 1) was modelled by the equation $Yti = \beta 0i + \beta 1iX1ti + \beta 2iX2ti + eti$. $\beta 0$ is the intercept or initial status pretreatment. $\beta 1i + \beta 2i$ represents the growth rate (slope) in Phase 1 (baseline) and Phase 2 (treatment), respectively. As stated earlier, our hypotheses concerned the mean difference in the rates of symptom change between the two phases of treatment. Also, due to the a priori power estimate and the low sample size, only random intercept and fixed-slope models were applied, using a restricted maximum likelihood estimator. Using linear tests post hoc, the baseline slope was tested against the treatment slope to see if they were significantly different from each other. The model building procedure followed the one described by Hox, Moerbeek, and van de Schoot (2010).

Fitting the models, the Level 1 residuals were inspected for normality (e.g., using qq-plots). All the residuals were normally distributed. Hence, the distributional assumptions of the models seem to be fulfilled.

2.8 | Statistical power

The within-subject changes are akin to repeated *t* tests. In the baseline phase, there are five or more treatment occasions. There are five measurement occasions in the active component phase. When we compare the fixed (mean) slopes for the two phases, this is like a dependent *t* test within a sample. In a similar study, Goldman et al. (2006) compared the effect of emotion-focused interventions with client-centred conditions, and they found effect sizes in the magnitude of 0.54–0.69 (Cohens d), favouring these interventions. Hence, if we expect a moderate effect ($d = .60$), alpha set to 0.05 (two-tailed), and the power is set to 0.80, we require 24 respondents to complete the treatment in order to find an effect.

3 | RESULTS

The comparison of mean scores for each condition is summarized in Table 1.

In the final model for anxiety (BAI), the random intercept was 22.9 (SE = 2.87), with a nonsignificant fixed slope for the baseline phase ($\beta 1i = -.08$, $p > .05$) and a significant fixed slope for the active component phase ($\beta 2i = -1.20$, $p < .000$). Testing the baseline slope versus the treatment slope, the difference was significant ($\beta = 1.12$, SE = 0.41, $p = 0.006$). Thus, for the average participant, the symptoms of anxiety as measured by BAI were reduced significantly more in the active component phase than in the baseline phase (see Figure 1 for the regression lines).

In the final model for depression (BDI-II), the random intercept was 22.9 (SE = 2.28), with a nonsignificant fixed slope for the baseline

TABLE 1 Symptoms score sorted by condition—Pre, mid, post: Mean (standard deviation)

	BDI pre	BDI mid	BDI post
5 Base	24,9 (6,6)	20,0 (7,5)	17,1 (7,7)
7 Base	20,7 (7,2)	21,7 (5,1)	20,2 (8,9)
9 Base	26,4 (6,5)	27,3 (7,8)	19,4 (9,6)
	BAI pre	BAI mid	BAI post
5 Base	28,9 (26,9)	18,4 (30)	17,1 (17,6)
7 Base	21,3 (7,6)	21,2 (8,5)	13,7 (4,2)
9 Base	26,9 (8,1	30 (9,5)	17,6 (10,4)
	FSCRS pre	FSCRS mid	FSCRS post
5 Base	25,7 (4,9)	23,4 (2,8)	19,4 (7,5)
7 Base	23,2 (6,4)	22,5 (8)	20,5 (4,2)
9 Base	26,4 (7,2)	26,3 (5,8)	22,7 (6,9)

Note. BDI = Beck's Depression Inventory; BAI = Beck's Anxiety Index; FSCRS = Forms of Self-Criticizing/Attacking and Self-Reassuring Scale.

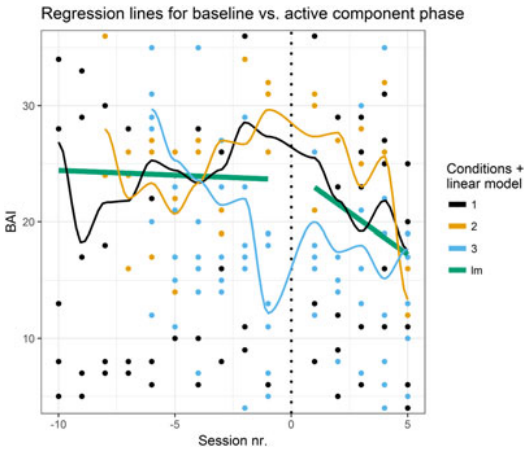

FIGURE 1 Regression lines for baseline versus active component phase, Beck's Anxiety Index (BAI). [Colour figure can be viewed at wileyonlinelibrary.com]

phase (β1i = −.03, p > .05) and a significant fixed slope for the active component phase (β2i = −.60, p < .003). Upon testing the baseline slope versus the treatment slope, the difference was significant (β = 0.63, SE = 0.29, p = 0.03). Thus, for the average participant, the depressive symptoms as measured by BDI-II were reduced significantly more in the active component phase as compared to the baseline phase (see Figure 2 for the regression lines).

As the two-chair dialogue is assumed to work via emotional change, we wanted to further explore if the somatic-affective items changed more than the cognitive items on the BDI-II. For the cognitive subscale, the random intercept in the final model was 7.52 (SE = .98), with a nonsignificant fixed slope for the baseline phase and the active component phase (β = −0.16, SE = 0.08, p = .044). Upon testing the baseline slope versus the treatment slope, the difference was significant (β = 0.63, SE = 0.29, p = 0.03). Upon testing the baseline slope versus the treatment slope, the difference was nonsignificant (β = 0.15, SE = 0.11, p = 0.2). Thus, the average participant reports did not

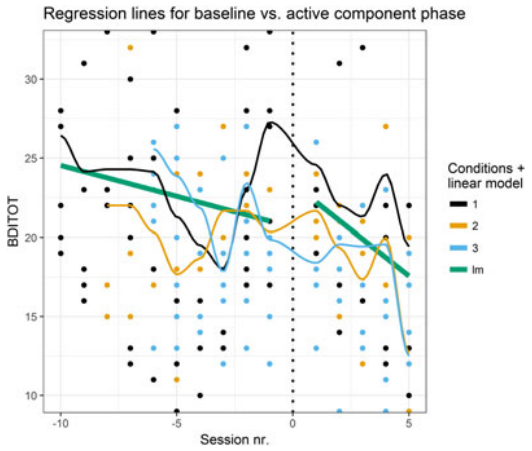

FIGURE 2 Regression lines for baseline versus active component phase, Beck's Depression Inventory-II full scale. [Colour figure can be viewed at wileyonlinelibrary.com]

change more on cognitive symptoms in the baseline phase in comparison with the treatment phase. For the somatic-affective subscale of BDI, the random intercept was 15.4 (SE = 1.41), with a nonsignificant fixed slope for the baseline phase and a significant fixed slope for the active component phase (β1i = −0.04, p > .05). Upon testing the baseline slope versus the treatment slope, the difference was significant (β = 0.49, SE = 0.20, p = 0.018). Thus, the average participant had a significant decrease in somatic-affective symptoms in the active component phase, whereas no change was observed in the baseline phase (see figure 3 for regression lines).

In testing the hypothesis that self-criticism would be reduced, we found, by using the subscale inadequate self from FSCRS (FSCRS-IS), a nonsignificant fixed slope for the baseline phase (β1i = −0.14, p > .05) and a significant fixed slope for the active component phase (β2i = −.43, p < .002). On testing the baseline slope versus the

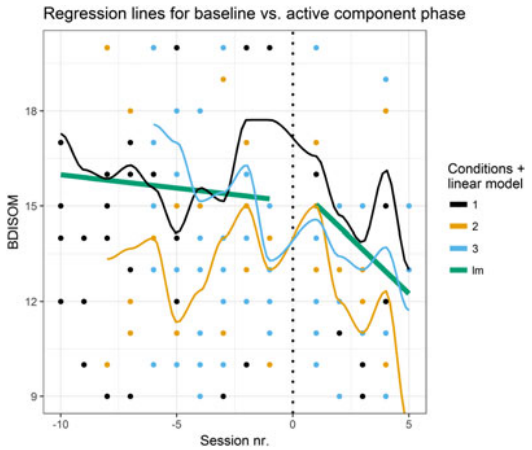

FIGURE 3 Regression lines for baseline versus active component phase, Beck's Depression Inventory-II somatic subscale. [Colour figure can be viewed at wileyonlinelibrary.com]

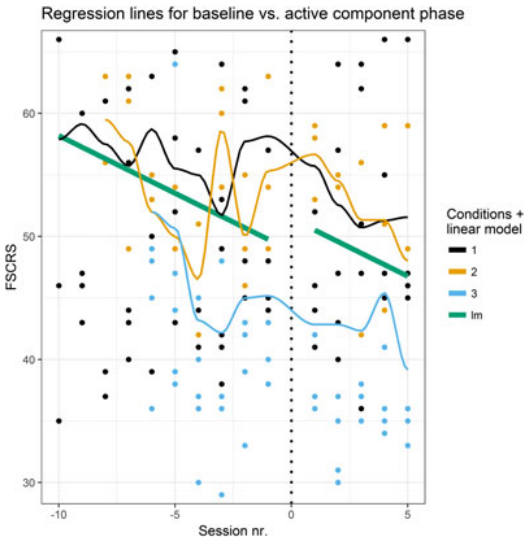

FIGURE 4 Regression lines for baseline versus active component phase, inadequate self form. [Colour figure can be viewed at wileyonlinelibrary.com]

treatment slope, the difference was nonsignificant (β = 0.29, SE = 0.27, p = 0.29). This implies that there were no differences in the rate of change in reported self-criticism between the phases (see Figure 4). As such, we modelled the second model, using only time as a predictor for change. This model was highly significant (see Figure 5). The random intercept was 24.2 (SE = 1.53), with a significant fixed slope for change over time (βi = −.26, p < .000). We also modelled the full-scale FSCRS, and both the baseline slope (β1i = −0.22, p > .05) and the chair-work slope (β2i = −0.36, p > .05) were nonsignificant. We modeled also here a second model, using only time as a predictor for change. This model was highly significant (βi = −0.29, p < .002). Hence, there is a

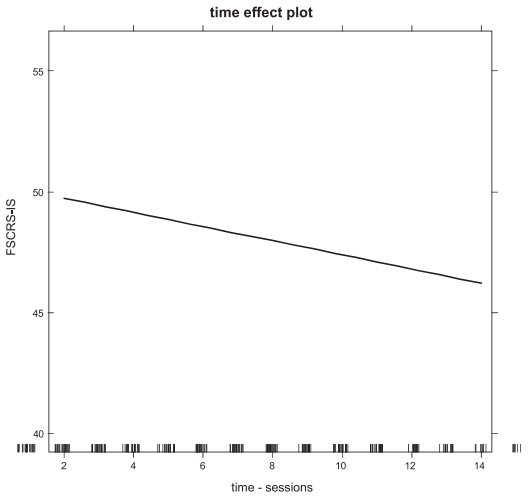

FIGURE 5 Inadequate self from Forms of Self-Criticizing/Attacking and Self-Reassuring Scale change slope for the entire treatment.

reduction in self-criticism that starts in the baseline phase and continues in the two-chair phase, but not a significant change after the introduction of the two-chair dialogue. Because the target of change for the two-chair dialogue is self-criticism, we were surprised to not observe a significantly larger change on this scale after the introduction of the chair work. As the chair work was assumed to work, partly by increasing the awareness of self-criticism, it was expected that some clients would report an increase in self-criticism during the treatment. Thus, we took a closer look at the change in self-criticism to see if some clients might have reported an increase in these symptoms. As a follow-up analysis using Tau-U (Parker, Vannest, Davis, & Sauber, 2011), a single-subject index of nonoverlap in the scores between the baseline phase and the treatment phase, 4 clients showed a significant increase in self-criticism after the baseline, 8 clients improved, and 9 clients stayed unchanged (see table 2). None of the 4 who got more self-critical showed an increase in the other symptoms. Hence, it seems like some clients get less self-critical, some stay unchanged, and some get more self-critical during this treatment phase.

As an adherence control, we modelled the change in WAI-S-P or the clients' experience of the working alliance throughout treatment. Specifically, we tested the bond component of WAI-S-P and found a nonsignificant fixed slope for the baseline phase (β1i = −.05, p > .05) and a nonsignificant fixed slope for the active component phase (β2i = .18, p > .05). Thus, there was no significant change in either of the two phases. We also tested the change in the bond component

TABLE 2 Individual Ta-U scores, inadequate self from Forms of Self-Criticizing/Attacking and Self-Reassuring Scale

	Ta-U	p-value	CI 90%
Client 1	0.1000	0.7595	−0.437<>0.637
Client 2	−0.1800	0.5815	−0.717<>0.357
Client 3	−0.9800	0.0027*	−1.517<> − 0.443
Client 4	−0.6000	0.0662*	−1.137<> − 0.063
Client 5	−1.1000	0.0008*	−1.637<> − 0.563
Client 6	0.3800	0.2446	−0.157<>0.917
Client 7	−0.9800	0.0027*	−1.517<> − 0.443
Client 8	0.3500	0.3055	−0.212<>0.912
Client 9	0.8750	0.0104**	0.313<>1.437
Client 10	−0.3750	0.2723	−0.937<>0.187
Client 11	0.9000	0.0084**	0.338<>1.462
Client 12	0.1250	0.7144	−0.437<>0.687
Client 13	0.7000	0.0404**	0.138<>1.262
Client 14	−0.9000	0.0137*	−1.501<> − 0.299
Client 15	1	0.0062**	0.399<>1.601
Client 16	−0.8667	0.0176*	−1.467<> − 0.266
Client 17	−0.7667	0.0358*	−1.367<> − 0.166
Client 18	0.4667	0.2012	−0.134<>1.067
Client 19	−1	0.0090*	−1.630<> − 0.370
Client 20	−0.0182	0.9548	−0.546<>0.510
Client 21	−0.6000	0.1003	−1.201<>0.001

Note. CI = Confidence interval.

*= significant decrease in self-criticism in active component phase.

**= significant increase in self-criticism in active component phase.

in a second model by using only time as a predictor for change. Again, this model was nonsignificant (β1i = .06, $p > .05$).

4 | DISCUSSION

Using a multiple baseline design, this study investigated whether a specific intervention—a two-chair dialogue—could add to the effect of empathically attuning to the clients' emotional process. In line with our first two hypotheses, a significantly larger reduction in the symptoms of anxiety and depression is seen when the two-chair dialogue has been added to the basic relationship conditions of EFT. Contrary to our third hypothesis, there is not a significantly larger impact on self-criticism after the introduction of the two-chair dialogue. However, the results suggest that there is a continuous significant drop in self-criticism throughout the treatment as a whole. Also, looking at both phases of the treatment separately, there is a significant drop in self-criticism in the active component phase but not in the baseline phase. Thus, the picture is somewhat unclear regarding the impact on self-criticism. Altogether, the present study does indicate that the two-chair dialogue intervention contributes to the changes in the clients' symptoms more so than when the therapist solely attunes to and focuses on the clients' emotion. These results are in line with our hypotheses and also supports findings from previous studies showing that adding therapist-initiated interventions aimed at activating and changing emotions lead to greater symptomatic change than relationship conditions alone (Goldman et al., 2006; Greenberg & Watson, 1998).

In EFT, symptoms of depression and anxiety are viewed as results of unprocessed emotion. One way that the two-chair dialogue intervention is assumed to bring about change is by fostering better emotional processing by means of (a) increasing emotional arousal and (b) by increasing the clients' ability to be in contact with and make meaning out of this emotional arousal (experiencing). Previous research on emotional processing suggests that the outcome is related to both increased emotional arousal (Boritz, Angus, Monette, Hollis-Walker, & Warwar, 2011; Holzer, Pokorny, Kachele, & Luborsky, 1997; Iwakabe, Rogan, & Stalikas, 2000; Missirlian, Toukmanian, Warwar, & Greenberg, 2005; Piliero, 2004; Pos et al., 2003) and the processing of this arousal (Greenberg & Safran, 1987; Pascual-Leone & Yeryomenko, 2016; Watson & Bedard, 2006). Research by Pascual-Leone and Greenberg (2007) also supports the idea that symptoms of psychological distress are reduced when an increase in emotional arousal is used to process previously unprocessed emotions.

One main finding in the present study suggests that the symptoms of anxiety decrease significantly more when the therapists utilize the two-chair dialogue intervention. In EFT, anxiety is seen as a secondary distress that can be alleviated by accessing and changing the underlying maladaptive emotions. Anxiety is thus understood as a reaction to the underlying threats to the clients' well-being, for instance the feeling of inadequacy. In the two-chair dialogue, the client is invited to move back and forth between the position of acting as the inner critic and experiencing the impact of receiving this criticism. Through this altering between positions, the first goal is to help the client get in touch with maladaptive emotions, for instance fear or shame, and then access adaptive emotions, such as anger and grief, that can change the former. Hence, the change is not assumed to come about by challenging the content of the threat, but rather by emotionally asserting against the threat, rendering the client in a different and healthier emotional state. However, there are several other explanations as to how the symptoms of anxiety have been reduced by this intervention. Firstly, one can argue that the intervention challenges the clients' perception of the underlying threat. For instance, if the client gets anxious when the critic puts him down, hearing the critique may help him challenge the content of the criticism. Another common understanding of how anxiety changes is that the client is exposed to his anxiety and gets help to experience it with mastery, so that the anxiety response will be diminished the next time.

Another main finding in this study is that the symptoms of depression as measured by the total BDI-II are significantly more reduced when the therapists utilize the two-chair dialogue intervention. As with anxiety, the EFT theory suggests that the symptoms of depression stem from maladaptive emotional states such as hopelessness and despair. Depressive symptoms are assumed to stem from a process where the inner critical voice activates a maladaptive state of either being defeated or hopeless. By inviting the client to alter between chairs, the therapist tries to help draw out and make explicit on how the client treats himself. The goal is to help the client react emotionally in a more adaptive fashion, for instance with assertive anger rather than passive helplessness. At the same time, it is possible that the change in depressive symptoms arises from giving the client an opportunity to challenge how he cognitively perceives himself. The dialogue between different parts of the client clearly has explicit cognitive aspects that support such a notion. We, therefore, wanted to explore the subscales of BDI-II, which has items that can be understood as either more cognitive or more somatic-affective. Interestingly, these subscales of BDI-II have revealed that the significant change shown in BDI-II total was due to large changes in the somatic-affective subscale and not in the cognitive subscale. These results indicate that the two-chair dialogue intervention has its prime effect on components such as feeling pleasure, interest, and energy. This can be interpreted as support for the theoretical assumption that the two-chair dialogue changes the emotional components before the cognitive components of depression. However, this should be further investigated by analyzing how the clients' change when the two-chair dialogue is introduced.

The third hypothesis has been rejected. We do not find a significant drop in the self-reported self-criticism after the introduction of the two-chair dialogue intervention, albeit having a significant and substantial drop throughout the entire treatment. This is a partly surprising finding, as self-criticism is the explicit focus of the intervention. On the other hand, it is not surprising to see that a good working alliance and empathic attunement to affect in itself is effective in reducing self-criticism. Self-criticism can be reduced by a number of different routes (Kannan & Levitt, 2013)—being empathically understood and validated in a caring therapeutic relationship is one of them. Still, we expected a drop in self-criticism after introducing an intervention directly targeted at this symptom. There are several possible explanations, one of which is statistical reasons. As there has been a continuous and substantial drop in self-criticism throughout the treatment, the design may have lacked the power to detect such changes.

This is supported by the fact that only the active component phase showed a significant decrease in self-criticism, albeit not significantly more so than the baseline phase. Another possible explanation is that self-criticism for some clients may get worse before it gets better. The two-chair dialogue intervention is designed to help clients explore their malignant inner voices in order to change the emotion that causes them. If a client is not initially aware of the harshness of his inner critic, he may become more aware of this once he starts exploring it in a two-chair dialogue, thus causing him to report more self-criticism. Our post hoc analysis of each client's trajectory using Tau-U reveals that four clients got worse after the introduction of the two-chair dialogue. If the assumption that some get worse before they get better is right, the intervention may not have been administered for a long enough period for self-criticism to change significantly more in the active component phase. Severe self-criticism has previously been proven hard to alleviate (Gilbert & Procter, 2006), and five sessions may not have been sufficient to create a significant change.

A similar reason for this finding, which is in line with the EFT theory, is that change in self-criticism typically happens bottom-up, starting with a change in emotional activation and ending with a change in the content of the inner dialogue. Thus, the five sessions may have created some emotional change without giving sufficient time for a cognitive consolidation that will reveal itself on self-report instruments. This assumption is in line with the above finding that only the somatic-affective subscale of the BDI-II has changed after the introduction of the two-chair dialogue.

The finding may also be due to the individual change profiles among the participating clients. As mentioned, looking at the change profile of each client using Tau-U, four of the clients have shown a significant increase in self-criticism, and eight clients have shown a significant decrease during the active component phase. Thus, it is somewhat unclear how the two-chair dialogue affects different clients. Seemingly, for some clients, the two-chair dialogue has the potential to substantially reduce self-criticism within a short time frame, whereas for others it seems less beneficial, perhaps even contra productive, or they may just need more time for self-criticism to decrease.

4.1 | Limitations and future research

There are also alternative explanations as to why self-reported symptoms on the BDI-II and BAI decreased after the introduction of the two-chair dialogue. One is that of the placebo effect. When the two-chair dialogue is introduced, the clients are asked by their therapists to do something completely different from what they have been doing in the baseline phase, that is, have a dialogue between different parts of themselves and physically move between the chairs. It is possible that the unusual nature of this intervention can lead the clients to expect an added effect. In other words, it can be that introducing other active and unusual interventions can lead to a similar change.

The design of this study has the potential to experimentally add certain components in order to measure its effect on the clients' self-report. However, the study does not directly indicate the mechanisms of change. Nor does it indicate what mediators may be in effect. Future research should analyze whether the two-chair dialogue actually impacts the within-session processes such as emotional arousal and depths of experiencing and meaning making. Also, a possible limitation to this design is that the tested intervention is added at the end of treatment, raising the reasonable question of whether the most change would occur later in the treatment or not. However, the idea behind the design is that the different lengths of baseline will make it possible to check if the change occurred when, and only when, the intervention has been added. Also, there is no significant difference in outcome between the different baseline groups. This makes it reasonable to infer that the change in symptoms is not only related to the fact that the intervention has been placed at the end of treatment. As such, this study suggests that the two-chair dialogue intervention has the potential to alleviate symptoms.

Another question that arises from this study is why the clients, as a group, have not reported symptomatic change on BDI-II and/or BAI after receiving five to nine sessions of psychotherapy, where the focus has been on building an alliance and empathically following the clients' process. Such an empathically attuned focus has previously been shown to be effective in treating depression (Elliott et al., 2013; Horvath, Del Re, Flückiger, & Symonds, 2011; Watson, Steckley, & McMullen, 2014). One explanation as to why the clients in this study have not reported change during the baseline phase is due to the limitations of the research design. First, the design has an interfering quality, in that it instructs the therapists to hold back on certain interventions when the process indicates otherwise. This may have influenced the therapists' presence or empathy—factors of particular importance for alliance building. There has been, however, no difference in the two phases of the clients' reporting on the bond aspect of WAI-S-P, making it less likely that the relationship conditions are poorer in the baseline phase. Still, in the baseline phase, the alliance has to be established. Thus, this phase may have been too limited in time to produce change in the symptoms. Future research should also investigate whether similar and dissimilar interventions can lead to similar outcome. To rule out explanations of placebo effect, one should supplement this research with a more detailed observation and micro-analysis of the clients' change processes in both phases.

5 | CONCLUSION

Using a multiple baseline design consisting of two treatment phases, the two-chair dialogue intervention seems to be associated with a significantly larger decrease in symptoms of depression and anxiety, when compared to a treatment phase consisting of empathic attunement to the clients' emotional processes. Contrary to our expectations, self-criticism does not decrease significantly more after the introduction of the two-chair dialogue. Self-criticism has, however, been significantly reduced in both the phases of treatment.

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Paper III

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“It’s heavy, intense, horrendous and nice”: Clients’ experiences in two-chair dialogues.

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Abstract

In this study, we conducted qualitative in-depth interviews to explore how clients experienced working with emotional processing and self-criticism in a two-chair dialogue intervention. Eighteen clients scoring high on self-criticism were interviewed upon completion of a short-term treatment (10–14 sessions) with Emotion-Focused Therapy (EFT), where the two-chair dialogue was used as the main intervention. A hermeneutic-phenomenological approach guided the research process, while a thematic analysis approach was used to analyze the interview transcripts. Our analysis revealed that clients who are asked to engage in the two-chair dialogue intervention often experience an embarrassment or awkwardness before they decide to engage. When engaged in the intervention, most clients found it intense and demanding, but also meaningful. A few clients found the intervention too intense to be of use. Many of those who participated reported that they became more aware of the fact that they were active agents who took part in their self-critical processes. The intensity and somewhat unusual nature of this intervention call for special attention to the working alliance before clients are invited to engage.

Keywords: two-chair dialogue; emotion-focused therapy; emotion processing; qualitative interview

Introduction

A growing body of theory and research places emotions in a central role when explaining the etiology and alleviation of psychological difficulties (Abbass & Town, 2013; Castonguay & Hill, 2012; Diener & Hilsenroth, 2009; Foa & Kozak, 1986; Greenberg, 2002; Vaillant, 1997). A shared assumption across several psychotherapeutic approaches is that psychological difficulties can be attributed to unprocessed or blocked emotional processes. The focus of psychotherapeutic work within these approaches is often to access and process emotions (Whelton, 2004). One psychotherapeutic model that has outlined emotional processing as a core change mechanism is Emotion-Focused Therapy (EFT). This is a humanistic approach to change where emotions are seen as core motivational processes with a high idiosyncratic relevance for the individual. Therefore, special attention is given to the clients' emotional experience (Greenberg & Paivio, 1997).

In EFT, a lot of emotional processing is assumed to happen in interventions that are commonly referred to as chair-work (Greenberg & Paivio, 1997). One such intervention is a two-chair dialogue, where the goal is to process and resolve distressing emotions related to the self-criticism. This intervention is a an imaginative dialogue between a criticizing self and a criticized self (Elliot, Watson, Goldman & Greenberg, 2004). It is assumed that the two-chair dialogue intervention is both emotionally evocative and that it provides a structure for expressing, making sense of and transforming emotions that were previously inhibited, out of awareness or too painful to attend to. The two-chair dialogue is used when clients are treating themselves in a critical or attacking manner. It is assumed within EFT that people become self-critical due to a shame-based self-organization. Thus, in these instances, clients are asked to have a dialogue between their self-critic and their experiencing self, where the goal is to evoke and process painful shame. The goal is to transform the shame by connecting with adaptive anger, sadness, and pride. In this study, we wanted to investigate how clients experience the process of working with their self-criticism in the two-chair dialogue. What is it like for self-critical clients to engage in, and utilize such an intervention? How do these clients experience and respond to working with emotional difficulties in this manner?

Several studies have investigated the process of change within the EFT model, supporting the assumption that the way clients attend to and make sense of their emotional arousal is related to the outcome of their change process (Goldman, Greenberg, & Angus, 2006; Greenberg & Paivio, 1998; Greenberg & Watson, 1998; Pascual-Leone & Greenberg, 2007). Previous research also suggests that chair work interventions in particular are effective in producing change in both outcome and emotional processing (Goldman et al., 2006; Greenberg & Paivio, 1998; Greenberg & Watson, 1998; Pascual-Leone & Greenberg, 2007; Stiegler, Schanche, & Molde, 2017). There is, however, a need for empirical studies of how clients experience and respond to chair-work interventions. Qualitative studies may be important to understand the first-person experience of emotional change processes during chair-work interventions. Knowledge of first-person experiences might help clinicians and researchers refine and enhance the effectiveness of the chair-work in EFT and other psychotherapeutic approaches. Only one previous study has conducted an in-depth investigation of clients' experiences of emotional processing during chair-work. In the study by Robinson, McCague, and Whissell (2014), clients were interviewed about their experience of EFT in a group setting. The participants highlighted the chair-work intervention as particularly important in their change process, and they also reported this intervention as being challenging and intense. This study had a rather broad focus of change, and was not specifically targeted at a more detailed investigation of how clients experience emotional processes in the chair work interventions. There have been other qualitative investigations of the clients' experience of EFT, but these have been specific to investigating changes in self-narrative (Angus & Kagan, 2013), or to experiences of having changed rather than of interventions (Elliott et al., 2009; Klein & Elliott, 2006; MacLeod, Elliott, & Rodgers, 2012). The present study thus contributes to the knowledge base by exploring: "How do clients with common mental health issues and destructive self-criticism experience the impact of a two-chair dialogue intervention targeted at destructive self-criticism in Emotion-Focused Therapy?"

Method

Setting

The data reported in this study was collected as part of a larger clinical trial in Norway. Participants were recruited as a part of this clinical trial, where the main focus was to investigate the effect of the two-chair dialogue intervention. In this trial, the treatment consisted of two phases in a multiple baseline design. The first phase consisted of fundamental Rogerian conditions with a particular focus on empathic attunement to affect. All participants had between 5 and 9 sessions of baseline treatment. Usually, in EFT, there are about 3 sessions to establish a good working alliance. Thus, the design of the study caused a different course of treatment from what is common in EFT. In the second phase, the two-chair dialogue was added for 5 sessions.

Participants

The participants were recruited from a public treatment program in Norway. This program is for people who are on sick leave due to common mental health difficulties. Those who are eligible for the program typically display mild to moderate symptoms of anxiety and/or depression, and need to meet the criterion for common mental health difficulties as assessed in an intake interview. As the main focus was on an intervention designed to alleviate destructive self-criticism, only participants moderate to high on self-criticism were included. Self-criticism was measured using The Forms of Self-Criticizing/Attacking and Self-Reassuring Scale (Gilbert, Clarke, Hempel, Miles & Irons, 2004). Twenty-one out of 24 participants in the larger study completed the entire treatment. The participants' symptoms were measured before each session, showing a reduction in symptoms of anxiety, depression and self-criticism. See Stiegler et al., 2017 for details. Out of the 21 who completed, 18 participants (13 women and five men) accepted to participate in the qualitative interview post treatment. Participants were aged 20–63 (mean age 38.3 years). All participants were native Norwegians.

Therapists and Therapist Training

There were six therapists providing the treatment. All 6 were clinical psychologists who had 5–13 years of clinical experience (mean 9.2 years). Four of the therapists were female, and two were male. The therapists had a minimum of 300 hours of EFT training over at least 3 years. In addition, they all had minimum

20 hours of supervision on their recorded practice. During the EFT training, there was a large focus on the basic Rogerian conditions that are considered within EFT as necessary conditions for change to occur. Thus, all therapists were trained both in the use of differentiated empathy, alliance building and presence, as well as in specific active interventions (like the two-chair dialogue intervention).

Methodological Approach

We wanted to explore how participants experienced working with their emotions using the two-chair dialogue. To do this, we conducted a qualitative interview study employing a hermeneutic-phenomenological approach to thematic analysis (Binder, Holgersen, & Moltu, 2012). Braun and Clarke (2006) claimed that thematic analysis "… is compatible with both essentialist and constructionist paradigms within psychology", but it is important that researchers make their epistemological assumptions clear. Our hermeneutic-phenomenological approach intends to interpret (hermeneutical) and explore the participants' lived experience (phenomenological). The assumption in this approach is that researchers will unavoidably influence the clients' experiences through the way the interview is conducted. The researchers' own background will also play a role in the dialectical process of making sense of the clients' meaning utterances. The researchers' background and preunderstanding are both a set of tools that make it possible to understand the phenomena he or she studies, and a potential source of prejudice and bias. Thus, the hermeneutic-phenomenological approach to qualitative interviews is best understood as a co-construction of meaning, based on clients' descriptions of their lived experiences, where the researchers need to be as reflexive as possible of his or her role as an interpreter (Finlay, 2002).

Data Collection Method

The interviews were conducted by the second, third, fourth and last author between August and September, 2015. Interviews were exploratory, guided by a semi-structured interview guide. The interview guide was developed as a part of a larger qualitative study. focusing on 1) clients' motivation for seeking help, 2) clients' experiences of the treatment and 3) the relationship with their therapist, and 4) clients' experiences of working with the two-chair dialogue. Only questions related to the research question will be presented here. The interview started with an open question about the participant's experience of having been in therapy. If the participant did not refer to

using chair-work interventions, the interviewer went on to ask if they noticed that "At some point, you began doing exercises where you used the chairs to work with individual topics. Did you notice that?" This was followed by questions concerning the participant's perceived aim with the intervention, how it influenced their process and if not already mentioned, if and how they experienced working with their presented issue using this intervention. See the appendix for a translated version of the interview guide.

All interviews were audio recorded and later transcribed by eight graduate students who were supervised by the second author. The graduate students were instructed to transcribe the material verbatim and to add short descriptions in parentheses about poignant non-verbal aspects.

Data Analysis

The data were analyzed using a thematic analysis as outlined by Braun and Clarke (2006). Analyses were conducted in accordance with the following procedures: 1) All five researchers read all the transcripts in order to familiarize themselves with the material at hand. 2) The first author closely examined the material and identified units of meaning relevant to the research question, using NVivo 11 (QSR International, 2015) computer software. More specifically, only parts of the interview material directly or indirectly related to experiences of using the two-chair dialogue intervention was investigated here. 3) Based on these units of meaning, the first author suggested tentative themes under which the units of meaning could be sorted. 4) With these tentative themes in mind, all five authors reread the transcripts so that possible themes could be added or redefined. 5) The first author rearranged the units of meaning under the newly agreed upon themes. All participants' references to their experience of the two-chair dialogue were assigned to one of the themes. This new sorting was 6) brought back to the research team for consensual discussion and final agreement on themes, descriptions, and sorting of units.

Researchers

The first author is a clinical psychologist and a Ph.D. student with 12 years of clinical experience and 8 years of training and practicing of Emotion-Focused Therapy. The second author is an Associate Professor in Clinical Psychology with eight years of clinical experience and two years of training in Emotion-Focused Therapy. The third

author is a Professor of Clinical Psychology with 20 years of clinical experience and three years of training in Emotion-Focused Therapy. The fourth author is an Associate Professor in Clinical Psychology with ten years of clinical experience. The last author is an Associate Professor in Clinical Psychology with 16 years of clinical experience.

Ethics

The study was approved by the Norwegian Regional Committees for Medical and Health Research Ethics. The participants signed voluntary consent before starting treatment. All interviews were conducted after the participants had completed their treatment. Interviewers were experienced psychotherapists and researchers who were alert to clients' well-being during the interview. All data was handled in accordance with guidelines from the Norwegian Regional Committees for Medical and Health Research Ethics. The research assistants that transcribed the material could not identify the name of the participant and were only given an ID, thus ensuring anonymity in the transcriptions.

Results

Our analysis of the data resulted in three main themes, presented here in an order that fits with the steps in the therapeutic process. We named these themes 1) Talking to a chair—an obstacle to overcome, 2) Heavy, intense, horrendous, and nice, 3) Realization—What am I doing to myself?

1. Talking to a chair – an obstacle to overcome

The first theme, "Talking to a chair – an obstacle to overcome", was reported by 14 participants and describes how the participants were at times somewhat reluctant to engage in the intervention. There were three main subcategories within this theme. The first subcategory was *feelings of embarrassment or awkwardness*. The second was *anxiety about performing*, and the third was *letting go of control*.

Fourteen of the participants reported some initial embarrassment or awkwardness when they were asked to engage in the two-chair dialogue. Eleven participants referred to this as a slight embarrassment, calling it "strange" or "… a bit embarrassing". Three participants experienced it as an intense feeling of shame; "… feeling totally naked" or

"awful". Even though it was embarrassing, only one participant expressed that she was unwilling to engage in the intervention.

> At first I thought, oh, My God! I'm easily embarrassed, so this is going to be awkward, right? But then I thought: "If this is going to help me, I need to be honest. Even though it is embarrassing for me, I need to say it out loud." So, it was like an obstacle to overcome.

This statement illustrates how many of the participants experienced the initial embarrassment as being faced with having to make a decision of whether to engage in the intervention or not. Even though many experienced that this sense of awkwardness faded with time, it was also reported by some as a constant obstacle. The participants elaborated on what they found so embarrassing about the two-chair dialogue. Mostly this was related to the unusual aspect of the two-chair dialogue. Some likened it to being in a play, while others reported feeling childish "…. because it felt a bit like something I would do when I was a child. I mean, it kind of resembled a kind of play from when I was young. That's the kind of feeling it gave."

Four participants also reported feeling unsure of whether they were going to get it right. This was talked about as having an element of *performance anxiety*—that they experienced the suggestions from the therapist as something they had to live up to: "When she suggested [the two-chair dialogue], I thought I couldn't do it. Like "no, I can't do this, it is not how I work, I am not able". I was certain I would fail at it."

One participant experienced the chair work as being too artificial for her to engage in the task properly, even though she performed what was asked of her. She stated that during the interventions "… it was hard to recreate the feelings that weren't there". Seven participants also experienced that letting go of control was an obstacle to overcome when they were to engage in the two-chair dialogue. Typically, the participants reported the *letting go-aspect* as a decision they made when engaging in this intervention:

> So, I was very much like; "Ok, here I simply need to let go." I've been working with letting go of control and thought to myself; "Well, if it looks stupid, so be it." And I went into it with all I had. Yes, it did feel terrible, but it helped.

Four participants experienced that letting go of control allowed them to turn their attention inwards. For instance, one participant talked about the therapist being in charge, something which helped her to stay in touch with her emotions: “For me it was therapeutic, cause I’m so used to always be in charge. The fact that she was in charge, helped me to […] stay with my emotions.”

Two participants talked about safety as a necessary precondition for being able to let go of control, while one participant felt that the therapist was too directive: “I guess all the sessions were good, but I did find the therapist a bit too directive”.

2. It’s heavy, intense, horrendous and nice

The second theme, “It’s heavy, intense, horrendous and nice”, was reported by 15 participants. This theme describes the participants experiences of the intervention as emotionally evocative, and that the intensity of emotions were experienced as demanding, painful, and helpful. There were four subcategories in this theme. The first subcategory was *physically demanding*, which left them feeling tired or exhausted both during and after sessions. The second was related to the *intensity of experience* during sessions, while the third pertained to experiencing the emotional intensity as *useful or productive*. The fourth subcategory was about feeling *too overwhelmed* for it to be useful.

When asked about their experience of using the two-chair dialogue, 15 participants described that they experienced their emotions more strongly. The experience of emotional intensity took on different qualities. 13 participants talked about the increased emotional intensity as experiencing their emotions in a different manner. This was typically referred to as *experiencing their emotions more intensely*, more clearly or more painfully, but also as nicely: “It was heavy, and intense, but also very …. somewhat horrendous. And very, nice actually. Because I learned a lot about myself.”

The participants described these painful aspects of the two-chair dialogue in different ways. Six participants talked about the intensity of specific painful emotions, five about being in distress, and nine about how it hurt.

> Participant: I have many pictures from this. A powerful one is when I was in the critic-chair.
> *Interviewer: Could you describe it to me?*
> Participant: It was very…naked. It was like getting a root canal. You get at the very nerve in a way. Like a straw into my soul.

Eleven participants described their experience with the two-chair dialogue as *physically demanding*. This was mostly talked about as something they felt as energetically draining during the intervention, and that the process could lead them to feel wiped out or exhausted after the session: "… it was really tiring. Both then and there, but also afterwards. Like, the rest of the day I felt mentally tired. Cause, I had been talking to and confronting myself, which demanded a lot of energy."

Although painful and demanding, the participants often described this heightened intensity as being relevant or *productive*. This ranged from talking about it as helpful pain (eight participants), to experiencing it as nice and more real compared to talking about it (six participants): "It became stronger. It became more real. More direct. Like there was no filter. And it threw me off a bit. So, it was like it was more targeted at my emotions. It was very useful."

However, four participants also experienced that the emotional intensity or emotional pain could be *too much*. They described this in terms of either having a negative experience, being in a confusion, being overwhelmed (two participants), or as not having the time to deal with all the emotional activation that emerged during the chair work (two participants): "It was very confusing because I felt I couldn't handle all the questions that popped up in me. It was too much in too little time." It was also pointed out by three participants that they would have needed the therapist to provide more support and time to deal with all that the emotions brought up at the end of the sessions:

> I couldn't collect myself at the end [of the sessions]. It was so tiring. And perhaps I would have wanted, if I was to do it again, more time at the end to help me gather myself. Not to leave the room in total confusion.

3. Realization - What am I doing to myself?

The third and final theme, "Realization—What am I doing to myself", described how the participants experienced that they gained new understandings of their own way of treating themselves through the two-chair dialogue. There were three subcategories under this theme. Firstly, there was the experience of *doing something to oneself* rather than simply talking about it. Secondly, there were experiences that had to do with *agency*. Finally, there was a subcategory having to do with the *realization* of internal processes.

All the participants (n=18) experienced that working actively in the two-chair dialogue was different from when they were solely talking about their difficulties. In different ways, they pointed out that *doing* or acting towards themselves in the chairs changed the process. Mostly, the two-chair dialogue was talked about as having different parts of themselves act on, and respond to, other parts of themselves (13 participants). This changed their perspective on their own difficulties. Most of the participants phrased this in ways that indicated that they experienced this aspect as helpful.

> You can talk about a lot of things, but you don't actually see it even though you're talking about it. You don't feel it on your body before you move from the judging side of you, over to the more vulnerable side, and actually tell the other part what it is doing to you.

Six participants explicitly described how they were actively *doing something to themselves* rather than "just talk about it", which led to their experiences feeling more real and immediate:

> So, I didn't just talk. In the chairs, it was more concrete in a way. […] I was saying some ugly, tough things that sort of cut into me and was more painful than simply talking about it. I think I felt it more. Cause, rather than talking about it in the past, it was like I was in the actual situation.

On a similar note, four participants also highlighted a difference between having cognitive insight into how they functioned, and experiencing the effect of what they did in the chairs:

> I can talk, and I can realize a lot of stuff. I can have insight into how I function, but it doesn't … It doesn't become as real before you actually get in the chair and see what you are doing towards yourself.

Ten participants also described how the two-chair dialogue helped them realize that they were active *agents* in creating their own inner experiences. A few of these statements focused on realizing that they could go home and treat themselves differently, but most of them talked about recognizing that they were an active part and had agency in their own emotional process:

> Most of all, the most important part for me was being active in producing all these feelings. It helped me understand why I acted that way I did, or rather, why it was this way. Why I get all these feelings, right.

Similarly, 13 participants also talked about how the two-chair dialogue helped them recognize and *realize* the negative content of their inner dialogue. Many of the participants reported a recognition of the harshness of their own self-critique. This recognition was typically reported as a surprising and emotionally evocative experience where they suddenly *realized* the degree and amount of negativity inherent in the message from the critical part of themselves. Sometimes the self-critical messages were so harsh that they couldn't put it into words:

> I think the most important part for me was realizing what I was doing inside my head, and how nasty it was. It was a real shocker. I remember not being able to state it at first, when I was acting as my critical voice. I remember not being able to actually say it. And I just started crying; "It is so nasty, I can't do it."

Discussion

Our findings in this study suggest three core themes that encapsulate the clients' experiences of using a two-chair dialogue intervention. The three themes can be understood as common aspects of working therapeutically with emotional change. Firstly, the client has to overcome some internal obstacles in order to engage in the task and evoke emotions. This is captured by the theme *Talking to a chair—an obstacle to overcome*. Then, after surmounting this obstacle, we suggest that there is a process where the client at times become aware of both being active in constructing and making

sense of the process (*What am I doing to myself?*), and on other occasions being submerged in the emotional experience (*Heavy, intense, horrendous and nice)*.

The first theme, *Talking to a chair –an obstacle to overcome*, highlights that the intervention in question, the two-chair dialogue, has some aspects that deviate from what most clients would anticipate for the therapeutic work. The intervention has some unusual social aspects where the client is invited to talk to an empty chair and to have a dialogue with an imagined part of him- or herself. It is expected that this unusual aspect of the intervention could create a hesitation or uncertainty in the client (Elliot et al., 2004). In learning EFT, there is usually a separate focus on how to introduce and initiate this intervention. As such, this theme comes as no surprise. It is possible that the obstacle would have been perceived as smaller if the client was asked to simply talk about his difficulties rather than act upon and do something to oneself.

It is also likely that the perceived obstacle is related to the second theme of having experienced the intervention as intense and painful, even as too much to handle. Furthermore, even though the first theme is called *talking to a chair*, the clients were imagining important others or parts of themselves in the chair. In that sense, it was not talking to a chair, but rather to an imagined part of themselves. This is likely to have emotional relevance, which could explain why many participants experienced it as intense and with emotional pain that at times were too much. A shared assumption in several psychotherapy models is that we tend to avoid painful feelings, both in therapy and in life (Abbass & Town, 2013; Foa & Kozak, 1986; Greenberg, 2002; Vaillant, 1997). Thus, when the clients were asked to partake in this intervention after having experienced it as intense and painful, it is reasonable to expect that there will be some hesitation.

The third theme also encapsulates that many participants experienced the process as "nice", or as hurting in a good way. It is likely that somehow this is part of why the clients did engage, even though it was an obstacle and it was painful. The three themes can thus be used to sum up quite a readily imagined process for many clients; dreading going into a session as an obstacle, engaging in an active intervention of *doing something to oneself*, which activates painful and intense emotions that feels relevant and "nice" to have tended to. It is also easy to imagine that clients who have

experienced the intervention as intense, would perceive it as an obstacle the next time they were asked to talk to an empty chair.

As our research team consisted of a fairly diverse group of clinicians and researchers, there were a few discrepancies in what we expected that the participants would report. The first theme, the obstacle of talking to a chair, however, was not unexpected to any of the researchers. Firstly, even if one has experience with the two-chair dialogue or not, it is a socially unusual thing to have your therapist tell you to talk to an empty chair. Still, the participants' descriptions highlighted the awkwardness most of them felt, which also points to the importance of building a good working alliance before using these interventions. A strong degree of safety and trust in the therapist was described as a necessary condition for engagement in two chair dialogue for some participants.

The second theme did not disconfirm our expectations in and of itself. The main intention of the chair work is to evoke emotions and have the client process them. However, it was somewhat surprising to hear many clients talk of it as highly intensive and physically exhausting. As such, we did not expect that many to report such high intensity. We expected more descriptions of adaptive or assertive feelings. It is possible that such feelings were embedded in what the participants described as nice or helpful. Finally, the realization-theme was also not surprising. What we did expect more of, was descriptions of change and of adaptive or assertive feelings. This was rather scarce, but might have been incorporated in participants' reports of the process as nice or useful. In sum, there were no major disconfirmations, but the degree of intensity many reported and perhaps the rather scarce reporting of adaptive or assertive emotions was different from our initial expectations.

Engaging in therapeutic tasks

The clients' engagement in psychotherapy is paramount for a good treatment outcome (Constantino, Castonguay, Zack, & DeGeorge, 2010). A commonly recognized prerequisite for client engagement is a good working alliance. Using Bordin's (1979) conceptualization of the working alliance, consisting of a safe relationship, and agreement of the method and the goal, it is clear that clients not only need to trust the therapist, but also experience the method and the goal as relevant to their process. As the two-chair dialogue is an unusual intervention, and perhaps not intuitively

meaningful for the client, it can be assumed to challenge the method and goal aspect of the alliance. The degree of fit between the clients construal of his or her problems and the method is central to the clients' engagement (Elkin et al., 1999). As the two-chair dialogue intervention is unusual, one might expect that clients were reluctant to engage in the intervention. However, most clients reported that they engaged in the intervention, despite of it being an obstacle. One possible explanation is that despite it feeling awkward to talk to an empty chair, it is also intuitively meaningful to do explicitly what is already being done intrinsically.

As mentioned, the perceived obstacle was not limited to the clients' first session using the two-chair dialogue intervention. Also after having engaged in the intervention, they continued to experience it as an obstacle to overcome. At the same time, many reported the intervention as intense and even painful. Interestingly, almost all clients stated that they engaged in the intervention even though it was emotionally painful. This suggests that the clients experienced the intensity and painful aspects as relevant. It is also possible that the bond in the alliance was strong enough to compensate for reluctance. For the participants in this study, there were at least five sessions preceding the intervention, providing enough time to establish a sufficient level of trust prior to introducing the two-chair dialogue. Also, the therapists' focus in the first sessions was on providing empathy, safety, and on tracking the clients' emotional state. These factors have previously been shown to be of importance in building a good therapeutic alliance and facilitating change (Castonguay, Constantino, & Holtforth, 2006; Wampold & Imel, 2015).

However, a few clients reported that they did not properly engage in the intervention. One client specified that it was due to not seeing the relevance for her difficulties, while another client reported the intervention as too directive. Both these complaints are relevant to the concept of the working alliance. Ideally, such complaints would have been picked up by the therapists and the treatment adjusted to the clients' process. However, as this was a research project where the therapists were instructed to use a specific intervention, it might have been more difficult for therapists to both accommodate the research aspects while tending to the clients' wishes. Still, the fact that a few clients did not engage suggests that the intervention may not be suitable for all clients. For instance, since the intervention is quite directive, clients with a certain

degree of reactance might have been less likely to engage (Norcross & Wampold, 2011).

Furthermore, the participants for this study were selected on the basis of being moderate to high on self-criticism. A common understanding of self-criticism is that it is the expression of shameful feelings (Gilbert & Irons, 2009). Shame is a highly aversive emotion that is often experienced as wanting to avoid the gaze of others (Gilbert & Andrews, 1998). It is, therefore, also possible that these clients were prone to experience this somewhat awkward intervention, as an obstacle to overcome. The fact that the sessions were also videotaped might have added to feelings of such embarrassment.

Experiencing emotions

Almost all participants experienced the intervention as emotionally intense, leading them to experience strong and sometimes painful feelings. One of the main intentions of the two-chair dialogue is to activate painful emotions in order to change them. The intervention is designed so that the client can imagine and encounter the stimuli that are related to his or her emotional injuries (Elliott & Greenberg, 1997). Then the therapist tries to facilitate stronger and opposing emotions that can transform the painful ones. Thus, when the process is successful, the client will experience a significant increase in the level of emotional arousal, both painful, strengthening, and soothing emotions. The intensity that most of the clients reported can possibly be attributed to such an increase in emotional arousal. More specifically, the two-chair dialogue intervention is intended to evoke feelings of inferiority and shame that underlie the self-critical message. Shame is usually experienced as an intense emotional pain (Whelton & Greenberg, 2005). It is possible that the strongly aversive quality that many participants reported reflects the pain of shame.

Emotions are also physical phenomena that reside in the body and engage the entire organism (Panksepp, Wright, Dobrossy, Schlaepfer, & Coenen, 2014). They involve action tendencies that are often muscular in nature. For instance, anger is often experienced as increased energy in the extremities and with a tendency to thrust forward (Panksepp et al., 2014). Crying in sadness is often experienced as a release of tension. Also, when people control or regulate emotions, they often involve muscular activity

(Lowen, 1974; Ogden & Fisher, 2015). As such, an increase in emotional arousal can be physically demanding, possibly explaining why many participants reported feeling tired and exhausted after the sessions. It is also likely that people who are seeking psychotherapy might have gotten used to restricting emotions related to their difficulties, rather than allowing them. As such, having an explicit focus on evoking and allowing emotions might create a shift in their experience of their bodily state.

Interestingly, many participants in different ways reported the intensity of emotions as both "horrendous, and nice". Emotions were experienced as two-sided, having both some demanding and painful aspects, but also some positive and constructive qualities. There are several explanations to this. Firstly, most emotion theorists see emotions as inherently adaptive, helping us to navigate and handle life's challenges (Damasio, 1998; Ekman, 1992; Ekman & Davidson, 1994; Izard, 1991; Panksepp, 2004; Plutchik, 1982). For instance, sadness feels painful, but the process of sorrow is often reported as having a bittersweet quality where one is dealing with the loss in order to be able to continue with one's life. Thus, the "nice" quality of the intensity might have to do with the emotions moving or adaptive quality. Even though we are motivated to avoid painful feelings, we also have an innate tendency to express our needs through emotions. Another explanation for the "nice" quality, might have been due to the clients experiencing adaptive and transformative emotions. According to EFT-theory, in successful treatments, painful maladaptive emotions are followed by adaptive and transforming emotions. Thus, it might be that the clients' reporting the intensity as nice, might have to do with having experienced adaptive emotions that influenced or transformed the pain aspect. Furthermore, it is common to understand inhibited emotions as more painful than emotions that are being allowed (Pennebaker & Hoover, 1986). In addition, giving emotions labels have been shown to have a down regulating effect on emotions (Lieberman et al., 2007). Yet another possible explanation of the "nice"-quality, has to do with mastery and expectancy. Emotions that are allowed to influence and inform the person, and then to be expressed, is likely to evoke a sense of mastery and calmness (Lieberman et al., 2007). Emotions are assumed to be directly related to our needs and desires. As such, allowing emotions might be experienced as helpful in navigating through life.

Dialectically constructing meaning

In EFT, it is suggested that the construction of meaning is constituted by a dialectical synthesis between experiential and conceptual processing (Greenberg & Pascual-Leone, 1995). The therapist is, therefore, guiding the clients' attention to alter between experiencing and giving a conceptual sense of this experiencing. Also, there is a dialectical process in the two-chair dialogue intervention. The participant is altering between doing something to himself or herself, for instance being self-critical, and experiencing and responding as the part that is receiving the message. The reported experiences of *What am I doing to myself?* could be understood as two dialectical processes where the client is not simply experiencing the effect of the self-critical message, or simply becoming aware of the message, but rather reporting a synthesis of *experiencing* and conceptualizing; and the awareness of being on both the giving and receiving end of this process.

A theoretical notion that captures central aspects of both these processes is what Rennie (2007) described as the alteration between reflexivity—understood as being self-aware, and radical reflexivity—understood as being aware of one's self-awareness. It is suggested that it is in the radical reflexive state, where the client is stepping out of the immediate experience, that he or she is able to see his own process and decide where to go with it. As such, the state of radical reflexivity is also a state of being agentic. The theme *What am I doing to myself?* can be understood as a chance for the client to step out of the reflexive state of feeling criticized and step into a radical reflexive state of becoming aware of the possibility to influence his next experience. Thus, the theme *What am I doing to myself?* can be understood as either the clients' experience of being able to influence the next step in the process, or in a larger sense, as the clients' realization that the emotional pain of being criticized is not something that they are passively receiving bur rather actively creating. The notion of this type of reflexivity and radical reflexivity is also relevant for the two other themes. One could see the theme […] *an obstacle to overcome* as a radical reflexivity where the client is aware of his self-awareness and needs to decide to engage in the task. The reported experiencing of emotions as *horrendous* and/or *nice* is a reflexive state where the client is aware of how he or she is feeling.

Researchers reflexivity

In line with recommended guidelines for qualitative interviews (Finlay, 2002), the interview material was handled with an awareness that the interviews and analysis unavoidably will be influenced by the researchers through co-construction of meaning. Both the main researcher and the other two members of the research team have been trained in EFT, and therefore, are quite familiar with the intervention in question. Two authors were, however, not affiliated with the EFT approach. The main researcher is working in a clinic where he is in charge of EFT training and supervision. Researcher allegiance is, therefore, an issue to be concerned with. The main researcher did not conduct any interviews but did take a central part in the consensual data handling. It is inevitable that preconceived notions have influenced the co-constructive process during the interview and during our consensual data handling. For instance, when developing the interview guide, we have been particularly interested in experiential and emotional aspects of the clients' processes. This may represent a strength in the sense that it makes us more refined in this investigation, and at the same time it poses a limit to a more open and neutral investigation. The research team has made an explicit effort to be reflexive about how preconceived notions could interfere with analysis and interpretations of the material through critical discussions, and tried to be especially sensitive to client experiences that challenged the EFT-model. For instance, we were particularly on the lookout for clients who might have experienced this evocative intervention as too intense. Also, we were sensitive to the fact that some clients might not benefit from this intervention.

Scope and limitations

The present study included 18 clients. This represents a limited sample and suggests caution when it comes to generalizing the findings. The participants had different therapists, were of different sex and age, and had slight differences in length of therapy. Other than that, the treatment was set up to be highly similar across participants, with two different phases of treatment in the same order and containing the same interventions. It seems reasonable to assume that the findings can inform clinicians about possible themes that could arise for clients who are considered for the two-chair dialogue intervention. Being more aware of the fact that clients might be in different emotional states at various stages of this intervention, could help clinicians to better facilitate the processes according to clients' needs. For instance, if the client is feeling

embarrassed at the initial phase of the intervention, empathic reassurance from the therapist might be of particular importance.

Another possible limitation of the study is related to the study design. Usually in EFT, the clients receive 3 sessions where the focus is on creating safety, rapport and finding a clear focus. In this design, they were given 5–9 sessions where the focus was on creating a good working alliance and empathically attunement to affect. The fact that the therapy drastically changed after such a long period of time, might have contributed to the clients' experiences of the chair work as awkward.

There is also a potential limitation in the data collection. The interview guide was developed within the context of a larger qualitative research project, making the interview quite extensive. Although this might have had concealed the research question, it is also possible that it might have exhausted the participant. It is possible that a shorter interview guide focusing on fewer topics would have provided richer and more valid data. In addition, the interview guide had specific questions that the interviewer asked if and when the participants answers did not focus on the research question. Although most participants talked about relevant topics without a great deal of probing, some of the data might come from somewhat leading questions.

Implications for research

Future research should investigate the characteristics of both the processes and the clients in those cases where the intervention was reported as too intense to be useful. Future research should also continue to investigate if and how the experiences of intensity in emotions and the realization of agency in self-criticism is related to the outcome of the therapeutic process. More research is also needed to better inform clinicians on how to facilitate beneficial processes best.

Implications for clinical practice

The awkwardness and intensity of this intervention calls for special attention to the working alliance before asking clients to engage. As some clients experience this intervention as too intense, it is important to a) inform the client in advance about the potential emotional intensity of the intervention, b) set aside enough time at the end of sessions to help the client sufficiently deal with vulnerable states before leaving the

clinic, and c) help clients identify personal and relational resources to utilize during the intersessional period. For most clients, it seems like the two-chair dialogue intervention might be a beneficial way of working with problematic ways of treating oneself.

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Appendix:

INTERVIEW GUIDE

EFT - Qualitative follow-up study

Introduction:

Thank you for setting up this interview.

Inform about intention/rationale for interview: I do not have advance knowledge about you. What you tell will be anonymous, the interviews will be anonymous so that nothing can identify you. Also, the results of all the interviews will be presented in scientific papers.

Instruction before interview: I'd like to talk to you about your experiences related to having carried out emosjonsfokusert therapy, and have some questions about how you have experienced it to go in this treatment—what you have experienced, which positive or negative experiences you have had in the course of treatment, and how you feel that it has helped or did not help you in what made you seek this treatment. In addition to the forms you've filled, it is also helpful for us to get to know each participant's specific experiences during and afterwards.

Background for seeking treatment

If I may begin with a general question and come up with some more specific questions later. First of all, can you tell us about how you experienced the therapy you went in?

At first, I would be happy to hear a little bit about how you came to seek this treatment. Is it okay?

a. Before you started: What was it that you wanted to change in your life?

b. What did you think were the reason for your difficulties? Has it changed during the therapy? Are you thinking differently about it now?

c. How did you envisage that the treatment should be before you started?

d. What was the would be most help to you before you started?

e. To what extent was the treatment you received in line with the expectations you had?

How it was for you to take part in the treatment

Can you tell us about how you experienced the first meeting with your therapist?

How did you experience the contact with the therapist? (possibly following up with "How did you feel the therapist understood your difficulty?"
Did this change for you during treatment?

What was the main objective you had in therapy? (goals)
a. Did you feel that the goal of therapy changed during treatment?

How did you work together to achieve this goal? (Method)?
a. Did you feel in any way that you were working on changed ways during treatment?
b. Follow up: What was it that changed? How was it for you?
c. What was known to you, and what did you feel and think when you did this?

Can you remember a situation during the therapy that was difficult or challenging for you?
a. Which situation was this? What happened?
b. What was known to you, and what did you feel and think
c. Did the therapist perceive that this was difficult or challenging for you?

How was this situation handled?
a. What did the therapist do?
b. What did you do?
c. What did you need to happened?
d. How did you experience the therapy after this?

IF NOT MENTIONED ALREADY: At some point did you begin doing exercises where you used the chairs to work with individual topics? Did you notice that?
How was it for you to begin with chair exercises?
How did you experience this transition?

What worked with you when you spent chair exercises? / Can you tell us about what you worked / talked about when you did this?
What did you aim during chair exercises?

Did you feel that the therapist brought out the purpose in a way that made sense to you?
How was it for you to work with these chair exercises?
In this way of working, the therapist takes part of the management. How did you do it?
Did you help these exercises of you work with things that were important to you?
Follow up in a more concrete manner: How? In what way?

This treatment you've gone through has a focus on emotions. How did you do it?
How was it for you to know your own feelings?
Was it different in chair exercises?
How was it for you that the focus was often on what you knew in your body?
Was it different in chair exercises?
How was it for you to talk about feelings?
Was it different in chair exercises?
Do you feel that the treatment has changed the way you relate to your feelings in everyday life? In what way?
How do you feel that this treatment has helped you in the ways you relate to other people? In what way?

This treatment you have gone through also has a strong focus on self-criticism.
How did you work with the way you talk to yourself?
Too much self-criticism can also be a challenge in therapy. How was that for you? (If yes: follow-up - could you elaborate / when / how)
What was most important to you in the work of self-criticism?
Was it different to work with the way you talk to yourself in the chair exercises? What was different? In what way?
You also filled the form of self-criticism for every hour. How was it for you?
Did you feel that it affected the work of self-criticism in the treatment? How? In what way?
Does this way of working change how you treat yourself? How? In what way?

After treatment

When you look back on the time that has been since you started treatment, what is the most important change that you experienced / changed for you / helped you?
What was most helpful to you? / What was it that helped you the most?

Have you noticed any other changes?

a. Are there things that have not changed or gotten worse since the therapy started?

Often, when we think back on something, we get specific memories or images that stand for something important. If you were to draw a picture, episode, or memory from therapy which are or were important to you, what would it be?

If the episode was positive, were there any important negative episodes as well?

Now, towards the end, I just want to ask you some questions about the job and the workplace. How do you feel that this treatment has helped you in your everyday work?

What made it difficult for you to be at work when you started treatment? (obs. private or job-related reasons for sick leave)

Did you feel afterwards that the treatment has helped you with this? / relate to this? In what way?

Coping: What do they describe as the main problem?

Mastery of work

Relate to colleagues

Respond to management

Concluding the interview

Were there some things you missed on therapy, or that you felt would better treatment for you?

What / how?

Was there anything you would have had more of?

Was there anything you would have had less of?

If a best friend of yours should have been in this kind of treatment, what would have been important for them to know?

Is there anything that was important to you, that we have forgotten or are not asked about? Something you have not mentioned?

Debriefing: How have you experienced your participation in this interview?

THANKS FOR PARTICIPATION!

Appendices

Appendix A – The Experiencing Scale

Appendix B – The Client Emotional Arousal Scale III

Appendix C – The qualitative interview guide

Appendix A – The Experiencing Scale

The Experiencing Scales ©

Klein, M. H., Mathieu, P., Gendlin, E., & Kiesler, D. J. (1986). The experiencing scales: A research and training manual (Vol. 1). Madison, University of Wisconsin Extension Bureau of Audio visual instruction, 1969 (copyrighted 1970).

Experiencing Scale, summarized

1. ***Objective and intellectual,*** giving no evidence og the personal significance of events they describe.
2. ***Personal but detached,*** no explicit reference to feelings, reactions or internal states.
3. ***Reactions*** to external events begin to appear.
4. ***Marked shift inwards*** with a focus on exploration of feelings and internal experiences. At level 4 clients are in direct contact with their fluid experience and speak "from it" as opposed to "about it".
5. ***Questions about experience*** and the self are raised and explored from an internal perspective.
6. ***Newly realized feelings*** and experience are integrated and explored to produce personally meaningful construction and resolve issues.
7. Shifts and new understanding in one particular area of experience are ***broadened to a wider range*** of experiences giving clarity and meaning.

The following are the criteria used by raters to establish Levels of Experiencing:

Stage One.

The chief characteristic of this stage is that the content or manner of expression is impersonal. In some cases the content is intrinsically impersonal, being a very abstract, general superficial or journalistic account of events or ideas with no personal referent established. In other cases, despite the personal nature of the content, the speaker's

involvement is impersonal, so that he/she reveals nothing important about himself and his/her comments could as well be about a stranger or an object.

a. *The content is not about the speaker.* The speaker tells a story, describes other people or event I which he is not involved, or presents a generalized or detached account of ideas. Nothing makes the content personal.
b. *The content is such that the speaker is identified with it in some way but the association is not made clear.* The speaker refers in passing to him/herself but his/her references do not establish hi/her involvement. First person pronouns only define the speaker as object, spectator, or incidental participant. Attention is focused exclusively on external events. For example, "As I was walking down the street I saw this happen…"; "He stepped on my toe." The speaker does not supply his attitudes, feelings or reactions. He/she treats himself/herself as an object or instrument or in so remote a way that the story could be about someone else. His/her manner of expression is remote, matter of fact, or offhand as in superficial social chit-chat, or has a mechanical or rehearsed quality.
c. *The content is a terse, unexplained refusal to participate in an interaction, or an avoidance or minimizing of an interaction.* Minimal responses without spontaneous comments are at stage one.

Stage Two.

The association between the speaker and the content is explicit. Either the speaker is the central character in the narrative or his/her interest in clear. The speaker's involvement, however, does not go beyond the specific situation or content. All comments, associations, reactions, and remarks serve to get the story or idea across but do not refer to or define the speaker's feelings.

a. *The content is a narrative of events in which the speaker is personally involved.* His/her remarks establish the importance of the content but make no reference to the quality of this involvement. Remarks and associations refer to the

external facets of the narrative, other people, the events, objects, the speakers actions; they do not give his/her inner reactions or perspective. If the narrative includes the speaker's thoughts, opinions, wishes, or attitudes, these only describe him intellectually or superficially. Some speakers refer to ideas and thoughts as if they were feelings; e.g., "I feel that I am a good farmer"; "I feel that people should be more considerate." If terms like "I think" or "I wish" could be substituted for "I feel" without changing the meaning, the remark is at stage two.

b. *The events narrated are impersonal but the speaker explicitly establishes that the content is important to him/her.* For example, he/she expresses interest in or evaluates an event, but does not show the quality or amount of his interest or concern.
c. *The content is a self-description that is superficial, abstract, generalized, or intellectualized.* No reference is made to the speaker's feelings or internal perspective. The segment presents the ideas, attitudes, opinions or moral judgments, wishes, preferences, aspirations, or capacities that describe the speaker form and external or peripheral perspective. One sees him from the outside.
d. *The content reveals the speaker's feelings and reactions implicitly but not explicitly.* If the speaker is emotionally aroused, it is evident from his/her manner, not from his/her words. If the content is the sort that ordinarily would be personally significant, the speaker does not say so. If the speaker sometimes mentions his/her feelings, he/she treats them abstractly, impersonally, as objects, or attributes them to others. Third person pronouns, especially 'one feels' indicate impersonalization.
e. *The content is an account of a dream, fantasy, hallucination, or free association.* These should be treated as narratives of external events. They are at stage two if the speaker's remarks associate him/her with the account but do not five his feeling reactions to it.

Stage Three.

The content is a narrative or description of the speaker in external or behavioral terms with added comments on his/her feelings or private experiences. These remarks are limited to the events or situation described, giving the narrative a personal touch without describing the speaker more generally. Self-descriptions restricted to a specific situation or role, are also stage three.

a. *The content is a narrative of events or description of an aspect of the speaker's environment (past, present, or future) with parenthetical personal remarks that give one of the following:*
    1) The speaker's feelings as the time of the event or in retrospect about it. For example, "He didn't call me back and I was angry" or "He didn't call me back; thinking about it now makes me angry."
    2) The personal significance or implication of the situation by relating it to the speaker's private experience. For example, "It reminded me of being scolded as a child"; "It was one of those queer moods that comes on me when I get tired. "
    3) The speakers state of awareness at the time of the event. Such remarks include details of motives, consciousness, private perceptions, or assumptions which are limited to the event. For example, : "I knew at the time that I was reacting too strongly"; " I was aware of wanting to defend myself "; " I did it even though I sensed how foolish it was." Accounts of dreams, hallucinations, fantasies, and free associations should be treated as narratives; they are at stage three if feelings are mentioned.
b. *The content is a self-description of circumscribed aspects of the speaker's life Style or role or of his feelings and reaction presented only in behavioral terms.* The speaker might, for example, describe how he functions as a parent or in his job, or tell what he does when he gets angry. Personal remarks enrich the description of the situation or reaction to it, but are limited to the immediate context.

c. *In response to a direct question, the speaker tells what his feelings are or were.* The interviewer's words are not needed to identify the feeling.

Stage Four.

The content is clear presentation of the speaker's feelings, giving his/her personal internal perspective or feeling about him/herself. Feelings or the experience of events, rather than the events themselves, are the subject of the discourse. By attending to and presenting this experiencing, the speaker communicates what it is like to be him/her. These interior views are presented, listed, or described, but are not interrelated or used as the basis for systematic self-examination or formulation.

a. *The initial content is a specific situation that is widened and deepened by the speaker's self references to show what he/she is like more generally or more personally.* The speaker must describes feelings in great detail, refer to feelings as they occur in a range of situations, provide personal reactions to specific feelings, or relate reactions to his own self-image. The feelings can be immediate responses or remembered responses to past situations. Self-descriptive comments must deal with internal or personal aspects of the speaker, not with moral evaluations or external or behavioral characteristics.
b. *The content is a story told completely from the personal point of view.* The details of feelings, reactions, and assumptions are integral to the narrative, so that what emerges is a detailed picture of the speaker's personal experience of the events.
c. *The content is a self-characterization in which the speaker tells about his personal perspective.* In talking about him/herself he/she makes explicit his/her feelings, personality, assumptions, motives, goals, and private perceptions. By revealing these internal parts of him/herself, the speaker gives a detailed picture of one or more of his/her states of being. The material presented is not analyzed or interrelated. He use of abstract terms or jargon to describe elements of personality must be expanded with some internal detail to warrant a rating of four. For example, the statement "my ego was shattered" would need elaboration, such as " I felt if I was nothing, that no one would ever notice me".

Stage Five

The content is a purposeful exploration of the speaker's feelings and experiencing. There are **two necessary components**. First the **speaker must pose or define a problem or proposition about him/herself explicitly in terms of feelings**. The problem or proposition may involve the origin, sequence, or implications of feelings or relate feelings to other private processes. **Second he/she must explore or work with the problem in a personal way.** The exploration or elaboration must be clearly related to the initial proposition and must contain inner references so that it functions to expand the speaker's awareness of his experiencing. Both components, the problem and the elaboration, must be present.

The proposition or problem must be given clearly or strongly and should include references to feelings or to the personal experience of the issue. If the internal basis of the problem is weak, as in references to undesired behaviors or styles, propositions about the external precipitants of the behavior or feelings, or presentation of temporal sequence of feelings, then the exploration or elaboration must have extensive inward references. It must be clear that the speaker is focusing on his inner experience rather than simply justifying his/her behavior.

The problem or hypothesis about the self must be oriented to feelings, private reactions, or assumptions basic to the self-image. It can be presented in different ways:

1) A feeling, reaction or inner process, and in some cases behavior pattenr, can be defined as problematic in itself or as seeming to conflict with other feelings or aspects of the self; for example, " My anger is the problem" or " Why am I so angry?".
2) The speaker may wonder whether or to what extent he has a specific feeling: not W what do I feel?" which would be a three or four, but " Do I relay feel angry?" or " How angry am I, really?"

3) The problem or proposition can be defined in terms of the personal implication, relationships, and inner ramifications of a feeling, including its origins or causes, its place in a temporal sequence of feelings and inner events, its mode of expression, or its personal and private implications. For example: “Do I get angry when I feel inadequate ?” or “My getting angry means I’ve lost control of myself” or “ I get angry just the way my mother used to”.
4) Feelings, reaction and internal processes may be compared.

All the problems or propositions about the self must be explored or elaborated with inner referents. Examples or illustrations may show how the speaker experiences the problem or proposition in different settings or at different times; if so, the pertinence of the illustration to the problem must be explicit. The problem or proposition may be related to other internal processes or reactions. Alternatively, through hypothesis, speculation, or analogy the speaker clarifies the nature or private implication of the central problem, its causes, or ramifications.

At Stage 5 the speaker is exploring or testing a hypothesis about his/her experiencing. While he/she must define the subject of this process clearly with inner references, his manner may be conditional, tentative, hesitant, or searching.

Stage Six.

The content is a synthesis of readily accessible, newly recognized, or more fully realized feelings and experiences to produce personally-meaningful structures or resolve issues. The speaker’s immediate feelings are integral to his/her conclusions about his/her inner workings. He/she communicates a new or enriches self-experiencing and the experiential impact of the changes in his attitudes or feelings about him/herself. The subject matter concerns the speaker’s present and emergent experience. His/her manner may reflect changes or insights at the moment of their occurrence. These are verbally elaborated in detail. Apart from the specific content, the speaker conveys a sense of active, immediate involvement in an experientially anchored issue with evidence of its resolution or acceptance.

a. *The feelings involved must be vividly, fully, or concretely presented.* Past feelings or past changes in feelings are vividly presented or relived as part of the speaker's current experience.
b. *The structuring process relates these immediately felt events to other aspects of the speaker's private perspective.* This, a feeling might be related to the speaker's self-image, his/her private perceptions, motives, assumptions, to another feeling, or to more external facets of the speaker's life, such as his/her behavior. In each case the nature of the relationship must be defined so that the details of how the speaker works inside and the precise, internal impact of the changes is revealed. It is not merely the existence of a relationship, nor a sequential listing of feelings and inner experiences, but the nature and quality of the association that is made clear.
c. *The synthetic, structuring process leads to a new personally meaningful inner experience or resolves an issue.* As a result of working with his/her feelings and other aspects of his/her private perspective, and exploring their relationship to each other, the speaker has new inner experiences. These may be new feelings or changed feelings, as when the speaker says, "now I am beginning to see that my feeling of guilt is caused by my ideas about work, and it makes me feel much less worried about that sense of guilt. What a relief! " Alternatively and issue may be resolved:" You know I've always kept my anger bottled up because I've been afraid of losing control of myself. Now I realize it wouldn't be so bad if I did; maybe I'd yell or throw something, that's all." IF the speaker starts with a concrete external problem, the related feelings must be presented as part of his present experience and the emergent formulation must change his perception of the problem in some way. For example, "I never asked a girl out because I'm so short. I'm still kind of afraid a girl might call me a shrimp or something, but I'm willing to take that risk now. I guess because I realize that even if she did, it wouldn't break me up. I wouldn't like her very much, but I'd feel better about myself for having at least

tried.” Some elements in the emergent structure may be external, behavioural, or intellectual as in a decision to act in a different way. Still, they must be clearly grounded to immediate feelings. It is never sufficient only to state that a resolution has taken place; the experiences underlying the restructuring process must be revealed or relived to satisfy the criteria for stage 6.

Stage Seven

The content reveals the speaker’s expanding awareness of his immediately present feelings and internal processes. He demonstrates clearly that he can move from one inner reference to another, altering and modifying his conception of himself, his feelings, his private reactions to his thoughts or actions in terms of their immediately felt nuances as they occur in the present experiential moment, so that each new level of self-awareness functions as a springboard for further exploration.

Formulations about the self at stage seven meet the requirements for stage six with the additional stipulation that they be applied to an expanding range of inner events or give rise to new insights. The development may follow one of several different patterns.

1) The speaker may start with an internally anchored problem, explore it, and reach and internally anchored conclusion that he/she then applies to a number of other problems.

2) He/She may arrive at several related solutions to a single problem and reintegrate them. Any self-analysis is followed by a more comprehensive or extensive synthesis.

3) The speaker may use several different formulations about him/herself, each of which meets the requirements for stage six, and integrate, relate, or reduce them through a more basic or general formulation.

4) He/she may start with one conclusion of the type reached in stage six and apply it to a range of situations, each with inner referents explicit, to show how the general principle applies to a wide area of his/her experience.

Experiencing at stage seven is expansive and unfolding. The speaker readily uses a fresh way of knowing himself to expand his experiencing further. Manner at this stage is often euphoric, buoyant, or confident; the speaker conveys a sense of things falling quickly and meaningfully into place.

Appendix B – The Client Emotional Arousal Scale III

1	Person does not express emotions. Voice or gestures **do not** disclose any emotional arousal
2	Person may allow some emotion, but there is **very little** arousal in voice or body ▪ there is no disruption of usual speech patterns ▪ any arousal is almost **completely restricted**
3	At this level of arousal as well as higher levels, the person allows emotions Arousal is **mild** in voice and body ▪ very little emotional overflow ▪ any arousal is still **very restricted** ▪ usual speech patterns are only **mildly disrupted**
4	Arousal is **moderate** in voice and body ▪ emotional voice is present: ordinary speech patterns are **moderately** disrupted by emotional overflow as represented by changes in accentuation patterns, unevenness of pace, changes in pitch ▪ although there is some freedom from control and restraints, arousal may still be **somewhat restricted**
5	Arousal is **fairly intense and full** in voice and body ▪ emotion overflows into speech pattern to a great extent: speech patterns deviate **markedly** from the client's baseline, and are fragmented or broken ▪ elevated loudness and volume ▪ arousal seems **only slightly restricted**
6	Arousal is **very intense and extremely full** as the person is freely expressing emotion, with voice and body. ▪ usual speech patterns are **extremely disrupted** as indicated by changes in accentuation patterns, unevenness of pace, changes in pitch, and volume or force of voice ▪ spontaneous expression of emotion and there is **almost no sense of restriction**
7	Arousal is **extremely intense and full** in voice and body ▪ usual speech patterns are **completely disrupted** by emotional overflow ▪ the expression is **completely dysregulated and unrestricted** ▪ arousal appears uncontrollable and enduring. ▪ falling apart quality: although arousal can be a completely unrestricted therapeutic experience, it may also be a disruptive negative experience in which the clients feels like they are falling apart **<u>control = containment in contrast to control = restriction</u>** * The distinguishing feature between level 6 and level 7 is that in level 6 there is the sense that although a person's expression may be fairly unrestricted, this individual would be able to contain or control his or her arousal, whereas in level 7, a person's expression is completely unrestricted and there is the sense that emotional arousal would not be within this person's control.

Appendix C – The qualitative interview guide

INTERVIEW GUIDE
EFT - Qualitative follow-up study

Introduction:

Thank you for setting up this interview.
Inform about intention/rationale for interview: I do not have advance knowledge about you. What you tell will be anonymous, the interviews will be anonymous so that nothing can identify you. Also, the results of all the interviews will be presented in scientific papers.
Instruction before interview: I'd like to talk to you about your experiences related to having carried out emosjonsfokusert therapy, and have some questions about how you have experienced it to go in this treatment—what you have experienced, which positive or negative experiences you have had in the course of treatment, and how you feel that it has helped or did not help you in what made you seek this treatment. In addition to the forms you've filled, it is also helpful for us to get to know each participant's specific experiences during and afterwards.

Background for seeking treatment

If I may begin with a general question and come up with some more specific questions later. First of all, can you tell us about how you experienced the therapy you went in?

At first, I would be happy to hear a little bit about how you came to seek this treatment. Is it okay?
a. Before you started: What was it that you wanted to change in your life?
b. What did you think were the reason for your difficulties? Has it changed during the therapy? Are you thinking differently about it now?
c. How did you envisage that the treatment should be before you started?

d. What was the would be most help to you before you started?

e. To what extent was the treatment you received in line with the expectations you had?

How it was for you to take part in the treatment

Can you tell us about how you experienced the first meeting with your therapist?

How did you experience the contact with the therapist? (possibly following up with "How did you feel the therapist understood your difficulty?"

Did this change for you during treatment?

What was the main objective you had in therapy? (goals)

a. Did you feel that the goal of therapy changed during treatment?

How did you work together to achieve this goal? (Method)?

a. Did you feel in any way that you were working on changed ways during treatment?

b. Follow up: What was it that changed? How was it for you?

c. What was known to you, and what did you feel and think when you did this?

Can you remember a situation during the therapy that was difficult or challenging for you?

a. Which situation was this? What happened?

b. What was known to you, and what did you feel and think

c. Did the therapist perceive that this was difficult or challenging for you?

How was this situation handled?

a. What did the therapist do?

b. What did you do?

c. What did you need to happened?

d. How did you experience the therapy after this?

IF NOT MENTIONED ALREADY: At some point did you begin doing exercises where you used the chairs to work with individual topics? Did you notice that?
How was it for you to begin with chair exercises?
How did you experience this transition?

What worked with you when you spent chair exercises? / Can you tell us about what you worked / talked about when you did this?
What did you aim during chair exercises?
Did you feel that the therapist brought out the purpose in a way that made sense to you?
How was it for you to work with these chair exercises?
In this way of working, the therapist takes part of the management. How did you do it?
Did you help these exercises of you work with things that were important to you? Follow up in a more concrete manner: How? In what way?

This treatment you've gone through has a focus on emotions. How did you do it?
How was it for you to know your own feelings?
Was it different in chair exercises?
How was it for you that the focus was often on what you knew in your body?
Was it different in chair exercises?
How was it for you to talk about feelings?
Was it different in chair exercises?
Do you feel that the treatment has changed the way you relate to your feelings in everyday life? In what way?
How do you feel that this treatment has helped you in the ways you relate to other people? In what way?

This treatment you have gone through also has a strong focus on self-criticism.
How did you work with the way you talk to yourself?
Too much self-criticism can also be a challenge in therapy. How was that for you? (If yes: follow-up - could you elaborate / when / how)
What was most important to you in the work of self-criticism?
Was it different to work with the way you talk to yourself in the chair exercises? What was different? In what way?
You also filled the form of self-criticism for every hour. How was it for you?
Did you feel that it affected the work of self-criticism in the treatment? How? In what way?
Does this way of working change how you treat yourself? How? In what way?

After treatment

When you look back on the time that has been since you started treatment, what is the most important change that you experienced / changed for you / helped you?
What was most helpful to you? / What was it that helped you the most?

Have you noticed any other changes?
a. Are there things that have not changed or gotten worse since the therapy started?

Often, when we think back on something, we get specific memories or images that stand for something important. If you were to draw a picture, episode, or memory from therapy which are or were important to you, what would it be?
If the episode was positive, were there any important negative episodes as well?

Now, towards the end, I just want to ask you some questions about the job and the workplace. How do you feel that this treatment has helped you in your everyday work?
What made it difficult for you to be at work when you started treatment? (obs. private or job-related reasons for sick leave)
Did you feel afterwards that the treatment has helped you with this? / relate to this? In what way?
Coping: What do they describe as the main problem?
Mastery of work
Relate to colleagues
Respond to management

Concluding the interview

Were there some things you missed on therapy, or that you felt would better treatment for you?
What / how?
Was there anything you would have had more of?
Was there anything you would have had less of?

If a best friend of yours should have been in this kind of treatment, what would have been important for them to know?

Is there anything that was important to you, that we have forgotten or are not asked about? Something you have not mentioned?

Debriefing: How have you experienced your participation in this interview?

THANKS FOR PARTICIPATION

Doctoral Theses at The Faculty of Psychology, University of Bergen

1980	Allen, H.M., Dr. philos.	Parent-offspring interactions in willow grouse (Lagopus L. Lagopus).
1981	Myhrer, T., Dr. philos.	Behavioral Studies after selective disruption of hippocampal inputs in albino rats.
1982	Svebak, S., Dr. philos.	The significance of motivation for task-induced tonic physiological changes.
1983	Myhre, G., Dr. philos.	The Biopsychology of behavior in captive Willow ptarmigan.
	Eide, R., Dr. philos.	PSYCHOSOCIAL FACTORS AND INDICES OF HEALTH RISKS. The relationship of psychosocial conditions to subjective complaints, arterial blood pressure, serum cholesterol, serum triglycerides and urinary catecholamines in middle aged populations in Western Norway.
	Værnes, R.J., Dr. philos.	Neuropsychological effects of diving.
1984	Kolstad, A., Dr. philos.	Til diskusjonen om sammenhengen mellom sosiale forhold og psykiske strukturer. En epidemiologisk undersøkelse blant barn og unge.
	Løberg, T., Dr. philos.	Neuropsychological assessment in alcohol dependence.
1985	Hellesnes, T., Dr. philos.	Læring og problemløsning. En studie av den perseptuelle analysens betydning for verbal læring.
	Håland, W., Dr. philos.	Psykoterapi: relasjon, utviklingsprosess og effekt.
1986	Hagtvet, K.A., Dr. philos.	The construct of test anxiety: Conceptual and methodological issues.
	Jellestad, F.K., Dr. philos.	Effects of neuron specific amygdala lesions on fear-motivated behavior in rats.
1987	Aarø, L.E., Dr. philos.	Health behaviour and sosioeconomic Status. A survey among the adult population in Norway.
	Underlid, K., Dr. philos.	Arbeidsløyse i psykososialt perspektiv.
	Laberg, J.C., Dr. philos.	Expectancy and classical conditioning in alcoholics' craving.
	Vollmer, F.C., Dr. philos.	Essays on explanation in psychology.
	Ellertsen, B., Dr. philos.	Migraine and tension headache: Psychophysiology, personality and therapy.
1988	Kaufmann, A., Dr. philos.	Antisosial atferd hos ungdom. En studie av psykologiske determinanter.

	Mykletun, R.J., Dr. philos.	Teacher stress: personality, work-load and health.
	Havik, O.E., Dr. philos.	After the myocardial infarction: A medical and psychological study with special emphasis on perceived illness.
1989	Bråten, S., Dr. philos.	Menneskedyaden. En teoretisk tese om sinnets dialogiske natur med informasjons- og utviklingspsykologiske implikasjoner sammenholdt med utvalgte spedbarnsstudier.
	Wold, B., Dr. psychol.	Lifestyles and physical activity. A theoretical and empirical analysis of socialization among children and adolescents.
1990	Flaten, M.A., Dr. psychol.	The role of habituation and learning in reflex modification.
1991	Alsaker, F.D., Dr. philos.	Global negative self-evaluations in early adolescence.
	Kraft, P., Dr. philos.	AIDS prevention in Norway. Empirical studies on diffusion of knowledge, public opinion, and sexual behaviour.
	Endresen, I.M., Dr. philos.	Psychoimmuniological stress markers in working life.
	Faleide, A.O., Dr. philos.	Asthma and allergy in childhood. Psychosocial and psychotherapeutic problems.
1992	Dalen, K., Dr. philos.	Hemispheric asymmetry and the Dual-Task Paradigm: An experimental approach.
	Bø, I.B., Dr. philos.	Ungdoms sosiale økologi. En undersøkelse av 14-16 åringers sosiale nettverk.
	Nivison, M.E., Dr. philos.	The relationship between noise as an experimental and environmental stressor, physiological changes and psychological factors.
	Torgersen, A.M., Dr. philos.	Genetic and environmental influence on temperamental behaviour. A longitudinal study of twins from infancy to adolescence.
1993	Larsen, S., Dr. philos.	Cultural background and problem drinking.
	Nordhus, I.H., Dr. philos.	Family caregiving. A community psychological study with special emphasis on clinical interventions.
	Thuen, F., Dr. psychol.	Accident-related behaviour among children and young adolescents: Prediction and prevention.
	Solheim, R., Dr. philos.	Spesifikke lærevansker. Diskrepanskriteriet anvendt i seleksjonsmetodikk.
	Johnsen, B.H., Dr. psychol.	Brain assymetry and facial emotional expressions: Conditioning experiments.
1994	Tønnessen, F.E., Dr. philos.	The etiology of Dyslexia.
	Kvale, G., Dr. psychol.	Psychological factors in anticipatory nausea and vomiting in cancer chemotherapy.

	Asbjørnsen, A.E., Dr. psychol.	Structural and dynamic factors in dichotic listening: An interactional model.
	Bru, E., Dr. philos.	The role of psychological factors in neck, shoulder and low back pain among female hospitale staff.
	Braathen, E.T., Dr. psychol.	Prediction of exellence and discontinuation in different types of sport: The significance of motivation and EMG.
	Johannessen, B.F., Dr. philos.	Det flytende kjønnet. Om lederskap, politikk og identitet.
1995	Sam, D.L., Dr. psychol.	Acculturation of young immigrants in Norway: A psychological and socio-cultural adaptation.
	Bjaalid, I.-K., Dr. philos	Component processes in word recognition.
	Martinsen, Ø., Dr. philos.	Cognitive style and insight.
	Nordby, H., Dr. philos.	Processing of auditory deviant events: Mismatch negativity of event-related brain potentials.
	Raaheim, A., Dr. philos.	Health perception and health behaviour, theoretical considerations, empirical studies, and practical implications.
	Seltzer, W.J., Dr.philos.	Studies of Psychocultural Approach to Families in Therapy.
	Brun, W., Dr.philos.	Subjective conceptions of uncertainty and risk.
	Aas, H.N., Dr. psychol.	Alcohol expectancies and socialization: Adolescents learning to drink.
	Bjørkly, S., Dr. psychol.	Diagnosis and prediction of intra-institutional aggressive behaviour in psychotic patients
1996	Anderssen, Norman, Dr. psychol.	Physical activity of young people in a health perspective: Stability, change and social influences.
	Sandal, Gro Mjeldheim, Dr. psychol.	Coping in extreme environments: The role of personality.
	Strumse, Einar, Dr. philos.	The psychology of aesthetics: explaining visual preferences for agrarian landscapes in Western Norway.
	Hestad, Knut, Dr. philos.	Neuropsychological deficits in HIV-1 infection.
	Lugoe, L.Wycliffe, Dr. philos.	Prediction of Tanzanian students' HIV risk and preventive behaviours
	Sandvik, B. Gunnhild, Dr. philos.	Fra distriktsjordmor til institusjonsjordmor. Fremveksten av en profesjon og en profesjonsutdanning
	Lie, Gro Therese, Dr. psychol.	The disease that dares not speak its name: Studies on factors of importance for coping with HIV/AIDS in Northern Tanzania
	Øygard, Lisbet, Dr. philos.	Health behaviors among young adults. A psychological and sociological approach
	Stormark, Kjell Morten, Dr. psychol.	Emotional modulation of selective attention: Experimental and clinical evidence.

	Einarsen, Ståle, Dr. psychol.	Bullying and harassment at work: epidemiological and psychosocial aspects.
1997	Knivsberg, Ann-Mari, Dr. philos.	Behavioural abnormalities and childhood psychopathology: Urinary peptide patterns as a potential tool in diagnosis and remediation.
	Eide, Arne H., Dr. philos.	Adolescent drug use in Zimbabwe. Cultural orientation in a global-local perspective and use of psychoactive substances among secondary school students.
	Sørensen, Marit, Dr. philos.	The psychology of initiating and maintaining exercise and diet behaviour.
	Skjæveland, Oddvar, Dr. psychol.	Relationships between spatial-physical neighborhood attributes and social relations among neighbors.
	Zewdie, Teka, Dr. philos.	Mother-child relational patterns in Ethiopia. Issues of developmental theories and intervention programs.
	Wilhelmsen, Britt Unni, Dr. philos.	Development and evaluation of two educational programmes designed to prevent alcohol use among adolescents.
	Manger, Terje, Dr. philos.	Gender differences in mathematical achievement among Norwegian elementary school students.
1998 **V**	Lindstrøm, Torill Christine, Dr. philos.	«Good Grief»: Adapting to Bereavement.
	Skogstad, Anders, Dr. philos.	Effects of leadership behaviour on job satisfaction, health and efficiency.
	Haldorsen, Ellen M. Håland, Dr. psychol.	Return to work in low back pain patients.
	Besemer, Susan P., Dr. philos.	Creative Product Analysis: The Search for a Valid Model for Understanding Creativity in Products.
H	Winje, Dagfinn, Dr. psychol.	Psychological adjustment after severe trauma. A longitudinal study of adults' and children's posttraumatic reactions and coping after the bus accident in Måbødalen, Norway 1988.
	Vosburg, Suzanne K., Dr. philos.	The effects of mood on creative problem solving.
	Eriksen, Hege R., Dr. philos.	Stress and coping: Does it really matter for subjective health complaints?
	Jakobsen, Reidar, Dr. psychol.	Empiriske studier av kunnskap og holdninger om hiv/aids og den normative seksuelle utvikling i ungdomsårene.
1999 **V**	Mikkelsen, Aslaug, Dr. philos.	Effects of learning opportunities and learning climate on occupational health.
	Samdal, Oddrun, Dr. philos.	The school environment as a risk or resource for students' health-related behaviours and subjective well-being.
	Friestad, Christine, Dr. philos.	Social psychological approaches to smoking.
	Ekeland, Tor-Johan, Dr. philos.	Meining som medisin. Ein analyse av placebofenomenet og implikasjoner for terapi og terapeutiske teoriar.

H	Saban, Sara, Dr. psychol.	Brain Asymmetry and Attention: Classical Conditioning Experiments.
	Carlsten, Carl Thomas, Dr. philos.	God lesing – God læring. En aksjonsrettet studie av undervisning i fagtekstlesing.
	Dundas, Ingrid, Dr. psychol.	Functional and dysfunctional closeness. Family interaction and children's adjustment.
	Engen, Liv, Dr. philos.	Kartlegging av leseferdighet på småskoletrinnet og vurdering av faktorer som kan være av betydning for optimal leseutvikling.
2000 **V**	Hovland, Ole Johan, Dr. philos.	Transforming a self-preserving "alarm" reaction into a self-defeating emotional response: Toward an integrative approach to anxiety as a human phenomenon.
	Lillejord, Sølvi, Dr. philos.	Handlingsrasjonalitet og spesialundervisning. En analyse av aktørperspektiver.
	Sandell, Ove, Dr. philos.	Den varme kunnskapen.
	Oftedal, Marit Petersen, Dr. philos.	Diagnostisering av ordavkodingsvansker: En prosessanalytisk tilnærmingsmåte.
H	Sandbak, Tone, Dr. psychol.	Alcohol consumption and preference in the rat: The significance of individual differences and relationships to stress pathology
	Eid, Jarle, Dr. psychol.	Early predictors of PTSD symptom reporting; The significance of contextual and individual factors.
2001 **V**	Skinstad, Anne Helene, Dr. philos.	Substance dependence and borderline personality disorders.
	Binder, Per-Einar, Dr. psychol.	Individet og den meningsbærende andre. En teoretisk undersøkelse av de mellommenneskelige forutsetningene for psykisk liv og utvikling med utgangspunkt i Donald Winnicotts teori.
	Roald, Ingvild K., Dr. philos.	Building of concepts. A study of Physics concepts of Norwegian deaf students.
H	Fekadu, Zelalem W., Dr. philos.	Predicting contraceptive use and intention among a sample of adolescent girls. An application of the theory of planned behaviour in Ethiopian context.
	Melesse, Fantu, Dr. philos.	The more intelligent and sensitive child (MISC) mediational intervention in an Ethiopian context: An evaluation study.
	Råheim, Målfrid, Dr. philos.	Kvinners kroppserfaring og livssammenheng. En fenomenologisk – hermeneutisk studie av friske kvinner og kvinner med kroniske muskelsmerter.
	Engelsen, Birthe Kari, Dr. psychol.	Measurement of the eating problem construct.
	Lau, Bjørn, Dr. philos.	Weight and eating concerns in adolescence.
2002 **V**	Ihlebæk, Camilla, Dr. philos.	Epidemiological studies of subjective health complaints.

	Rosén, Gunnar O. R., Dr. philos.	The phantom limb experience. Models for understanding and treatment of pain with hypnosis.
	Høines, Marit Johnsen, Dr. philos.	Fleksible språkrom. Matematikklæring som tekstutvikling.
	Anthun, Roald Andor, Dr. philos.	School psychology service quality. Consumer appraisal, quality dimensions, and collaborative improvement potential
	Pallesen, Ståle, Dr. psychol.	Insomnia in the elderly. Epidemiology, psychological characteristics and treatment.
	Midthassel, Unni Vere, Dr. philos.	Teacher involvement in school development activity. A study of teachers in Norwegian compulsory schools
	Kallestad, Jan Helge, Dr. philos.	Teachers, schools and implementation of the Olweus Bullying Prevention Program.
H	Ofte, Sonja Helgesen, Dr. psychol.	Right-left discrimination in adults and children.
	Netland, Marit, Dr. psychol.	Exposure to political violence. The need to estimate our estimations.
	Diseth, Åge, Dr. psychol.	Approaches to learning: Validity and prediction of academic performance.
	Bjuland, Raymond, Dr. philos.	Problem solving in geometry. Reasoning processes of student teachers working in small groups: A dialogical approach.
2003 V	Arefjord, Kjersti, Dr. psychol.	After the myocardial infarction – the wives' view. Short- and long-term adjustment in wives of myocardial infarction patients.
	Ingjaldsson, Jón Þorvaldur, Dr. psychol.	Unconscious Processes and Vagal Activity in Alcohol Dependency.
	Holden, Børge, Dr. philos.	Følger av atferdsanalytiske forklaringer for atferdsanalysens tilnærming til utforming av behandling.
	Holsen, Ingrid, Dr. philos.	Depressed mood from adolescence to 'emerging adulthood'. Course and longitudinal influences of body image and parent-adolescent relationship.
	Hammar, Åsa Karin, Dr. psychol.	Major depression and cognitive dysfunction- An experimental study of the cognitive effort hypothesis.
	Sprugevica, Ieva, Dr. philos.	The impact of enabling skills on early reading acquisition.
	Gabrielsen, Egil, Dr. philos.	LESE FOR LIVET. Lesekompetansen i den norske voksenbefolkningen sett i lys av visjonen om en enhetsskole.
H	Hansen, Anita Lill, Dr. psychol.	The influence of heart rate variability in the regulation of attentional and memory processes.
	Dyregrov, Kari, Dr. philos.	The loss of child by suicide, SIDS, and accidents: Consequences, needs and provisions of help.
2004 V	Torsheim, Torbjørn, Dr. psychol.	Student role strain and subjective health complaints: Individual, contextual, and longitudinal perspectives.

	Haugland, Bente Storm Mowatt Dr. psychol.	Parental alcohol abuse. Family functioning and child adjustment.
	Milde, Anne Marita, Dr. psychol.	Ulcerative colitis and the role of stress. Animal studies of psychobiological factors in relationship to experimentally induced colitis.
	Stornes, Tor, Dr. philos.	Socio-moral behaviour in sport. An investigation of perceptions of sportspersonship in handball related to important factors of socio-moral influence.
	Mæhle, Magne, Dr. philos.	Re-inventing the child in family therapy: An investigation of the relevance and applicability of theory and research in child development for family therapy involving children.
	Kobbeltvedt, Therese, Dr. psychol.	Risk and feelings: A field approach.
2004 H	Thomsen, Tormod, Dr. psychol.	Localization of attention in the brain.
	Løberg, Else-Marie, Dr. psychol.	Functional laterality and attention modulation in schizophrenia: Effects of clinical variables.
	Kyrkjebø, Jane Mikkelsen, Dr. philos.	Learning to improve: Integrating continuous quality improvement learning into nursing education.
	Laumann, Karin, Dr. psychol.	Restorative and stress-reducing effects of natural environments: Experiencal, behavioural and cardiovascular indices.
	Holgersen, Helge, PhD	Mellom oss - Essay i relasjonell psykoanalyse.
2005 V	Hetland, Hilde, Dr. psychol.	Leading to the extraordinary? Antecedents and outcomes of transformational leadership.
	Iversen, Anette Christine, Dr. philos.	Social differences in health behaviour: the motivational role of perceived control and coping.
2005 H	Mathisen, Gro Ellen, PhD	Climates for creativity and innovation: Definitions, measurement, predictors and consequences.
	Sævi, Tone, Dr. philos.	Seeing disability pedagogically – The lived experience of disability in the pedagogical encounter.
	Wiium, Nora, PhD	Intrapersonal factors, family and school norms: combined and interactive influence on adolescent smoking behaviour.
	Kanagaratnam, Pushpa, PhD	Subjective and objective correlates of Posttraumatic Stress in immigrants/refugees exposed to political violence.
	Larsen, Torill M. B. , PhD	Evaluating principals` and teachers` implementation of Second Step. A case study of four Norwegian primary schools.
	Bancila, Delia, PhD	Psychosocial stress and distress among Romanian adolescents and adults.
2006 V	Hillestad, Torgeir Martin, Dr. philos.	Normalitet og avvik. Forutsetninger for et objektivt psykopatologisk avviksbegrep. En psykologisk, sosial, erkjennelsesteoretisk og teorihistorisk framstilling.

	Nordanger, Dag Øystein, Dr. psychol.	Psychosocial discourses and responses to political violence in post-war Tigray, Ethiopia.
	Rimol, Lars Morten, PhD	Behavioral and fMRI studies of auditory laterality and speech sound processing.
	Krumsvik, Rune Johan, Dr. philos.	ICT in the school. ICT-initiated school development in lower secondary school.
	Norman, Elisabeth, Dr. psychol.	Gut feelings and unconscious thought: An exploration of fringe consiousness in implicit cognition.
	Israel, K Pravin, Dr. psychol.	Parent involvement in the mental health care of children and adolescents. Emperical studies from clinical care setting.
	Glasø, Lars, PhD	Affects and emotional regulation in leader-subordinate relationships.
	Knutsen, Ketil, Dr. philos.	HISTORIER UNGDOM LEVER – En studie av hvordan ungdommer bruker historie for å gjøre livet meningsfullt.
	Matthiesen, Stig Berge, PhD	Bullying at work. Antecedents and outcomes.
2006 H	Gramstad, Arne, PhD	Neuropsychological assessment of cognitive and emotional functioning in patients with epilepsy.
	Bendixen, Mons, PhD	Antisocial behaviour in early adolescence: Methodological and substantive issues.
	Mrumbi, Khalifa Maulid, PhD	Parental illness and loss to HIV/AIDS as experienced by AIDS orphans aged between 12-17 years from Temeke District, Dar es Salaam, Tanzania: A study of the children's psychosocial health and coping responses.
	Hetland, Jørn, Dr. psychol.	The nature of subjective health complaints in adolescence: Dimensionality, stability, and psychosocial predictors
	Kakoko, Deodatus Conatus Vitalis, PhD	Voluntary HIV counselling and testing service uptake among primary school teachers in Mwanza, Tanzania: assessment of socio-demographic, psychosocial and socio-cognitive aspects
	Mykletun, Arnstein, Dr. psychol.	Mortality and work-related disability as long-term consequences of anxiety and depression: Historical cohort designs based on the HUNT-2 study
	Sivertsen, Børge, PhD	Insomnia in older adults. Consequences, assessment and treatment.
2007 V	Singhammer, John, Dr. philos.	Social conditions from before birth to early adulthood – the influence on health and health behaviour
	Janvin, Carmen Ani Cristea, PhD	Cognitive impairment in patients with Parkinson's disease: profiles and implications for prognosis
	Braarud, Hanne Cecilie, Dr.psychol.	Infant regulation of distress: A longitudinal study of transactions between mothers and infants
	Tveito, Torill Helene, PhD	Sick Leave and Subjective Health Complaints

	Magnussen, Liv Heide, PhD	Returning disability pensioners with back pain to work
	Thuen, Elin Marie, Dr.philos.	Learning environment, students' coping styles and emotional and behavioural problems. A study of Norwegian secondary school students.
	Solberg, Ole Asbjørn, PhD	Peacekeeping warriors – A longitudinal study of Norwegian peacekeepers in Kosovo
2007 H	Søreide, Gunn Elisabeth, Dr.philos.	Narrative construction of teacher identity
	Svensen, Erling, PhD	WORK & HEALTH. Cognitive Activation Theory of Stress applied in an organisational setting.
	Øverland, Simon Nygaard, PhD	Mental health and impairment in disability benefits. Studies applying linkages between health surveys and administrative registries.
	Eichele, Tom, PhD	Electrophysiological and Hemodynamic Correlates of Expectancy in Target Processing
	Børhaug, Kjetil, Dr.philos.	Oppseding til demokrati. Ein studie av politisk oppseding i norsk skule.
	Eikeland, Thorleif, Dr.philos.	Om å vokse opp på barnehjem og på sykehus. En undersøkelse av barnehjemsbarns opplevelser på barnehjem sammenholdt med sanatoriebarns beskrivelse av langvarige sykehusopphold – og et forsøk på forklaring.
	Wadel, Carl Cato, Dr.philos.	Medarbeidersamhandling og medarbeiderledelse i en lagbasert organisasjon
	Vinje, Hege Forbech, PhD	Thriving despite adversity: Job engagement and self-care among community nurses
	Noort, Maurits van den, PhD	Working memory capacity and foreign language acquisition
2008 V	Breivik, Kyrre, Dr.psychol.	The Adjustment of Children and Adolescents in Different Post-Divorce Family Structures. A Norwegian Study of Risks and Mechanisms.
	Johnsen, Grethe E., PhD	Memory impairment in patients with posttraumatic stress disorder
	Sætrevik, Bjørn, PhD	Cognitive Control in Auditory Processing
	Carvalhosa, Susana Fonseca, PhD	Prevention of bullying in schools: an ecological model
2008 H	Brønnick, Kolbjørn Selvåg	Attentional dysfunction in dementia associated with Parkinson's disease.
	Posserud, Maj-Britt Rocio	Epidemiology of autism spectrum disorders
	Haug, Ellen	Multilevel correlates of physical activity in the school setting
	Skjerve, Arvid	Assessing mild dementia – a study of brief cognitive tests.

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