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Practitioner Report

A pilot investigation of emotion-focused two-chair dialogue intervention for self-criticism

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Self-criticism plays a key role in many psychological disorders and predicts poor outcome in psychotherapy. Yet, psychotherapy research directly targeting self-critical processes is limited. In this pilot study, we examined the efficacy of an emotion-focused intervention, the two-chair dialogue task, on self-criticism, self-compassion and the ability to self-reassure in times of stress, as well as on depressive and anxiety symptoms among nine self-critical clients. Results showed that the intervention was associated with significant increases in self-compassion and self-reassuring, and significant reductions in self-criticism, depressive symptoms and anxiety symptoms. Effect sizes were medium to large, with most clients exhibiting low and non-clinical levels of symptomatology at the end of therapy, and maintaining gains over a 6-month follow-up period. Although preliminary, these finding suggest that emotion-focused chair work might be a promising intervention addressing self-criticism.

Key Practitioner Message:

- Self-criticism is an important process in a variety of clinical disorders and predicts poor outcome in brief therapy for depression. Yet, little is known about how self-criticism can be effectively addressed in psychological treatment.
- Practitioners can benefit from increasing their awareness of self-critical processes in their clinical work, and from directly working with emotions in addressing self-criticisim.
- Emotion-focused two-chair dialogue intervention can be effective in reducing self-criticism, increasing self-compassion, and decreasing depressive and anxiety symptoms, and these improvements are largely maintained six months after therapy.

Keywords: Emotion-Focused Therapy, Self-Criticism, Self-Compassion

Self-criticism—the tendency to harshly and punitively judge and scrutinize oneself—is a central feature of many forms of psychological suffering. Studies have shown that self-criticism is important in depression (Cox, McWilliams, Enns, & Clara, 2004; Zuroff, Santor, & Mongrain, 2005), social anxiety (Cox, Fleet, & Stein, 2004; Cox et al., 2000), post-traumatic stress disorder (Cox, MacPherson, Enns, & McWilliams, 2004), borderline personality disorder (Southwick, Yehuda, & Giller, 1995), self-injurious behaviors (Glassman, Weierich, Hooley, Deliberto, & Nock, 2007), suicidality (Fazaa & Page, 2009; Klomek et al., 2008), bi-polar disorders (Francis-Raniere, Alloy, & Abramson, 2006), schizophrenia (Mayhew & Gilbert, 2008) and eating disorders (Dolhanty & Greenberg, 2009; Fennig et al., 2008). Such broad evidence clearly indicates that self-criticism is a transdiagnostic process.

Most of the research on self-criticism has been based on Sydney Blatt's theory of depression vulnerability (Blatt, 2004; Blatt & Zuroff, 1992; Zuroff, Mongrain, & Santor, 2004), which largely views this construct as a personality dimension placing individuals at risk for developing depression. More recently, Gilbert and colleagues (Gilbert & Irons, 2005; Gilbert & Procter, 2006) have examined self-critical processes and developed a therapeutic approach specifically designed to reduce shame and self-criticism by helping patients develop self-compassion. Still, psychotherapy research directly focusing on targeting self-critical processes during treatment is

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scarce. This is particularly surprising given that self-criticism appears to be central across a wide range of psychological disorders and because self-critical patients do not respond as well to psychotherapy (Blatt, Quinlan, Pilkonis, & Shea, 1995; Rector, Bagby, Segal, Joffe, & Levitt, 2000). Thus, more research is needed to advance our understanding regarding how to address self-criticism in psychotherapy. The purpose of the current study was to explore the effects of a specific emotion-focused task, the two-chair dialogue intervention, on levels of self-criticism, self-compassion, as well as on associated depressive and anxiety symptoms, among individuals who identified themselves as highly self-critical.

Emotion-focused therapy (EFT; Greenberg, Rice, & Elliot, 1993; Greenberg & Watson, 2006) is an empirically supported, process–experiential therapy that emphasizes a strong therapeutic relationship based on the client-centered principles of empathy, genuineness and unconditional acceptance given by Carl Rogers (1951). After building a strong relational foundation, emotion-focused therapists initiate various experiential interventions designed to help clients develop emotional awareness, access primary adaptive emotions, regulate dysregulated emotions and change maladaptive emotions (Greenberg, 2008). EFT is a marker-guided therapy, in which therapists apply particular interventions in response to specific client behaviors that naturally emerge in therapy. For example, expression of unresolved feelings towards an attachment figure suggests that an empty chair for unfinished business intervention is indicated. The empty-chair intervention is designed to facilitate processing, transforming and resolving these feelings (Greenberg & Foerster, 1996; Greenberg & Malcolm, 2002; Paivio & Greenberg, 1995). Similarly, when a marker for self-criticism emerges in the course of EFT, two-chair work for conflict splits (explained below) is indicated.

In EFT, based on gestalt therapy principles (Perls, 1969; Perls, Hefferline, & Goodman, 1965), self-criticism is conceptualized as a conflict split between two aspects of the self, where one part of the self harshly criticizes, judges, evaluates and blocks the experiences and healthy needs of another, more submissive part of the self. The dominant part of the self is usually labeled as the "inner critic," and the more submissive part is often labeled as the "experiencing self" (Greenberg & Watson, 2006). In a two-chair intervention, the client is asked to enact a dialogue between the inner critic and the experiencing self using two chairs. The client is asked to "be" the inner critic and speak to the experiencing self using one chair and then enact the experiencing self and respond to the self-critical attacks from the second chair. During the dialogue, the client switches chairs whenever the roles are switched, using empathic guidance and emotion coaching from the therapist to explore, process and provide space for expressing emotions and needs associated with each part of the self (Elliott, Watson, Goldman, & Greenberg, 2004; Greenberg et al., 1993).

From an EFT perspective, the emotions (and their associated needs) that are involved in such conflict splits are particularly important. When clients enact the inner critic, they often express feelings of anger, hate, contempt and/or disgust with the self, and when enacting that part of themselves that is the target of the attacks, they often experience feelings of powerlessness, hopelessness and helplessness that later differentiate into feelings of shame, fear or sadness, depending on the nature of the critical attacks (Greenberg & Watson, 2006).

Whelton and Greenberg (2005) conducted an experiment in which individuals who were induced into a dysphoric state were asked to criticize themselves from one chair for 5 min and then respond to their criticism from another chair for another 5 min while their verbal content, as well as their emotional facial expressions, were coded. They found that participants with higher trait self-criticism (measured with the depressive Experiences Questionnaire; Blatt, D'Afflitti, & Quinlan, 1976) were more contemptuous when they expressed criticism and less resilient when asked to respond to the criticism. In other words, individuals who naturally tended to criticize themselves used more insults and were more punitive when expressing criticism and were more apt to accept the criticism submissively, to experience more sadness and shame, and were less likely to argue back or dismiss the self-critical attacks. Interestingly, participants from both the high and low self-criticism groups expressed criticism, but only those with high trait self-criticism responded to these attacks submissively, suggesting that such submissive response lies at the heart of self-critical vulnerability to depression. Greenberg and Watson (2006) argued that the non-resilient (collapsed) response to self-critical attacks is a key component of the depressed state.

This analysis of self-critical processes, which emphasizes intrapsychic transactions, is strongly compatible with Gilbert's evolutionary model of depression, shame and self-criticism from which he developed a group-based approach designed to increase self-compassion (compassion-focused therapy, CFT; Gilbert & Irons, 2005; Gilbert & Procter, 2006). According to Gilbert's model, the ability to self-sooth develops in a context of secure attachment with early caregivers. In a developmental context characterized by abuse and neglect, the affect regulation system responsible for self-soothing and safeness does not develop properly because the individual invests most of his/her attentional resources to detect and respond to threats. In such context, a self-critical style is often internalized as a safety strategy to prevent further abuse and to establish a better (less inferior) social rank (Gilbert & Irons, 2005). Importantly, both the evolutionary and EFT models view self-criticism as a type of self-to-self

relationship wherein one part dominantly attacks and criticizes and the other submissively receives the attacks. In both models, the clinician attempts to change how parts of the self view and respond to each other.

The purpose of the emotion-focused two-chair dialogue intervention is emotional transformation and integration of the disjointed aspects of the self (Greenberg, 1979, 1980, 1983; Greenberg & Webster, 1982). A basic assumption guiding this intervention (and EFT in general) is that in order for the self-critical split to be resolved, it needs to be enacted and experienced. Thus, it is not sufficient to merely talk about and intellectually understand the split process. It is necessary to actually experience the emotions of each part of the self to undergo emotional transformation and integration. Two processes are particularly important in progressing towards a resolution in this intervention: (a) the feelings of anger, hate, contempt and disgust expressed by the inner critic are transformed into feelings of compassion and empathy towards the experiencing self that, in turn, helps to facilitate self-soothing and self-reassuring capabilities in times of stress; and (b) the feelings of shame and powerlessness expressed by the experiencing self are transformed into resilient assertiveness, often through the expression of adaptive anger, which then helps the client to better resist self-critical attacks and behave according to his/her adaptive and authentic needs. These two processes eventually lead to negotiation and integration between the parts of the self and to new possible responses to environmental demands (a more detailed description of the components of the two-chair intervention is provided in the method section).

On the basis of the theoretical foundation of EFT and CFT, we expected that addressing self-critical processes in the two-chair dialogue task would be associated with changes in multiple measures of self-criticism and self-compassion as well as with reductions in depressive and anxiety symptoms. We used both widely used measures of trait self-criticism (the self-criticism subscale from the Depressive Experiences Questionnaire; Blatt et al., 1976) and trait self-compassion (Neff, 2003), and a more recently developed focused measure of self-criticism and self-reassurance developed by Gilbert, Clarke, Kempel, Miles, and Irons (2004). To examine the study hypotheses, we recruited participants who identified themselves as highly self-critical and provided 5–8 therapy sessions based on EFT two-chair work.

METHOD

Clients and Procedure

Inclusion and exclusion criteria for this study were assessed during a telephone screening conducted by a second-year clinical psychology doctoral student, by using a self-report measure of self-criticism administered before the first session (Forms of Self-Criticizing/Attacking and Self-Reassuring Scale, FSCRS, Gilbert et al., 2004), and by the study therapists during the first session. The FSCRS includes two subscales measuring two aspects of self-criticism—one focusing on a sense of inadequacy and one focusing on hating and wanting to hurt the self (the FSCRS also includes a third subscale measuring self-reassurance; see description of this instrument in the Measures section). To participate, clients had to score at least one standard deviation above the mean reported in the study by Gilbert et al. (2004) in at least one of these two subscales. Exclusion criteria included psychosis, current or history of self-harm, bi-polar disorders, organic brain injury or other severe disturbances not suitable for a brief treatment.

Clients were recruited via advertisements posted in the community and via university-wide email listserv announcing the availability of a brief psychotherapy treatment for people who are self-critical and have low self-esteem. Seventeen people responded to our advertisements during the recruitment period (January 2008 to May 2008). Twelve individuals met the inclusion criteria based on the telephone screening and the FSCRS. However, two clients were screened out after the first session based on clinical judgment made by their therapist and the study supervisor. These two clients had psychotic and paranoid symptoms and were deemed inappropriate for an experiential form of brief therapy. In addition, one client decided to drop out after the first session. The analysis reported here, therefore, is based on 10 clients, with pre-therapy scores of the client who dropped out being carried over (intent-to-treat analysis). Characteristics of these clients are presented in Table 1. The study protocol was approved by the [removed for anonymous peer review] institutional review board, and all participants provided written informed consent for research participation. No adverse events occurred during the study.

Therapists and Training

Four doctoral students in clinical psychology with at least 3 years of clinical experience served as therapists in the study. One therapist (the first author) had basic training in EFT, and for the other three therapists, this study was the first exposure to EFT. Before seeing the study clients, all therapists participated in a 4-month long EFT training (emphasizing client-centered principles and two-chair dialogue work) conducted by an experienced emotion-focused therapist [removed for anonymous peer review]. The training included readings and several experiential workshops that involved viewing video-taped sessions and role plays. During the therapy phase, the therapists met with [removed for anonymous peer review] once a week for supervision that was based on viewing video-recorded therapy sessions.

Table 1. Client characteristics at baseline

ID	Age	BDI	BAI	DEQ SC*	SCS	FSCRS HS	FSCRS IS	FSCRS SR
1	42	38	46	1.35	1.69	10.00	30.00	15.00
2	56	25	42	1.29	2.62	7.50	29.00	11.00
3	50	10	6	0.33	2.27	8.75	19.00	21.00
4	49	41	32	1.96	1.81	3.75	34.00	13.00
5	58	31	22	0.54	2.73	11.25	34.00	7.00
6	47	5	29	2.27	3.23	12.50	24.00	23.00
7	21	22	19	1.17	1.62	5.00	28.00	20.00
8	57	20	9	1.59	2.42	3.75	25.00	20.00
9	37	20	11	0.41	2.69	6.25	26.00	17.00
10	47	30	1	2.02	1.50	8.75	35.00	8.00
	46.4 (11.13)	24.20 (11.37)	21.7 (15.35)	1.29 (0.69)	2.26 (.58)	7.75 (3.05)	28.40 (5.10)	15.50 (5.62)

BDI = Beck Depression Inventory. BAI = Beck Anxiety Inventory. DEQ SC = Depressive Experiences Questionnaire self-criticism subscale. SCS = Self-Compassion Scale. FSCRS HS = Forms of Self-Criticizing and Self-Reassuring Scale Hated-Self Scale. FSCRS IS = Forms of Self-Criticizing and Self-Reassuring Scale Inadequate-Self Scale. FSCRS SR = Forms of Self-Criticizing and Self-Reassuring Scale Self-Reassuring Scale.
*DEQ SC scores are standard scores.

Treatment Adherence

Although adherence was not formally assessed, videotaped portions of all therapists' sessions were reviewed by [removed for anonymous peer review]. All segments viewed showed that all therapists were adept at using client-centered principles, identifying self-critical markers and appropriately setting up chair work. In conducting the protocol, no segment reviewed was ever found to be out of mode; that is, all therapists were found to be following the prescribed protocol of two-chair work. In general, the first session was dedicated to building strong therapeutic alliance and the rest of the sessions were dedicated to chair work and processing of materials that emerged during the chair work.

Treatment Components

In the paragraphs below, we briefly present the steps towards a successful resolution of the two-chair task based on the work of Greenberg and his colleagues (Elliott et al., 2004; Greenberg et al., 1993) using examples of each step from one client in the study. The client, whom we will call Sarah (ID = 2), is a middle-aged woman who started therapy with moderate to high depressive symptoms (Beck Depression Inventory [BDI] = 25) and severe anxiety (Beck Anxiety Inventory [BAI] = 42). Although formal diagnostic assessment was not part of this study, it was evident that her anxiety centered on social concerns, and she would likely qualify for a diagnosis of social anxiety disorder. She described experiencing physical and emotional abuse growing up and being self-critical and feeling worthless and anxious from a young age.

Identifying the marker. Because clients in this study were recruited by virtue of their suffering from self-criticism, markers for self-criticism were clearly evident in all cases right from the start. For example, in the middle of the first session, Sarah described her difficulties with social anxiety. As she described how much effort it takes for her to be around other people, she became overtly agitated and the therapist commented:

Therapist: What's going on right now as you are talking about this? What's going on inside? I'm noticing your legs and…

Sarah: I'm nervous… anxious… I get nervous and anxious and then I'm like "oh shut up" like my mind is going "shut up!" "Shut up!"

Therapist: Like there is a part of you that keeps silencing you?

Sarah: Exactly… like it doesn't matter, it's OK, just shut up… basically you know… just shut up (laughing).

Therapist: And that part seems quite harsh…

Sarah: Oh yeah! Oh yeah!

Therapist: Making you nervous…

Sarah: Oh yeah. Oh yeah. And my language goes down very quickly… my verbal acuity… I can't think… I start bumbling… I can't do a complete thought.

Therapist: Did that just happen here?

Sarah: It will start pretty soon (laughing)… That has been the issue you know… I was talking to my husband last night and I told him you know I don't know why my language skills go down, my communication skills

go down to nothing, I'm bumbling, I am an idiot, I sound like an idiot, I can't complete a thought… it's like I don't have the brain to do it.

This example demonstrates a conflict between one part (the inner critic) that harshly silences her and criticizes her social behavior and another part (the experiencing self) that is left feeling anxious, shaking and unable to speak. The reflections of the therapist introduce the idea that the two conflicting parts of Sarah are interacting with each other.

Initiating the dialogue. In the second or third session, after a sufficiently strong therapeutic alliance had already been formed, therapists invited clients to conduct an experiment designed to get a better understanding of the thoughts, feelings and motivations of the two parts. For example, in the second session when Sarah could easily identify the conflict and the "constant chatter" (as she called it), the therapist said

Therapist: So why don't we take this chatter, take this dialogue between those two parts, and we'll give each part a chair and see what each part has to say, how each part feels… and I'll guide you through it.

Sarah: OK.

Therapist: (Arranges two chairs facing each other). Can you come over here and tell her… I guess, if you can be the critic, and tell her… I guess… tell her about the wrong things she is doing with other people.

Sarah: OK. (Moves to the critic's chair, sigh and begin criticizing after a few seconds, referring to an incident that occurred earlier that day). You are such a mean little bitch. I am sure… why do these people irritate you so much? They are evidently all right and you are wrong… cause you're the one who ended up being irritated about all this endless gossip. You're not in there so you must be the mean one, not them.

Turns to the therapist and says "this is harder than I thought it would be."

Therapist: Uh-huh, yes.
Sarah: It's hard because you never say these things out loud.

Therapist: Right. Right. And you're doing just fine.
Sarah: Umm.

Therapist: And there is no hurry.

Sarah: OK (sighs with relief and continues). Why did they bother you so much? You're so stupid for letting all their television talk and gossip bother you. You're just so stupid; you're just being a mean little jealous bitch (starting to use contemptuous tone of voice).

As the dialogue begins, the client experiences how different it feels to actually *do* (i.e., speak aloud) the criticism as compared with thinking it, and mentions this to the therapist. She seems to be surprised by the contempt she expressed. Using a client-centered style, the therapist reassures her, which seems to be important in helping her feel comfortable and continue to dialogue. The therapist then continues to facilitate the dialogue by guiding the client to express specific criticism, accentuate her contemptuous tone and explore her affective response to the criticisms from the experiencing-self chair. The purpose here is to help the client develop awareness of how she is criticizing/silencing herself and to deepen and differentiate the affective responses to the criticisms. For example,

Sarah: (From the experiencing chair, in response to her critic saying that she criticizes to take care of her): But that's never worked. All I've felt is lonely, and anxious, and fearful, and less than, isolated. It's never worked (voice shifts from external blaming to internally focused). How can that be taking care of me? (Tearing up)

Therapist: Tell her what's happening right now.

Sarah: You don't know how much it hurts.

Therapist: (Whispers) Yeah, tell her.

Sarah: It's so painful.

New emotional experiences and assertion of needs. As the dialogue progresses, the initial emotional response of the experiencing self often differentiates into more underlying emotions. In Sarah's case, her initial anxiety shifted into sadness and loneliness. A basic premise in EFT is that primary adaptive emotions are important because they orient the client to become aware of and *entitled* to adaptive needs and wants. A sense of entitlement is essentially the opposite of feeling worthless. For example, underlying sadness can orient clients towards a need for comfort and acceptance. It is the visceral experience of sadness that facilitates the expression of the need and the experience of being entitled to having the need met. The following excerpt demonstrates this process. During the fourth session, Sarah experienced positive affect because she felt that her self-awareness was improving. This was the first time Sarah expressed positive affect that led the critic to express concern in the next talk turn. Moving to the critic's chair she said:

Sarah: That's fine. However you need to be careful. You know how you are, you start and then you jump off , and there will be all these good things and then you'll be totally

disappointed, and you will go back to… it's easier to just… just to go with the flow, and to mix. You mix better.

Therapist: Yeah, don't take any risks.

Sarah: Oh no! Because you are taking a risk now, if you start saying things with people. Now if you say, "Oh that's what I think" and if they won't agree, it will isolate you. And you don't want to be isolated. You want to be part of the group. It's better to be in the middle. That's where you are protected. The problem in the past was that you stood out too much. The more you open your mouth the more different and isolated you are. So you just need to smile and nod, that's how people like you.

Therapist: And that's why I am silencing you? That's why I'm stifling you?

Sarah: Yes, I'm protecting you. I'm your protector.

Therapist: OK, change.

Sarah: (Moves to the experiencing chair). But sometimes I don't want to be protected (whispering). I would like to have confidence, I want to have self-esteem. I want to be able to voice my knowledge, and it's OK to be a bit different, it doesn't bother me. And I can't do that if I think it's a cause for being different not a cause for me being myself.

Therapist: It's like "you're preventing me from being myself"?

Sarah: Uh-huh, you're preventing me from being myself, 'cause, really, outside of everything that you say I'm probably just about as good as anybody else… as far as emotions… I'm not evil, I'm not bad. I need you to have confidence in me, not protect me too much, move your arms around me so that I can move forward.

Therapist: Yes, tell her again what you need from her.
Sarah: I need you to put your arms around me, encourage me and support me.

In the above segment, the critic moves from harsh self-attacks to a statement of standards and values and its protective function becomes clear. The experiencing self then strengthens and asserts her needs.

Softening of the critic. The experience of pain and hurt in the experiencing chair, as well as the newly emerged assertion of needs, often lead to a softening of the critic and to an expression of compassion and understanding. For example, in the fourth session, after Sarah stated from the experiencing chair that she needed the critic to tell her she is OK, the therapist asks her to move to the critic's chair.

Therapist: OK, come over here. (Sarah moves to the critic chair). So she's making that request…

Sarah: I can tell you that you're OK. You're bright, and sensitive, and an intelligent person. I have confidence in you that you will be able to take care of things, and that you're not out of control. Life is hard but you'll be able to handle all this stuff. I can tell you that I'm confident in you, that you're worthwhile.

Therapist: What's that like to say that?

Sarah: It feels good. I feel good saying that to her.

Therapist: What do you feel towards her?

Sarah: I feel like supporting you like that. I feel like you can be who you are (starts tearing).

Therapist: What do you feel towards her?

Sarah: I feel a lot of compassion for you and understanding. I want to… (making a hugging motion).

Therapist: Yeah, what was that?

Sarah: I feel like hugging you and holding you and giving you the strength that I know you need right now.

Therapist: Yeah, do that again.

Sarah: That's what I want to do. I want to envelope you in this great big warm cloak of safety (sniffling).

Therapist: Here, why don't we take a second so that you can visualize hugging her?

It is important to note that it took several enactments in which Sarah, from the experiencing chair, expressed anger at the inner critic and made requests for support before the critic showed such compassion and support. In earlier enactments, the critic rejected her requests. In fact, at earlier stages, Sarah angrily demanded that the inner critic disappear, and it took several sessions for her to express an attachment-based need for support.

Integration and negotiation. When clients reach this stage, the two sides begin to negotiate how to work together and solve problems collaboratively while being sensitive to each others' feelings and needs. Alternatively, some clients report experiencing integration, feeling more united, often commenting that they do not feel that the two parts are separate anymore. In Sarah's case, negotiation talk was evident in the last session while processing her experiences with the therapist, not in a two-chair

dialogue context. She mentioned that she did not want her critic to completely vanish and that she now appreciated the protective functions of the critic and would like to continue to rely on it. At the same time, she felt more empowered to demand that the protection is done differently—in a nicer and more compassionate manner. Representing her critical aspect, she agreed and asked for guidance to help her to become more supportive and reassuring.

Measures

The following measurement instruments were administered at baseline (before the first session), 1 week after termination, and at three post-therapy follow-up points (2, 4 and 6 months after therapy was over).

Forms of Self-Criticizing and Self-Reassuring Scale. The FSCRS is a 22-item scale measuring the extent to which people are self-critical/self-attacking or self-supportive/self-reassuring in response to setbacks or failures (Gilbert et al., 2004). The scale measures two aspects of self criticism—one focusing on feelings of inadequacy ("there is a part of me that feels I am not good enough") and one focusing on hating and wanting to hurt the self ("I have become so angry with myself that I want to hurt or injure myself"). The self-reassuring subscale measures the capability to be self-supportive and self-reassuring ("I am able to remind myself of positive things about myself"). Respondents are given the probe "when things go wrong for me…" and answer a series of questions on a five-point Likert scale (ranging from 0 = "not at all like me" to 4 = "extremely like me"). Gilbert et al. (2004) found high internal reliability coefficients for all three subscales and expected correlations with other measures of self-criticism and depression.

In addition to examining how experiential two-chair work affects self-criticism and self-reassuring, the FSCRS was used as a screening tool. To recruit clients with high levels of self-criticism, clients had to score at least one standard deviation above the mean reported in Gilbert et al. (2004) study in either the inadequate self or hated self subscales. For the inadequate self subscale, Gilbert et al. found a mean of 16.75 (SD = 8.44) and for the hated self subscale, the mean was 3.86 (SD = 4.58) among 246 female undergraduate psychology students. Similar means were found in subsequent studies using the FSCRS (Gilbert, Durrant, & McEwan, 2006). Thus, clients in this study scored above 25.19 on the inadequate self subscale or above 8.44 on the hated self subscale (see Table 1 for baseline scores on all measures).

Beck Depression Inventory-II. The BDI-II is a 21-item instrument measuring depressive symptoms. Scores can range from 0 to 63 with higher scores reflecting greater symptomatology. It is widely used and has excellent psychometric properties (Beck, Steer, & Brown, 1996).

Beck Anxiety Inventory. The BAI is structured in a similar way to the BDI. It also has 21 items, and total scores range from 0 to 63 with higher scores reflecting more severe anxiety symptoms (Beck, Epstein, Brown, & Steer, 1988). Items on the BAI capture both psychological and somatic complaints. Like the BDI, it has very good psychometric properties (Beck & Steer, 1990; Beck et al., 1988).

Depressive Experiences Questionnaire. The Depressive Experiences Questionnaire (DEQ) (Blatt et al., 1976) is a 66-item self-report questionnaire based on Blatt's depression vulnerability theory. The questionnaire yields two orthogonal factors: self-criticism and dependency. The dependency factor mainly deals with issues of interpersonal relationships such as abandonment, separation, loss, rejection and a need to be loved and cared for, and predisposes people to the anaclitic depression subtype. The self-criticism factor reflects high levels of perfectionism, strong need to achieve high standards and fear of failure, and is associated with the introjective depression subtype (Blatt, 2004; Blatt & Zuroff, 1992). The DEQ has very good psychometric properties as reported by Blatt (2004) and Blatt and Zuroff (1992). For the purpose of the current study, only the Self-Criticism Scale was used.

Self-Compassion Scale. The Self-Compassion Scale (SCS) (Neff, 2003) is a 26-item scale that measures several aspects related to self-compassion. It includes six subscales measuring self-kindness, common humanity, mindfulness, self-judgment, isolation and over-identification, where items on the latter three are reverse scored, and the means of all items are computed to get a total self-compassion score. The SCS measures an inclination to be kind and compassionate towards oneself, especially in times of stress or perceived failure. The psychometric properties of the SCS are very good (Neff, 2003).

RESULTS

Data Imputation

Clients completed all questionnaires online using a website that was designed for this study. During some of the follow-up assessments, the website did not function properly, and therefore, some data were missing. Specifically, client no. 002 did not have a BDI score at the first follow-up assessment; client no. 004 did not have a BDI score at the second follow-up assessment; and client no. 010 did not have a BDI score at the third follow-up assessment, a BAI score at the first and third follow-up

Table 2. Means, standard deviations (in parentheses) omnibus F values (analyses of variance) and effect sizes for the seven outcome measures at five measurement points

	Baseline	Post	2 months	4 months	6 months	Omnibus F	Partial η^2
BDI	24.20 (11.37)	11.30 (12.61)	11.59 (13.65)	13.40 (14.05)	11.54 (15.58)	6.37_a**	0.41
BAI	21.70 (15.35)	10.80 (14.26)	8.70 (10.76)	9.70 (11.78)	9.70 (14.46)	7.45_a**	0.45
DEQ SC	1.29 (0.69)	0.23 (1.04)	−0.12 (1.66)	0.07 (1.44)	−0.32 (1.33)	7.15_a**	0.44
SCS	2.26 (0.58)	2.82 (0.75)	3.04 (1.12)	2.96 (0.98)	3.31 (1.07)	5.77_a**	0.39
FSCRS IS	28.40 (5.10)	18.20 (7.55)	18.00 (12.00)	18.60 (11.17)	17.12 (11.91)	5.52_a*	0.38
FSCRS HS	7.75 (3.05)	4.88 (4.84)	4.50 (5.14)	5.38 (5.62)	5.91 (7.11)	2.56_a	0.22
FSCRS SR	15.50 (5.62)	20.90 (6.69)	20.60 (6.08)	20.40 (6.67)	21.54 (8.21)	3.35*	0.27

Omnibus F values with subscripts are corrected for sphericity violation (Huynh-Feldt epsilon). BDI = Beck Depression Inventory. BAI = Beck Anxiety Inventory. DEQ SC = Depressive Experiences Questionnaire self-criticism subscale. SCS = Self-Compassion Scale. FSCRS HS = Forms of Self-Criticizing and Self-Reassuring Scale Hated-Self Scale. FSCRS IS = Forms of Self-Criticizing and Self-Reassuring Scale Inadequate-Self Scale. FSCRS SR = Forms of Self-Criticizing and Self-Reassuring Scale Self-Reassuring Scale.
*$p < 0.05$.
**$p < 0.01$.

assessments, and self-compassion scores at the third follow-up assessments. Missing data were imputed using a method appropriate for repeated-measures analyses that relies on available individual and group level data (Tabachnick & Fidell, 2007). Degrees of freedom for the analyses were corrected accordingly.

Data Analysis

To examine the effect of the treatment on the dependent variables (depressive symptoms, anxiety symptoms, DEQ Self-Criticism Scale, FSCRS Inadequate-Self Scale, FSCRS Hated-Self Scale, FSCRS Self-Reassuring Scale and self-compassion total scores), seven repeated-measures analyses of variance (ANOVAs) were conducted with time of assessment (baseline, post-therapy and the three follow-ups) as the repeated measure factor. Significant effects were found for all dependent variables except for FSCRS Hated-Self Scale, which only approached statistical significance ($F[2,21] = 2.56$, $p < 0.10$) (see Table 2).[1]

Planned contrasts between each two adjacent measurement points complemented the ANOVA findings by revealing in five of seven measures significant effects only for the pre–post comparisons, indicating that most of the improvement in the dependent variables occurred from pre to post-therapy and that gains were maintained during the 6-month follow-up period. The pre–post contrasts for the Self-Reassuring Scale of FSCRS and the SCS were not significant but their pre to 6-month follow-up contrasts were significant, suggesting that clients continued to improve on these measures after therapy was over. Indeed, an exploratory contrast examining the difference between post-therapy and 6-month assessments revealed a significant post-therapy improvement in self-compassion ($F[1,9] = 6.56$, $p = 0.03$). The same contrast for the Self-Reassuring subscale of the FSCRS was not significant. For the hated-self subscale, the pre–post contrast was significant, whereas the pre-6-month contrast was not, suggesting that the improvements achieved on this scale during therapy were lost during the follow-up period. Overall, significant pre-6-month contrasts were found for all scales except the hated-self subscale (see Table 3).

To provide a more complete picture regarding the treatment's impact on depressive and anxiety-related symptoms, Table 4 describes individual clients' scores on the BDI and BAI. Table 4 shows that most clients improved on both symptomatic measures and ended treatment with scores in the low clinical range. For example, as seen in Table 4, all clients ended treatment with a BDI score below 13 except client no. 1, client no. 7 who dropped out after the first session and her baseline scores were carried over on all measures, and client no. 8 who ended with a BDI score of 14. This pattern was largely maintained after 6 months. Regarding anxiety symptoms, all clients except client no. 1 and no. 7 ended treatment with a BAI score of 10 or less, a pattern that was largely maintained during the follow-up period.[2]

[1]Because of the small sample size ($n = 10$), parallel non-parametric analyses were also conducted (Friedman tests). Treatment effects on the Inadequate-Self and Self-Reassuring FSCRS subscales, which were significant in the parametric tests, were only marginally significant in the non-parametric tests ($p = 0.09$ and $p = 0.1$, respectively). The rest of the non-parametric results completely corresponded with the parametric results.

[2]Client no. 1 did not engage in two-chair work because she experienced several life crises during therapy and needed therapeutic support (as opposed to intense experiential work). This client showed worsening in all measures despite continuing psychotherapy during the follow-up period (not related to the study). Aggregated significant effects in the study variables were obtained despite the worsening of this client and despite carrying over the baseline scores of the client who dropped out after the first session (client no. 7).

Table 3. Pre–post and pre-6-month *F* values and effects sizes for the seven outcome measures

	Pre–post *F*	Pre-6-month *F*	Pre–post Cohen's *d*	Pre-6-month Cohen's *d*
BDI	9.82*	7.71*	1.13	1.11
BAI	6.21*	9.14*	0.71	0.78
DEQ SC	18.65**	16.68**	1.54	2.33
SCS	5.16	11.46**	0.98	1.82
FSCRS IS	10.43*	8.34*	2.00	2.21
FSCRS HS	5.53*	1.04	0.94	0.60
FSCRS SR	3.91	5.83*	0.96	1.07

BDI = Beck Depression Inventory. BAI = Beck Anxiety Inventory. DEQ SC = Depressive Experiences Questionnaire self-criticism subscale. SCS = Self-Compassion Scale. FSCRS HS = Forms of Self-Criticizing and Self-Reassuring Scale Hated-Self Scale. FSCRS IS = Forms of Self-Criticizing and Self-Reassuring Scale Inadequate-Self Scale. FSCRS SR = Forms of Self-Criticizing and Self-Reassuring Scale Self-Reassuring Scale.
*$p < 0.05$.
**$p < 0.01$.

Table 4. Individual scores on the Beck Depression Inventory and Beck Anxiety Inventory for individual clients

Client no.	BDI baseline	BDI post	BDI 6 months	BAI baseline	BAI post	BAI 6 months
1	38	42	49	46	48	47
2	25	8	15	42	9	13
3	10	0	0	6	1	0
4	41	5	0	32	2	0
5	31	4	4	22	3	6
6	5	6	1	29	6	4
7*	22	22	22	19	19	19
8	20	14	2	9	10	4
9	20	1	3	11	10	4
10	30	11	19.44	1	0	0

BDI = Beck Depression Inventory. BAI = Beck Anxiety Inventory.
*Client no. 7 dropped out after the first session, and her scores were carried over.

DISCUSSION

Self-criticism is a common and insidious clinical problem. Despite being a feature in many psychological problems, research on psychotherapy designed to reduce self-criticism is strikingly limited. In fact, other than research on CFT (Gilbert & Procter, 2006), which is just starting to surface, and earlier studies on two-chair work (Greenberg, 1979, 1980, 1983; Greenberg & Webster, 1982), we are not familiar with psychotherapy research studies on treatment directly targeting self-criticism. Although the earlier studies by Greenberg and his colleagues examined the effects of two-chair work for conflict splits, most of them examined decisional conflicts (i.e., to stay in or to leave a difficult relationship), not self-critical splits. The findings from the current study indicate that two-chair work was associated with reductions in self-criticism, anxiety symptoms and depressive symptoms, and increases in self-compassion and self-reassuring among clients presenting with high levels of self-criticism. These findings suggest that emotion-focused two-chair work might be a promising intervention with self-critical clients, worthy of further study.

Several specific findings deserve further attention. On the one hand, overall reductions in scores on the Hated-Self Scale of the FSCRS did not reach statistical significance. Observing the scale's means suggests that most of the reduction in this scale occurred during therapy, but after therapy was over, scores rose up again. This pattern is also evident in a significant pre–post contrast and a nonsignificant pre-6-month contrast. On the other hand, reductions in the FSCRS Inadequate-Self Scale were significant and maintained during the follow-up period. These findings may suggest, as Gilbert et al. (2004) argued, that these two subscales measure different aspects of self-criticism and that a pattern of strong feelings of hate and disgust with the self, as well as wanting to injure the self, is more difficult to change, especially in brief treatment. Such self-hate, often evident in personality disorders, seems to require longer and more intensive treatment.

In addition, although the omnibus ANOVA for the SCS and the Self-Reassuring Scale of the FSCRS were significant, only the pre-6-month contrasts for these

measures were significant. The pre–post contrasts were not. In other words, the continuation of improvement in these measures after therapy was over was needed for the omnibus test to reach significance level. These findings suggest that self-compassion is a process that requires more time to occur and that it may continue to occur even after therapy is over.

Overall, these results are consistent with recent conceptualizations of self-criticism as an internal conflict or dialogue (split) between two aspects of the self. Although the idea of "multiple voices" or multiple self-aspects has older roots in humanistic psychotherapy (Elliot & Greenberg, 1997; Stiles, 1999), only recently has this idea received more theoretical (Gilbert et al., 2004) and empirical (Kelly, Zuroff, & Shapira, 2009; Whelton & Greenberg, 2005) support. For example, Whelton and Greenberg (2005) successfully demonstrated an enactment of self-critical splits under controlled experimental conditions, and Kelly et al. (2009) conducted an analogue study, providing brief self-help interventions based on the idea that aspects of the self interact with each other. Such studies demonstrate that the idea of vocal multiplicity can be adequately examined under controlled settings. The idea that each side of the split has its own set of cognitions, emotions, needs and motivations, and that each self aspect is undergoing a different change process (i.e., one develops compassion and the other develops resiliency) is critical in understanding self-criticism and self-compassion. In our view, self-report measures that ignore this split and its associated emotional processes might not adequately capture the complex manner in which self-criticism makes individuals vulnerable to psychopathology, and therapeutic approaches that do not take into account the internal dialogue between self aspects might be less efficient in facilitating change. Both assumptions, of course, are empirical questions that warrant further study.

These findings also have important implications regarding the role of self-compassion and self-reassurance in depression and anxiety. Self-compassion is receiving growing clinical (Germer, 2009) and research (Adams & Leary, 2007; Laithwaite et al., 2009; Leary et al., 2007; Neff, Kirkpatrick, & Rude, 2007) attention, showing its importance in coping with negative events and promoting psychological health. Recent research has shown that self-reassuring capabilities are associated with less depressive symptoms (Gilbert, Baldwin, Irons, Baccus, & Clark, 2006). However, less than a handful of studies, most examining group-based mindfulness interventions, have shown increases in self-compassion as a result of therapy (Orzech, Shapiro, Brown, & McKay, 2009; Shapiro, Astin, Bishop, & Cordova, 2005; Shapiro, Brown, & Biegel, 2007). CFT (Gilbert, 2009) is also a type of group therapy that has been shown to increase self-compassion (Gilbert & Procter, 2006). To our knowledge, the current study is the first to show that self-compassion can be affected in individual therapy with self-critical clients. Our results suggest that it is possible to help individuals who harshly berate themselves to develop self-compassion and self-soothing capabilities that last after therapy is over.

Future Research Direction

Future research on emotion-focused chair work with self-critical clients needs to more systematically assess the occurrence of resolution components and their association with self-report process and outcome measures. In addition, it would be important to examine the effects of the intervention on more implicit outcomes, perhaps using subliminal priming paradigms (Baldwin & Dandeneau, 2005). For example, Baldwin (2001) showed that subliminally priming individuals with a critical authority figure led to harsher self evaluation compared with neutral priming. Using such a priming task before and after therapy might reveal therapy-induced effects on implicit self-critical processes that would provide additional, more objective, support for the effectiveness of the intervention that goes beyond clients' explicit reports.

Also, the role of emotional processing in psychotherapy with self-critical clients should be examined. In their work with other marker-guided interventions in EFT, Greenberg and colleagues demonstrated that emotional processing is a critical factor in facilitating change (Goldman, Greenberg, & Pos, 2005; Pascual-Leone & Greenberg, 2007; Pos, Greenberg, Goldman, & Korman, 2003). For example, in a study examining the process of resolving unfinished business, Greenberg and Malcolm (2002) showed that clients who experienced more intense emotions were more likely to be categorized as resolvers (i.e., to engage in resolution components of the empty-chair task) and had better outcome compared with clients who did not. In-session emotional processing within the two-chair task is also likely to be important in resolving self-critical splits.

Finally, the construct of authentic functioning also deserves closer examination. Most of the clients in the study, while enacting the experiencing self, expressed a desire to be or act more authentically, and they demanded that their inner critic let them do so. For example, in Sarah's case, authentic functioning was blocked or interrupted by the inner critic for fear that she would "say stupid things" and become "too different" and isolated. For her, an important change occurred when she decided that she wanted to act more authentically and developed confidence that this would not lead to isolation. Future research in psychotherapy with self-critical clients should formally assess authentic functioning as a change process.

Limitations and Conclusions

This study contains all of the limitations of a small pilot study (small sample size, no control group, lack of validated measures of adherence), and therefore, the results need to be interpreted cautiously until replicated in a larger, more controlled study. Having no males in the sample obviously poses serious problems for generalizing the results, and future studies need to be more gender balanced. Despite these limitations, this study provides a solid first step in studying self-critical and self-compassionate processes within a psychotherapeutic context.

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