RESOLVING SOCIAL INHIBITION DURING EMOTION-FOCUSED THERAPY FOR DEPRESSION: A TASK ANALYTIC DISCOVERY

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Abstract

The aim of this study was to create a model of the resolution of social inhibition (SI) during emotion-focused therapy (EFT; Greenberg et al., 1993) for depression. Employing the steps of the discovery phase of a task analysis (Greenberg, 2007), a rational model of the resolution of SI was first developed. Client markers of SI were also conjectured. Following this, performances of the resolution and non-resolution of SI over a course of EFT therapy for depression were observed, using archival data of six clients from clinical trials of EFT for depression (Greenberg & Watson, 1998; Goldman et al., 2006). Resolution was defined as having an SI score on the *Inventory of Interpersonal Problems* (Horowitz et al., 1988) in the normal range, as indicated by norms, at 18-month follow-up post therapy. The empirical observations were then synthetized with the rational model to create a final rational-empirical model outlining the resolution of SI. The final model identified 6 components: (1) SI Markers; (2) Maladaptive shame and fear expressed by the client's inhibited self; (3) Client connects SI Agent to painful past original source; (4) A power shift that results in an overcoming of the part of client that perpetuates SI (through expression of assertive anger and hurt/grief, needs for support and acceptance, and deservingness of needs); (5) Client is willing to take risks despite potential hurt/grief; and (6) Increased expression of self-assertion. Theoretical and clinical implications of the findings are considered. Limitations and future research directions are discussed.

Keywords: social inhibition, depression, emotion-focused therapy, interpersonal problems, task analysis, discovery phase

Dedication

To my sister and best friend, Ines Dias Ferreira. It was because of her unwavering encouragement, support, and confidence in me, that I had the courage to pursue this Ph.D. many years ago.

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Introduction

Depression (MDD) is ranked among the leading causes of disability worldwide (Kessler & Bromet, 2013). An estimated 298 million people worldwide are living with MDD, including 3.2 million Canadians (Ferrari et al., 2013; Pearson et al., 2013). Depression results in significant economic burden and costs Canadians billions in health care and loss of productivity (Lim et al., 2008). It also has an important impact on health-related quality of life, functioning, mortality due to intentional injury, and health care utilization (Steensma et al., 2016). Consequently, adults with depression have a substantially lower healthy life expectancy than those without depression. In fact, the burden of MDD on healthy life expectancy in Canada appears to be greater than that associated with other chronic conditions such as diabetes, hypertension, and obesity (Steensma et al., 2016).

Depression has a profound effect on interpersonal functioning (Wongpakaran et al., 2012) and interpersonal problems are commonly reported by depressed individuals seeking psychotherapy (Horowitz et al., 1988). Social inhibition (SI), an interpersonal problem involving persistent feelings of anxiety or embarrassment in the presence of others and the inhibition of emotions or behaviours to avoid disapproval and humiliation (Horowitz et al., 2003), has been hypothesized to play a crucial role in depression (Blatt, 1974; Trew, 2011).

Currently, cognitive-behavioural and experiential psychotherapies are both empirically validated, equally effective short-term treatments for moderately depressed adults (Shea & Elkin, 1996; Shea et al., 1992; Greenberg & Watson, 1998; Goldman et al., 2006; Watson et al., 2003), however, these treatments have only modest effects and relapse rates are estimated to fall between 50% to 80% (Andrews, 2001; APA, 2010; Judd, 1997; Westen & Morrison, 2001).

Moreover, despite interpersonal problems being cited as both a cause and consequence of depression (Hames et al., 2013), little is currently known about how psychological treatments for depression address interpersonal problems (e.g., McFarquhar et al., 2018). As such, one path to improving treatments for depression may be to improve treatment of interpersonal problems (Blatt, 1974; Hames et al., 2013; Horowitz, 2004).

The *Inventory of Interpersonal Problems* (IIP; Horowitz et al., 1988) is a measure of interpersonal difficulties that is widely used in randomized control trials (RCT) for depression (McFarquhar et al., 2018; Shea & Elkin, 1996). In RCTs of EFT for depression (Goldman et al., 2006; Greenberg & Watson, 1998), there was a reduction in interpersonal problems, such as SI, as measured by the IIP. Moreover, clients receiving EFT for depression have shown greater resolution in interpersonal problems compared to clients receiving other therapies, such as goal focused (McFarquhar et al., 2018), cognitive-behavioral therapy (Watson et al., 2003) and client-centered therapy at 18-month follow-up (Ellison et al., 2009). Furthermore, SI, compared to other interpersonal problems, showed one of the largest improvements in EFT for depression (Goldman et al., 2006; Greenberg & Watson, 1998; Heinonen & Pos, 2020). Thus, a subset of clients who received EFT resolved their depression *as well as* reduced their SI scores on the IIP from problematic to average levels and maintained this improvement at 18-month follow-up.

So, how did clients resolve their SI during EFT for depression? To answer this, the current study employed the steps involved in the discovery phase of a task analysis (Greenberg, 2007) using a subset of client data from the original EFT for depression RCTs (Goldman et al., 2006; Greenberg & Watson, 1998). First, a rational model of the resolution of SI was proposed based on existing literature, clinical experience, and consultation with an EFT expert, Dr. Alberta Pos. Then, in-session performances of the resolution and non-resolution of SI were empirically

observed over the course of a client's entire therapy (16 to 20 sessions) for 3 resolving and 3 non-resolving clients. Resolution was defined as SI scores on the IIP being in the normal range at 18-month follow-up. Outcome on the IIP was measured at 18-month follow-up for two reasons. One reason, as indicated by Barkham and colleagues (2002), is that interpersonal problems may not show improvement during a short-term treatment for depression. That is, changes in the realm of interpersonal problems may require a longer time to 'show up'. The second reason outcome was measured at 18-month follow-up was to ensure that it was not the alliance with the therapist that was impacting a change in IIP scores because treatment had been already terminated for over a year at follow-up. The next stage of the discovery phase yielded an empirically observed model. Both the initial rational model and the empirical observations were then synthetized to create a final rational-empirical model of the resolution of social inhibition during EFT for depression.

This study is divided into five chapters. In chapter one, reviews of the literature on social inhibition, EFT, and task analysis are provided. In chapter two, the research method and steps involved in the discovery phase of task analysis are explicated. In chapter three, a rationally derived conceptualization of SI is presented along with hypothesized client markers of social inhibition. Then, the rational model of the resolution of SI is proposed. In chapter four, a final rational-empirical model is presented along with client excerpts from therapy transcripts. Finally, in chapter five, study findings, clinical implications, limitations, and future research directions are discussed.

Chapter One: Literature Review

The first step of any task analysis (Greenberg, 1984, 1991, 1996, 2007) is to conduct a thorough and comprehensive review of the literature that can inform hypotheses in a rational model. The following literature review is divided into three main sections: (1) a review of literature relevant to the phenomenon of social inhibition and depression, (2) a review of EFT treatment, and finally (3) a review of the task analysis method. Throughout the following literature review, hypotheses that may be used to inform the rational model are outlined in each section under the heading 'Hypotheses for Rational Model'.

Social Inhibition

A review of the research on social inhibition (SI) highlights relevant broad issues in this literature. First, research on inhibited behaviour has been largely limited to studies involving animals and young children (Dyson et al., 2011). As such, research on adult SI is scant (Denollet & Duijndam, 2019). Second, there are many terms used to describe an individual who spends time alone, in solitude, and not interacting with others (e.g., social inhibition, social withdrawal, wariness, shyness, reticence, and social isolation). For many years, these various terms and operationalizations were used interchangeably, which resulted in confusion in the literature (Rubin & Asendorpf, 1993). The provided literature review attempts to disambiguate some of these terms. Third, there has been further confusion concerning the distinctions among the clinical concepts of SI, social anxiety disorder, and avoidant personality disorder (APA, 2013). Again, this literature review attempts to address these issues by adding to the literature on adult SI, and by clarifying the varying terms and concepts used in the literature, starting with the definition of SI used in the current study.

Defining Social Inhibition

In the current study, SI was operationalized, or measured, using the *Inventory of Interpersonal Problems* (IIP; Horowitz et al., 1988). The IIP is a self-report measure that identifies an individual's most salient interpersonal difficulties. The IIP was developed from the theoretical concepts of Harry Stack Sullivan (1953, 1954, 1956, 1962, 1964), who emphasized that interpersonal connections were central to development and well-being. The IIP adheres to the Interpersonal Circumplex Model (Leary, 1996; Wiggins, 1996), which outlines two axes of interpersonal behaviour. One axis is affiliation, which runs on a continuum from warm (friendliness or affiliation) to cold (hostility or distance), while the second axis is dominance, which runs on a continuum from dominance (interpersonal assertion) to submission (passivity). Both axes are assumed to measure the important interpersonal motivations and behavioral tendencies of attachment and identity needs (Greenberg & Goldman, 2007). Scores on these dimensions are used to identify eight interpersonal problem patterns. These include being too dominant, too vindictive, too socially inhibited, too accommodating, too non-assertive, too self-sacrificing and/or too intrusive and needy. The Socially Inhibited (previously Socially Avoidant) scale is considered to represent individuals who are both too distant and too submissive. Appendix A provides a list of the SI scale items of the IIP.

Scores on the IIP range from normal tendencies in responding to social situations to psychopathological levels of functioning (Asendorpf, 1993b; Duijndam et al., 2020; Horowitz, 2004). An individual who scores high on SI has persistent feelings of anxiety or embarrassment in the presence of others and inhibits the expression of their emotions or behaviours in order to avoid assumed humiliation, criticism, disapproval, or rejection (Horowitz et al., 2003). Socially inhibited individuals find it difficult to initiate social interactions, express feelings to others, join

groups, or socialize and are described as introverted, aloof, distant, and unsociable. Socially inhibited individuals may also be more anxious and withdrawn in social situations because they experience increased sensitivity to social evaluation and are particularly worried about the possible threat of negative reaction from others (Denollet & Duijndam, 2019; Marin & Miller, 2013; Perez-Edgar et al., 2011). As a result, they limit their social life and avoid activities that involve perceived social risk (Horowitz et al., 2003).

Scores on the IIP may reflect a personality trait, or an individual's tendency to behave in relatively consistent ways across situations (Asendorpf, 1993b; Duijndam et al., 2020; Horowitz, 2004; Joiner, 2000; Joiner & Timmons, 2009; Lewinsohn & Gotlib, 1995; Trew, 2011). However, an elevated SI score on the IIP may also reflect a current state of SI occurring within a major depressive episode. In the current study, SI scores on the IIP were measured at pre-treatment, post-treatment, and at 18-month follow-up. No longitudinal assessment of social inhibition occurred; therefore, no empirically supported conclusions will be drawn in this study concerning clients' IIP scores representing trait or state SI.

Hypotheses for Rational Model. Based on the above description of SI, it is expected that socially inhibited individuals will express narratives involving anxiety in social contexts, social avoidance, self-criticism, and inhibited behaviours and feelings. It is expected that they will report socially inhibited behaviour especially within the context of interactions with dominant and/or abandoning others.

Development of Social Inhibition

The tendency to respond in a socially inhibited way is thought to develop in a client's early formative years. A developmental perspective emphasizes the way in which early social

processes shape biological tendencies to form enduring interpersonal patterns, such as SI (Alden & Taylor, 2010). While it is normal for children to be initially shy, timid, and fearful in novel situations, many children eventually warm up to situations or people as they become more familiar, and their anxiety lowers (Rubin & Asendorpf, 1993). Socially inhibited children, however, remain wary and withdrawn in social situations (Rubin et al., 1997). It is thought that although the socially inhibited children want to engage with others, they inhibit themselves (Rubin et al., 1997). It is assumed that this inhibition is likely due to a combination of being in an unfamiliar situation and the child having social-evaluative concerns (Asendorpf, 1990). Thus, for some individuals, SI may reflect a stable tendency to be wary and an inability to act in a relaxed and natural way in the face of social stimuli (Kagan et al., 1988). This is differentiated from unsociability and shyness. Unsociability refers to a disinterest in socializing with others (Asendorpf, 1990), commonly seen in adults with Cluster A personality disorders (APA, 2013), while shyness has referred to a child's initial inhibited response in novel social situations only (Burgess et al., 2001; Rothbart, 2011).

Some (Dyson et al., 2011; Essex et al., 2010) argue that a socially inhibited interpersonal style is temperamental in nature and expressed as a moderately stable trait across the lifespan. There has been support that behavioural inhibition tendencies remain consistent from middle childhood into at least early adulthood (Gest, 1997; Rothbart, 2011). However, not all inhibited children will go on to be inhibited adults (Rubin & Asendorpf, 1993) and some inhibition appears to resolve in time. Temperament may reflect only a vulnerability to expressing behaviours. Therefore, it may be the interaction between temperament and a child's environment that determines whether SI is expressed and maintained. In other words, SI may be "the result of environments acting on young children who inherited a particular physiology" (Schwartz et al.,

1999, p. 1008). Others (Li et al., 2022) are currently exploring the neurological etiology of SI in rats that may one day shed light on the neurodevelopmental bases of SI in humans.

Attachment and Social Inhibition

Attachment and parenting are hypothesized to play key roles in the development of SI in early life (Asendorpf, 1990; Fox et al., 2005; Kagan et al., 1988; M. R. Leary, 2007; Lewis-Morrarty et al., 2012; Rapee, 2002; Rubin et al., 2009). Interpersonal problems are thought to reflect maladaptive interpersonal cycles learned from early attachment struggles and as such, different types of interpersonal problems have been associated with particular attachment issues (Bartholomew & Horowitz, 1991; Horowitz et al., 2003). Social inhibition has been associated with both a fearful and an avoidant attachment style (Bartholomew & Horowitz, 1991; Haggerty et al., 2009). A fearful attachment style involves both a negative view of self and a negative view of others (Bartholomew & Horowitz, 1991). Within a fearful attachment style, socially inhibited individuals are thought to have learned to view their attachment figure(s) as unreliable and themselves as unworthy of a helpful response from others (Bowlby, 1977). An avoidant attachment style, on the other hand, involves a negative view of the other and a view of the self as competent. Socially inhibited individuals with attachment avoidance uneasily rely on others because they view others as undependable and less competent than themselves, and thus, they are more likely to be independent (Haggerty et al., 2009). Therefore, it is possible to theorize subtypes of SI based on attachment being either anxious or avoidant. The difference would be marked by a view of others being unreliably available due to either unavailability or incompetence.

In general, the broader difference between secure and insecure attachment may be more helpful in distinguishing individuals with SI from individuals without SI. Individuals with

insecure (versus secure) attachment patterns are more reluctant to explore and socially interact with others and are thought to be guided largely by fear of rejection (see Rubin et al., 2001). A socially inhibited individual needing support from others, tends to inhibit requesting support due to their anticipation of negative responses from others. These expectations are likely learned from past experiences (Horowitz et al., 2003).

Parenting and Social Inhibition

Evidence shows that parenting beliefs and styles can be both a cause and a consequence of a child's SI. In support of parenting style preceding a child's SI, the development of SI has been associated with parents having an overcontrolling or authoritarian parenting style (i.e., being the dominant other) (Hetherington & Martin, 1986; Parker, 1983). For example, in one study, Rubin and Mills (1990) presented stories to mothers describing hypothetical incidents involving their child consistently behaving in a socially withdrawn manner among familiar others. They found that compared to mothers of non-anxious children, mothers of anxious-withdrawn children were more likely to suggest the use of high control strategies (e.g., directives) and were less likely to display low-power strategies (e.g., redirecting the child) in reaction to their child's socially withdrawn behaviour. These mothers also expressed more anger, disappointment, embarrassment, and guilt about their child's socially withdrawn behaviour. Moreover, a parent's depression has also been related to the development of SI in children (Parker, 1983). For instance, pre-school children of depressed mothers exhibit significantly more inhibited and anxious-withdrawn forms of play with both familiar and unfamiliar playmates than do children of non-depressed mothers (Kochanska, 1991).

Parental beliefs and attitudes can also influence the development and maintenance of a child's socially inhibited behaviour. Researchers (Rubin et al., 1989) found that children of

mothers who believed that social skills were primarily determined by their child's temperament factors and were not learned, were less socially assertive and successful during peer exchanges. Also, mothers who believed that the attainment of social coping skills were relatively unimportant compared to their child's temperament had preschool children who were observed to cry more when attempting to meet their social needs and had less success in their interpersonal negotiations (Rubin et al., 1989).

On the other hand, there is also evidence showing that parenting beliefs and style are a consequence of their child's SI. That is, parents' beliefs about how to socialize children may be determined by children's dispositional characteristics (Rubin et al., 1999). Infant and toddler inhibition can influence parenting beliefs and attitudes that further reinforce the development of socially withdrawn behaviours in children (Mills & Rubin, 1993; Rubin et al., 1991). For example, early social fearfulness and inhibition have been found to elicit overprotective, overcontrolling parenting responses (Rubin et al., 1995). In addition, parental perceptions of their child's shyness and social wariness at age two predicted their expressed lack of encouragement and independence for their child at age four (Rubin et al., 1999).

Impact of Having Social Inhibition in Childhood

Inhibition in childhood can have profound effects on healthy functioning throughout the lifespan. For instance, childhood withdrawal and behavioural inhibition has been associated with later loneliness and difficulties in peer interactions (Chronis-Tuscano et al., 2009), social phobia (Rapee & Spence, 2004), and other internalizing problems (Rubin et al., 2009), as well as an increased susceptibility to adverse physiological and behavioural effects of social stress (Fox et al., 2005; Kagan et al., 1988; Rapee, 2002). A common childhood temperamental difficulty, being behaviorally inhibited has also been noted (Rothbart, 2011) in social inhibition. Behavioral

inhibition has been regarded as a precursor of internalizing/overcontrolled behavior patterns later in life (e.g., Fox et al., 1995). Indeed, depressed adults generally reported having had more behavioural inhibition in childhood (Gladstone & Parker, 2006). There have been strong associations between childhood inhibition and anxiety disorders as well. A longitudinal study (Schwartz et al., 1999) found significant associations between inhibited behaviours at two years of age and generalized social anxiety at 13 years of age. Some have argued that the link between an inhibited temperament in childhood and increased risk for social anxiety is so strong, that childhood inhibition is not simply a risk factor for anxiety, but rather a milder form of the disorder (see Perez-Edgar & Guyer, 2014). This link between SI and anxiety may also speak to the importance of further understanding links among depression, anxiety and SI.

Hypotheses for Rational Model. Given research supporting the existence of a socially inhibited temperament in early life, it is hypothesized that socially inhibited adults seeking therapy for depression will have narratives describing long-standing inhibition and inhibition of their interpersonally aggressive feelings, thoughts, and behaviours. It is hypothesized that these individuals will have narratives involving painful past experiences in which their attachment needs were not met. Since SI is related to attachment histories in which the attachment figure is undependable/unreliable/unhelpful, it is expected that socially inhibited individuals will express having a heartfelt unmet need for support from a significant other. Furthermore, with SI being related to a more controlling and dominant parenting style, it is hypothesized that individuals with SI may express having had parents who expressed this dominant parenting style.

Social Inhibition, Depression, and Other Psychopathologies

Interpersonal theorists emphasize the importance of interpersonal functioning as a major component of psychological health (Horowitz et al., 2003). Individuals who struggle to flexibly adapt within interpersonal environments are likely to experience thwarted goals, strained relationships, and psychological distress (Girard et al., 2017). For example, a socially inhibited individual may wish to be close to others but due to previous experiences of disappointment or rejection, will be wary of trusting others. Consequently, their wariness may result in continued frustration of their need for closeness, which likely further contributes to their depression and other distress. As such, socially inhibited individuals may be prone to experiencing depression because of continued isolation and lack of support. The comorbidity of SI and depression is well established (see Koyuncu et al., 2019 for a review). Indeed, interpersonal problems have been shown to relate to various forms of psychopathology, with Horowitz (2004) suggesting that symptomatic differences and symptom severity may be due to frustrated interpersonal motives and the degree to which interpersonal desires or motives are blocked (Beutler, 2011). Social inhibition has been associated with major depressive disorder (MDD), social anxiety disorder (SAD), and avoidant personality (AvPD). For instance, Barrett and Barber (2007) found that both individuals with major depression only and individuals with co-morbid major depression and AvPD reported having socially inhibited interpersonal styles.

In a factor analysis examining interpersonal problems across 16 different personality and syndromal disorders, it was found that MDD, SAD, and AvPD all load onto a "detachment" factor consisting of a socially inhibited and non-assertive interpersonal style (Girard et al., 2017). The symptom areas that overlapped between these disorders captured social inhibition, fears of negative evaluation, and feelings of inferiority (Girard et al., 2017), all of which may relate to

depression (Greenberg & Watson, 2006). Given the established link among these particular issues, the below sections will focus on the literature of SI in the context of major depression, social anxiety, and avoidant personality disorder.

Social Inhibition and Depression

Social inhibition has been identified as a key interpersonal problem in individuals with MDD (Barrett & Barber, 2007). Individuals with MDD have been found to have more problems with social isolation, avoidance of social situations, lack of assertiveness and being cold or distant, which together reflect having a socially inhibited interpersonal style (Barrett & Barber, 2007). Furthermore, avoidance of interpersonal conflicts has been noted as an important component in the development and maintenance of depression (Joiner, 2000). While depressed individuals may avoid interpersonal conflicts to prevent the experience of imagined negative outcomes, the avoidance of interpersonal conflict may contribute to depression in several ways (Joiner, 2000). First, interpersonal avoidance can lead to a decrease in social support leading to loneliness, isolation, and depression (Joiner, 2000; Lewinsohn & Gotlib, 1995). Some (e.g., Lewinsohn and Gotlib, 1995) have proposed behavioral theories of depression that focus specifically on the role of isolation in depression. Second, interpersonal avoidance can prevent the individual from improving social skills and from learning how to deal with interpersonal problems (Joiner, 2000; Joiner & Timmons, 2009; Lewinsohn & Gotlib, 1995; Trew, 2011). Finally, interpersonal avoidance may lead to loss of social opportunities, and loss can also trigger depression (Heikkinen et al., 1997).

Cognitive theories of depression (Beck, 1976; Disner et al., 2011) characterize depression as a bias toward negativity in information processing and thinking. Specifically, depression has been associated with a negative view of the self, with depressed individuals devaluing

themselves, often being highly critical regarding their own abilities, and again generally seeing themselves as worthless and inadequate (Swallow & Kuiper, 1988). Depressed individuals, compare themselves to others they perceive to be better, and tend to engage in self-critical evaluation, which further contributes to the maintenance of depression (Ahrens & Alloy, 1997; Buunk & Brenninkmeijer, 2000; Swallow & Kuiper, 1988; Thomson & Zuroff, 2004).

Within the general depression literature, there is agreement across theoretical orientations on the existence of two 'content' subtypes in depression that involve either a vulnerability to issues of dependency or independence (Beck, 1983; Blatt, 1974; Blatt, Shahar, & Zuroff, 2001; Whelton & Greenberg, 2005). Sullivan's (1940, 1953) interpersonal theory of depression viewed depression as a result of the frustration of one of two basic needs: security (feeling loved and safe bond with others) or self-esteem (feeling of self-worth). A socially inhibited interpersonal style has been associated with the independent subtype of depression (Alden & Beiling, 1996; Alden & Phillips, 1990; Blatt, 1974; Dinger et al., 2015; Sato & McCann, 2007), also known as the 'introjective' or 'self-critical' depression in psychodynamic therapy (Blatt, 1974; Blatt, Shahar, & Zuroff, 2001), 'autonomous' type in cognitive therapy (Beck, 1983), or 'bad self' depressive dilemma in emotion-focused therapy (Whelton & Greenberg, 2005).

This independent subtype of MDD describes an emphasis on individuality, self-reliance, personal achievements, and a sense of power to do what one wants (Beck, 1987). Members of this independent subtype typically overvalue mastery in their personal strivings (e.g., work) and avoid relationships until they have obtained a sense of worthiness from their work, a state that rarely achieved (Blatt, 1974). These individuals are more critical of themselves and others, and although they avoid relationships, tend to be more sensitive to receiving respect and recognition (Horowitz et al., 2003; Luthar & Blatt, 1993). That is, these individuals are concerned with

gaining status, power, and self-worth in order to feel worthy of respect and validation from significant others (Sullivan, 1953). The intense efforts to maintain independence and detachment are thought to be defensive expressions of exaggerated autonomy to deal with loss of self-esteem and feelings of worthlessness, blame, and guilt (Blatt & Levy, 2003).

Self-criticism is a widely implicated depressogenic cognitive-affective structure and an important treatment target in virtually all treatments of depression (Arieti & Bemporad, 1980; Beck, 1983; Blatt, 1974; Greenberg et al., 1993). From an EFT perspective (Greenberg, 2017; Greenberg and Watson, 2006), self-critical depression is conceptualized as the experienced activation of a 'bad self' self-organization brought on by self-critical processes within the client (Greenberg et al., 1990). During this depressogenic 'bad self' experience, there is chronic activation of secondary emotions in the critical self (e.g., self-blame and self-anger) as well as shame-based maladaptive emotions in the criticized self of feeling inherently worthless, helpless, and/or unlovable. Furthermore, many have suggested that the internal voice of self-criticism is an ''introject'' of a voice originating outside the self and internalized in the process of social development, usually in crucial early relationships with parents (Perls et al., 1951; Greenberg, 1984; Blatt & Levy, 2003).

Perfectionism also plays a key role in the development and maintenance of independent, self-critical, depression (Blatt, 1974; Whelton & Greenberg, 2005). Another important role in the development of depression is the self-interruption of emotions and needs (Greenberg et al., 1993). These are also discussed further in the sections below.

Perfectionism

To avoid humiliation or rejection, socially inhibited individuals tend to be highly self-critical and perfectionistic (Ludwig & Lazarus, 1972). Three different types of perfectionism (Hewitt & Flett, 1991) have been noted. First, self-oriented perfectionism involves setting exceedingly high, unrealistic standards for oneself, intensive self-scrutiny and censuring one's own behaviour, as well as an inability to accept flaws, faults, or failure within oneself. This may manifest in the form of self-criticism and self-interruption of one's emotions and behaviours seen in depressed clients (Greenberg & Watson, 2006), as well as ruminating about negative interpersonal events (Aldao et al., 2010; Nepon et al., 2011). Second, socially prescribed perfectionism involves the perceived need to attain standards set by significant others. Depressed individuals often believe that others maintain unrealistic expectations that are difficult, if not impossible, to meet, but that one must meet these standards to win approval and acceptance (Blatt, 1974). The third type of perfectionism is other-oriented. This type of perfectionism is aimed at others and is characterized by demanding that others meet exaggerated, unrealistic standards. Socially inhibited individuals can be as critical of others as they are of themselves (Ludwig & Lazarus, 1972).

Within self-critical depression, self-oriented and socially prescribed perfectionism are likely maintained and enforced by a socially inhibited coercive aspect of self that verbalizes "shoulds", "oughts", and evaluations (Perls, 1969; Greenberg et al., 1993). The self-critic enforces standards of perfection and when these standards are not reached, the critic lashes out, using hostility, disgust, or contempt towards another part of self that is left feeling hopeless, powerless, and depressed. The critical voice may often be the internalized result of previous interpersonal experiences with critical, humiliating others, who have created an maladaptive

emotional scheme of core shame (Greenberg et al., 1993). This indicates that the socially inhibited aspect of self may be the internalized voice of the authoritarian parent.

An Internalized Rule: Inhibition of Emotional and Behavioural Expression

Interrupting emotions in relationships has been shown to relate to the maintenance of depression and other psychopathology (e.g., Greenberg et al., 1993; Gross, 1989; Gross & John, 2003; Kashdan et al., 2006; Pennebaker, 1989, 1995). Self-interruption involves one aspect of the self that interrupts, blocks, or constricts the experience and expression of feelings or needs of another part of the self (Greenberg, 2017). Self-interruptive processes are formed, and generally respond to environments, that did not allow for the full expression of emotions and needs (Elliott et al., 2004). Loyalty of the socially inhibited client to important others who have demanded interruption of emotion is often expressed. This means that the socially inhibited client often has chosen the need to belong to others over their need to individuate and has preferred to stay problematically attached to an important other (Pos & Paolone, 2018; Winnicott, 1954). This indicates another potential route to depression for the socially inhibited individual. The interruption of experience prevents the socially inhibited individual from being able to access important information required to take adaptive action towards meeting needs that contribute to their overall well-being. When one is cut off from their emotional information, there is a loss of vitality that is often seen in major depression (Greenberg et al., 1993).

It should be noted that the socially inhibited individual will often inhibit experience and/or expression of feelings, and as such, does not express their feelings directly to others (Horowitz et al., 2003; Tackman & Srivastava, 2016). Specifically, they also view assertive behaviour in themselves and others as “bad” and aggressive and as such, attempt to inhibit emotional expressions of anger, in particular (Ludwig & Lazarus, 1972). However, when anger

is important but inhibited, its adaptive capacity is lost, leading to the diminished ability to effectively navigate violations and obstacles. This may result in feelings of resignation, powerlessness, and hopelessness also seen in depression (Greenberg & Watson, 2005).

While having difficulty feeling or expressing anger, socially inhibited individuals may not avoid feelings related to fear or shame (Blatt et al., 2001; Sadikaj et al., 2015; Wang et al., 2014). Indeed, fear and shame might be the most characteristic emotions states for socially inhibited individuals who are depressed and who likely experience both helplessness (passivity) and a desire to avoid embarrassment (distance) (Heinonen & Pos, 2020; Horowitz, 2004).

In addition to interrupting their emotions, socially inhibited individuals may inhibit their behaviours as well. They find it difficult to join groups (Horowitz et al., 2003), withdraw from every day social life, have difficulty with conversational behaviour and making and maintaining contact with others (Asendorpf, 1993a), and avoid getting close to others (Denollet & Duijndam, 2019). As such, socially inhibited individuals tend to feel cut off from others and consequently, have a subjective sense that they do not belong which further isolates them and further contributes to their depression (de Moor et al., 2018). This pattern of behavioural and experiential avoidance prevents individuals from effectively processing situations and the emotions related to those situations, which only maintains their emotional distress and MDD (Rapee & Heimberg, 1997).

Hypotheses for Rational Model. Taken together, the research points to SI as a key component in the development and maintenance of the independent, or self-critical, subtype of depression. It is therefore hypothesized that depressed individuals with a socially inhibited interpersonal style will more likely express self-criticism and high standards of perfection. They will also report engaging in social avoidance and isolation. These individuals will likely express

feelings of worthlessness, defectiveness, and hopelessness and a sense that they are "failing" to meet internal or external expectations. As such, these individuals will likely experience and express maladaptive fear and shame, in addition to difficulties with expressing anger or assertive behaviour.

Overlap In Social Inhibition, Social Anxiety, and Depression

While there is overlap, the constructs of SI and social anxiety are frequently viewed as distinct (Kupper & Denollet, 2014). One important distinction is that SI is often used to describe the trait of being socially inhibited, which ranges from normal to problematic, whereas social anxiety disorder is a diagnostic category that refers to disordered levels of social inhibition and consequently, disordered functioning (Duijndam et al., 2020). Thus, not all individuals who would be considered socially inhibited would meet criteria for having a social anxiety disorder. Research suggests, however, that an association exists between having a socially inhibited temperament and having a social anxiety disorder (Krupnick et al., 1995).

Studies have also examined the confluence of SAD and MDD (Alden & Phillips, 1990; Tsuchiya et al., 2009). Social anxiety and depression frequently co-occur, either concurrently and sequentially (Jacobson & Newman, 2017). Alden and Phillips (1990) found that the profile of interpersonal problems of individuals with comorbid social anxiety and depression were different from those individuals with depression alone. Specifically, individuals with comorbid depression and social anxiety were more socially inhibited and non-assertive than individuals who were depressed only, who were warmer and more accommodating. Given the known links among social anxiety, depression, and SI, it is not surprising that social anxiety and depression have striking interpersonal similarities (Alden & Phillips, 1990). Interpersonally, each state is characterized by under-responsive, or inhibited social behaviours, such as non-assertiveness

(e.g., Gotlib & Meltzer, 1987; Libet & Lewinsohn, 1973; Jones & Carpenter, 1986; Stravynski & Shahar, 1983; Trower, 1980). Furthermore, in social situations, each group is characterized by cognitions related to self-criticism and self-perceptions around themes of SI and inadequacy (e.g., Ahrens et al., 1988; Gotlib & Meltzer, 1987; Heimberg et al, 1989; Stravynski & Greenberg, 1983; Youngren & Lewinsohn, 1980).

Hypotheses for Rational Model. Given the overlap among social anxiety disorder, depression, and social inhibition, it is expected that SI clients with MDD may complain of symptoms that would also be seen in social anxiety disorder, such as feelings of anxiety in social situations, inhibited social behaviours (e.g., social avoidance and non-assertiveness), as well as self-criticism, and concerns about others finding fault with them.

Social Inhibition and Avoidant Personality Disorder

A high SI score on the IIP has also been associated with avoidant personality disorder (AvPD) (Horowitz et al., 2003). An individual with a personality disorder tends to enact trait-like maladaptive patterns in relation to significant others that maintain their psychological ties to them and preserves a self-image that is acceptable to that personality disordered individual (Horowitz et al., 2006). Avoidant personality disorder (AvPD) involves a widespread pattern of inhibition around people, feeling inadequate, and being very sensitive to negative evaluation (American Psychiatric Association, 2013). The interpersonal motive underlying AvPD, as in SI, is assumed to involve avoiding interpersonal judgment and rejection (Horowitz et al., 2006). There is evident overlap between AvPD and social anxiety disorder. In fact, in the DSM 5, avoidant personality disorder is viewed as potentially being better understood by the descriptions offered in the more generalized social anxiety disorder section and vice versa (American Psychiatric Association, 2013). Notes in the DSM 5 refer the reader to both social anxiety and

AvPD sections for more comprehensive understanding of both disorders. Difficulties disambiguating AvPD and social anxiety are therefore noted in the DSM. Given that AvPD (Miki, 2003) was the most common PD diagnosis in the York Depression I and II studies further complicates this picture, and points to the importance of understanding SI, MDD, SAD and AvPD relationships.

Social Inhibition and Problems with Individuation

The psychodynamic literature on individuation (Pine, 1985; Winnicott, 1974, 1992) in personality disorders provides a framework for understanding why individuals with AvPD have difficulties with SI and non-assertiveness (Pos & Paolone, 2019). Individuation refers to the developmental process in which one separates from the identities of others (usually primary caregivers) and begins to consciously exist as an individual. An individuated individual has a cohesive, nuanced, and related sense of self, a definite sense of identity, an interest in interpersonal relationships, and a capacity to understand the perspectives of others (Blatt & Levy, 2003) is present.

On the other hand, failure to individuate, referred to as being *unindividuated*, is when an individual remains problematically attached to the identity of another (Pos & Paolone, 2019). An unindividuated person learns to be socially inhibited in early experiences if a dominant other did not support their individuation as a child. While the relationship with the dominant other is painful, a child may be forced to regulate and interrupt difficult feelings in order to stay problematically attached to the dominant other(s) because, in early life, the need to remain attached likely trumps the need to individuate (Maslow, 1943). Over time, this socially inhibited response likely generalizes and as such, unindividuated persons tend to respond in predictable ways to dominant others (Pos & Paolone, 2019). Therefore, individuals with personality

disorders such as AvPD show a socially inhibited and non-assertive interpersonal style because they have learned that a submissive response is needed to remain attached, and therefore "safe". The pain of remaining problematically attached is likely preferable to what is assumed would be the intolerable experience of crushing loneliness or existential fear if they tried to individuate (Pos & Paolone, 2019).

Hypotheses for Rational Model. Given the association and overlap among avoidant personality disorder, SI, and depression, it is expected that socially inhibited clients may complain of symptoms that would also be seen in AvPD, such as inhibition around people, feelings of inadequacy and being very sensitive to negative evaluation. Furthermore, if clients with SI also have features consistent with AvPD, it is possible that for these clients it will be much more difficult to resolve SI (i.e., assert their feelings, needs, boundaries) because of deeper existential issues that get triggered from any disruption in relationships with dominant others that may indicate individuation difficulties.

Emotion-focused Therapy for Treatment of Social Inhibition in Depression

Emotion-focused therapy (EFT) for depression (Greenberg et al., 1993) has shown promise as a treatment for interpersonal problems (Greenberg & Watson, 2006; McFarquhar et al., 2018; Pos & Paolone, 2019). The overlap between treating SI and depression may, therefore, be particularly salient during EFT treatment for depression (Greenberg & Watson, 2006). Specifically, this may be because EFT for depression targets many aspects of social inhibition, such as self-criticism, self-interruption, as well as the early painful interpersonal experiences that may be the source of the present-day SI. Below, a general description of EFT is provided to

outline terms and concepts that will be used within the rational and the final rational-empirical models.

General Description of EFT

EFT is marker driven, developed from an integration of client-centered conditions and gestalt interventions (Greenberg et al., 1993). EFT helps clients become aware of and make productive use of emotion. Because socially inhibited individuals fear expressing assertive emotion that can be construed as inappropriate or that would cause rejection, the socially inhibited individual will not be able to be genuinely emotional. In emotion science literature (e.g., Frijda, 1986), emotions are viewed as providing vital information relevant to our needs and to help us respond rapidly to support our survival. Within EFT, *emotion schemes* are viewed as being organized around an activated core need and are seen as the main source of our experience. It appears that the socially inhibited person has as a core need, the need to be attached, and that this need may trump their need to be individuals. EFT in general appears to reify individual needs over attachment needs. As a result, only those SI individuals who maintain their ability to individuate may do well working in an EFT model.

Emotions can be sources of adaptive information about our needs and wants that help orient us towards our goals, from an EFT perspective not all emotions are adaptive or healthy. Greenberg and colleagues (Greenberg et al., 1993; Greenberg & Watson, 2006; Greenberg, 2015) distinguish among the below classes of emotions that are worked with differently in therapy.

Primary Adaptive Emotions. Primary adaptive emotions are immediate healthy responses to a situation. They provide useful information that help organize us to adaptively

respond in the service of meeting important needs. For example, it is adaptive to feel fear in response to danger and prepare to escape, or to become angry at violation and prepare to assert one's boundaries. A goal of EFT is to help clients regulate their emotional functioning, so they are better able to access these adaptive emotional responses which help combat more maladaptive feelings (Greenberg, 2010). From an EFT perspective, it will be important for the socially inhibited client to both express primary assertive anger to another when needed, as well as express primary adaptive loneliness for connection in order to resolve SI.

Primary Maladaptive Emotions. Primary maladaptive emotions, also immediate responses to a situation, are habitual responses that are connected to earlier traumatic experiences and unmet needs. They do not provide useful information about adaptively responding in the present situation and as such, often leave individuals feeling "stuck" in very familiar emotional pain (i.e., depressed, or anxious) related to past events. These feelings likely served a useful purpose in the past, but in the current situation are no longer appropriate. In therapy, these maladaptive emotion schemes are activated, accessed, and transformed with alternative adaptive and resilient emotions. From an EFT perspective it would be likely that the non-resolving SI individual will express early shame and fear of rejection and not proceed to experiences and expressions of adaptive emotions such as assertive anger.

Secondary Emotions. Secondary emotions are emotional reactions to primary emotions (e.g., being afraid of anger) or to cognitions (e.g., feeling anxious in response to worries) rather than to environmental situations. Secondary emotions can serve a defensive function (e.g., being angry protects against vulnerable sadness) as well as can serve an emotion regulating function (e.g., self-interruption of deeper pain). Most secondary emotions are symptomatic feelings, such as phobic fear in anxiety and hopelessness in depression. In therapy, these emotions are validated

and then explored to access the underlying primary emotions that give rise to them. From an EFT perspective, it would be the vulnerability to experience secondary depression and fear in the socially inhibited part of self, and the power of the social inhibitor to make the socially inhibited part of self feel powerless to access and fearlessly try to connect with another, that would likely maintain social inhibition. Those who resolve SI would feel the need to connect, and risk reaching out in a genuine way. They would express primary assertive anger at the source of their inhibition, and primary adaptive grief over lost closeness as a result of their SI. As such, from an EFT perspective the resolver of SI will be able to access emotion that underlies secondary emotion.

In EFT, the general change process involves exploring secondary emotions so that one may access maladaptive emotions of shame, sadness or anxiety, that may ultimately be transformed into more adaptive emotions, such as sadness, grief, pride, assertive anger, or joy (Greenberg & Watson, 2006). Research has shown that clients who resolved their self-critical depression over the course of EFT exhibited more transformation of secondary and primary maladaptive emotions to primary adaptive emotions (Choi et al., 2015). It has also been noted (Tarba, 2015) that accessing and expressing grief, understanding, and assertive anger in EFT was associated with remission of depression symptoms. Similarly, clients' expression of more primary adaptive emotions and less secondary emotions predicted better depression outcomes at termination and at 18-month follow-up (Rinaldi, 2015; Wong, 2016). It is unlikely that emotion processes in the resolution of SI will differ. It is expected, therefore, that resolution of SI during EFT for depression will also follow EFT reduction of secondary emotion and increase expression of primary adaptive emotion, in particular, expressions of assertive anger and hurt/grief.

Emotion Processes in Social Inhibition

The emotion processes involved within changes to interpersonal problems during EFT have been examined (Heinonen & Pos, 2020). Specifically, Heinonen and Pos (2020) investigated whether different types of emotional processes were involved in and/or beneficial to ameliorating different interpersonal problems occurring or reported by 23 clients undergoing EFT treatment for depression. The authors reviewed the occurrence of emotional states within sessions that clients had reported as most helpful over the course of treatment and reported several relevant findings. First, the most prevalently expressed maladaptive emotion state across all interpersonal problems was shame/fear or maladaptive emotion. In an EFT model accessing expression of adaptive emotion states first involves the expression of unmet needs, and maladaptive emotion. Interestingly, it was expression of hurt/grief that was associated with improvement for socially inhibited individuals. The authors suggested that for SI clients, reaching hurt/grief appeared curative because it marks a deep internal focus on what has been personally needed and lost.

It was noted that socially inhibited clients could have possibly (and plausibly) accessed assertive anger in later sessions that were not examined in their study. This points to the limitations of quantitative research and to the advantages of a task analytic method that can observe an entire path of therapy.

Hypotheses for Rational Model. Given that some depressed clients resolved their SI during EFT treatment, it is hypothesized that the resolution of SI will follow the general change process of EFT for MDD (Greenberg & Watson, 2006), moving from secondary to primary maladaptive emotions with the goal of accessing transformative adaptive emotions. More specifically, it is hypothesized that clients' expression of secondary emotions will relate to

observed markers of SI, such as the rejecting anger involved in self-criticism and the anxiety involved in self-interruption. It is expected that clients will freely express maladaptive shame and fear. Finally, it is expected that clients will express transformative emotion states, such as the expression of needs, hurt/grief, and assertive anger.

Task Analysis Method

While EFT for depression shows promise in alleviating interpersonal problems, a better understanding of the close-up processes of psychotherapeutic change for specific interpersonal problems, such as SI (Heinonen & Pos, 2020), is needed. Task analysis (Greenberg, 1984, 1991, 1996, 2007) provides an ideal method for investigating *how* social inhibition is addressed during EFT for depression.

Overview of Task Analysis Method

The task analytic approach to psychotherapy research, was introduced first by Greenberg (1984, 1991, 1996, 2007). It provides a method for investigating therapeutic change processes in a manner that allows for hypothesis generation in a new area of research. It also provides an intensive, observational method to identify and describe key change events in therapy. Events refer to "clinically meaningful client-therapist interactional sequences that involve a beginning point, a working-through process, and an end point." (Greenberg, 2007, p. 16). The event considered in the current study was the task of resolving social inhibition. The main objective of a task analysis is to break down the goals, sub goals, and activities within an event or task to obtain a clear conceptualization of how the event or task influences therapeutic change.

Task analysis has been used to study the resolution of several cognitive-affective problems in EFT. These have been resolving problematic reactions (Rice & Greenberg, 1984),

resolving indecision or self-critical splits (Greenberg, 1984), resolving unfinished business with a significant other (Greenberg, 2007), resolving undifferentiated distress (A. Pascual-Leone, 2005), and resolving a state of hopelessness (Sicoli, 2005). It has also been used to study broader phenomena that do not occur in a stepwise fashion, nor lead to an ultimate "resolution", such as how clients interrupt their emotions (Weston, 2018), explicating the components of therapist expressed presence (Colosimo & Pos, 2015), and discerning observable components of tenderness expressed within couples therapy (McNally, 2020).

An overall task analysis proceeds in two general phases: a discovery-oriented phase and a validation-oriented phase. The discovery phase emphasizes building models based on both a rational (top-down) and an empirical (bottom-up) approach. The validation phase involves using developed measures to validate and further hypothesis test group differences in additional, more classical, research. This phase is intended to more rigorously and statistically evaluate the hypothesized model gleamed from the discovery phase.

Task Analysis Procedure

The discovery phase of a task analysis involves seven procedural steps completed in a specified sequence (Greenberg, 1984, 2007). Below is a broad overview of these steps. In parentheses, are noted where these steps will be presented in the current study.

Step 1. Specify the Task. The first step involves specifying and describing the cognitive-affective problem under investigation. In this study, the task under investigation was the long-term resolution of SI during EFT for depression (Chapter Two: Method).

Step 2. Explicate the Clinician-Investigator's Cognitive Map. In this step, the investigator declares perspectives and assumptions that are brought to the analysis to make explicit the framework from within which the investigation will be done (Chapter Two: Method).

Step 3. Specify the Task Environment. This step involves specifying the setting in which the task being analyzed takes place and how the data for the study are being accumulated (Chapter Two: Method).

Step 4. Construct the Rational Model. This step involves creating a rational model of the task based on previous research, clinical experience, and consultation with experts in the field. In the current study, a rational conceptualization of SI and a rational model of the resolution of SI are hypothesized (Chapter Three: The Rational Model).

Step 5. Conduct the Empirical Analysis. This step involves extensive observation of actual data in order to create a model of real performance of the task under investigation. A thorough explanation of the process involved in the empirical analysis is outlined in the method section of the current study (Chapter Two: Method).

Step 6. Synthesize the Rational-Empirical Model. In this step, the rational model is compared against the empirical model. Surprises observed empirically are evaluated. Both rational and observed models are synthesized to create the rational-empirical model of the task (Chapter Four: The Final Rational-Empirical Model).

Step 7. Explaining the Model: Theoretical Analysis. In this final stage of the discover phase, the relevance of the final rational-empirical model in relation to its application among current theory and its theoretical implications is discussed (Chapter Five: Discussion).

Next, these steps are outlined in greater detail in Chapter Two.

Chapter Two: Method

Archival Dataset

Six full-treatment client cases were analyzed in this study. The six clients used were drawn from an archival dataset of video and audio recordings of therapy sessions from York University: Depression I study (Greenberg & Watson, 1998), and Depression II study (Goldman et al., 2006) RCTs of EFT for depression. In the original Depression studies, all clients received 16-20 sessions of either EFT or client-centered (Rogers, 1951) treatment, at no cost, in exchange for their participation in the research studies. The current study included EFT cases only, to examine how SI was resolved during EFT exclusively. To be included in the original studies, all clients met criteria for a major depressive disorder based on the Structured Clinical Interview for DSMIV (SCID-IV; Spitzer et al., 1995), had a score of least 16 or above on the *Beck Depression Inventory* (BDI: Beck et al., 1961), and had a Global Assessment of Functioning (GAF) score of at least 50. Exclusion criteria included current treatment for, or currently receiving medication, for depression, having made a recent suicide attempt, having a current bipolar or psychotic disorder, being engaged in current substance or alcohol abuse, having antisocial or borderline personality disorder diagnoses, being currently suicidal or being in a currently abusive relationship. For full information on the original Depression studies' inclusion and exclusion criteria, see Greenberg and Watson (1998) and Goldman et al. (2006).

Selection of Client Cases for Empirical Analysis

The primary investigator accessed RCT archival data (i.e., video and audio recordings) for a total of 21 cases who had completed long-term follow-up after receiving a full course of EFT treatment for depression (e.g., 16-20 sessions). Of the 21 possible cases, six clients were

purposively selected. These included three “pure gold” clients who exemplified the resolution of SI. These were clients who began therapy with the highest SI scores (of the 21 possible cases) and showed the largest difference in SI scores from pre-treatment to 18-month follow-up. Another three clients exemplified the non-resolution of SI. These were clients who also began therapy with the highest SI scores (of the 21 possible cases) but had the least change in SI scores from pre-treatment to 18-month follow-up. To ensure that long-term resolution of SI had occurred, 18-month follow-up SI scores on the IIP were examined. Thus, clients were selected based on their pre-treatment and 18-month follow-up SI scores.

The possible range of SI scores on the IIP is 0-32. The IIP manual (Horowitz et al., 1988) indicates that the average adult SI score is 6.7 with a standard deviation of 6.1. A score of 13 and above (i.e., 6.7 + 6.1=12.8) was used to represent clients for whom SI scores are more than one full standard deviation above average to represent a pre-treatment problem with SI. As such, a pre-treatment SI score of 13 was deemed to signify a client with a problem with SI.

The six clients selected for analysis reported pre-treatment SI scores of 13 or higher, indicating that SI was a problem for them. Three clients exemplified resolution because they had 18-month follow-up IIP scores in the average range (i.e., 6.7 ± 6.1), indicating that SI was no longer in the problematic range. Two clients were selected as non-resolvers because they had SI scores higher than 13 at 18-month follow-up, indicating that they still had issues with SI. A third client exemplified a non-resolver who, while indicating a reduction in SI post-treatment, returned to a problematic score at 18-month follow-up. Table 1 displays client total number of sessions, pre-, post- and 18-month follow-up IIP scores, and pre-, post-, and 18-month follow-up BDI scores.

Table 1

Client Sessions, IIP Scores, and BDI Scores

Resolvers	Total Sessions	IIP Pre	IIP Post	IIP 18-month	BDI Pre	BDI Post	BDI 18-month
Client 1	16	29	3	3	35	8	6
Client 2	18	19	3	7	18	4	6
Client 3	20	16	8	6	25	8	3
Non-Resolvers							
Client 4	20	28	18	25	26	0	8
Client 5	20	17	18	23	28	16	17
Client 6	20	21	8	25	25	5	9

Note. Clients were assigned numerical identifiers to maintain anonymity. IIP=Inventory of Interpersonal Problems – Social Inhibition Subscale Score; IIP Pre= one week prior to treatment; IIP Post= one week after treatment termination; 18-month= 18 months after treatment termination. BDI= Beck Depression Inventory; BDI Pre= one week prior to treatment; BDI Post= one week after treatment termination; BDI 18-month= 18 months after treatment termination.

Client Demographics

Five clients were Caucasian, and one client was of Asian descent. Of the resolvers, two clients were female and one male. One female client was married with two children, one male client was divorced. One female client was unmarried but was cohabiting with a male partner. Of the non-resolvers, two clients were male, and one was female. One male client was a university undergraduate student and single, one male client was married with a child, and one female client was divorced. While Chi square analysis indicated no significant differences in demographics (p's > .05), the small sample size cautions the reader from reaching conclusions (N = less than 5 per cell).

Therapists

Therapists in the original York Depression I and II studies were randomly assigned to clients. Each therapist in the original trials served as their own control by seeing an equal number of clients in each treatment condition. In the current study all cases received EFT, so treatment was held constant. Also in the current study, six different therapists, randomly assigned to each of the six clients, were observed in the analysis. All six therapists were female and Caucasian. In terms of level of training, three therapists were advanced Ph.D. level clinical psychology graduate students, and three therapists were registered clinical psychologists. All therapists received a minimum of 48 hours of training in EFT over a period of 24 weeks, followed the treatment protocol for EFT (Greenberg et al., 1993), and had their tapes regularly reviewed to ensure adherence to the treatment model (Goldman et al., 2006; Greenberg & Watson, 1998).

Measures

All participants in the original studies completed several measures at pre-treatment (one week before treatment), post-treatment (one week after treatment termination) and 55 of 74 clients also provided measures at 18-month follow-up. Only the measures relevant in the current study are mentioned below. For a full review of outcome and process measures used in the original studies, please see Greenberg and Watson (1998) and Goldman et al. (2006).

Inventory of Interpersonal Problems (IIP; Horowitz et al., 1988)

The IIP is a self-report measure, originally consisting of 127 items describing common interpersonal problems. Recent reports have used the 64-item version (IIP-64; Horowitz et al., 2003). The IIP is used to evaluate a person's distress from interpersonal problems relative to a standardized adult U.S. sample. Individuals are asked to consider whether items have been a

problem for them (i.e., “It is hard for me [to do X] or “I [do X] too much”). Clients rate the distress associated with these problems on a 5-point Likert scale ranging from 0- *not distressed at all by this problem* to 4- *extremely distressed by this problem*. Authors reported test-retest reliability between .89 and .98 and internal consistency ranging from .89 to .94. Cronbach’s alpha for the IIP 64 item scale in the current outcome studies was good, $\alpha = .93$ (Urusov, 2020).

Beck Depression Inventory (BDI; Beck et al., 1961)

The BDI is a 21-item, self-report inventory in which respondents are asked to choose one of five alternatives that best describes their experience of depressive symptoms over the past two weeks. Higher scores reflect greater severity of depression (possible range = 0 – 63). In a review of 10 years of research using the BDI, Beck and colleagues (1988) reported validity coefficients ranging from .66 to .86, and internal consistency coefficients ranging from .73 to .93. The BDI also has been shown to have good discriminant and concurrent validity (Beck, et al., 1988). When the test is scored, a value of 0 to 3 is assigned for each item score and then the total score is compared to a key to determine the depression’s severity. Scores of above 16 were considered as showing depression and BDI scores below 10 were assumed to fall into the normal population range (Beck, 1972). Good final outcomes were considered to have an 18-month BDI score below 10**.** Some non-resolvers reported good long-term outcome on the BDI but not on their SI subscale IIP scores.

Task Analysis Procedures

The procedures involved in the current task analysis are described below.

Step 1. Specify the Task

The first step of the task analysis was to clearly specify and describe the client task of interest (Greenberg, 1984, 2007). The task of interest was the long-term resolution of SI. Thus, SI and the long-term resolution of SI are defined below.

Defining Social Inhibition

Social inhibition was defined/operationalized as a pre-treatment SI score of 13 or higher on the IIP, which was deemed to signify a problem with SI. All six clients used in the empirical analysis had a pre-treatment score of 13 or higher (Table 1).

Defining the Resolution of Social Inhibition

The long-term resolution of more problematic SI was defined as a client having a post-treatment IIP score in the average range (i.e., 6.7 average score ± 6.1 standard deviation of the average score which indicated the mean average score on the SI subscale could be .06 to 12.8) that was maintained or resolved at 18-month follow-up. Non-resolution of SI was defined as an IIP social inhibition score of 13 or higher at 18-month follow-up, indicating that the problem with SI had not been resolved (Table 1).

Step 2. Explicate the Clinician-Investigator's Cognitive Map

This step required the investigator to articulate her perspectives and assumptions, prior to building the synthesized empirical model. This is done to identify sources of potential bias. The primary clinician-investigator of the current study had been informed by years of study as an undergraduate and graduate student in clinical psychology and had been immersed in research,

theory, and practice of emotion-focused therapy for depression. In undertaking this investigation, the primary investigator held the following assumptions:

1. There is a well-established relationship between depression and SI.
2. Social inhibition involves a constellation of genetic, behavioural, cognitive, and affective components.
3. Social inhibition can vary from average to problematic levels.
4. Social inhibition is an interpersonal difficulty that will require at least one course of short-term therapy to resolve.

As an EFT researcher, the following assumptions were also held:

5. Emotions are a source of meaning and organizing action or motivation that provides clients with information essential to meeting important needs. As such, I was potentially biased in my observation of primary emotion in good outcome cases. I guarded against this, carefully re-observing case material as fairly as possible.
6. 'Dysfunction' generally is assumed to involve being 'stuck' in maladaptive and/or secondary emotion states. I was potentially biased in my observation of maladaptive and secondary emotion in poor outcome cases. I guarded against this by carefully re-observing case material as fairly as needed.
7. Resolving dysfunctional states involves transforming maladaptive emotions into more adaptive and resilient emotion states.
8. Problematic SI involves secondary and maladaptive emotion schemes and as such could be conceptualized and treatable within an EFT framework.

Step 3. Specify the Task Environment

The resolution of SI occurred during individual EFT therapy for depression in the context of protocol-adherent (Greenberg et al., 1993) clinical trails (Greenberg & Watson, 1998). Length of therapy ranged from 16 to 20 sessions.

Step 4. Construct the Rational Model

A hypothetical rational model was conjectured how the resolution of SI occurred during EFT treatment for depression. Conjectures arose from the comprehensive and thorough literature review, clinical experiences, and consultation with a clinical psychologist and expert in EFT, Dr. Alberta Pos. The rational model attempted to answer the question "How did clients resolve their social inhibition during EFT for depression?" This model later served as a reference point with which to compare and contrast resolution versus non-resolution cases observed in the empirical analysis step. The rational model will be presented in Chapter 3.

Step 5. Conduct the Empirical Analysis

Rigorous observation of clients performing the resolution of SI occurred. Three cases exemplifying resolution and three cases exemplifying non-resolution cases were observed in this step of the task analysis. Identification of optimal elements involved in the resolution of SI were reported.

Analytic Procedure

Two raters, a clinical psychology graduate student (primary investigator) and a clinical psychologist and expert in EFT, Dr. Alberta Pos, met weekly to micro-analyze video-recorded therapy sessions. The raters strived to use video-recordings and transcripts of therapy sessions.

However, in instances where video-recordings were unavailable or were poor quality, these were supplemented or supplanted with audio-recordings of the sessions. Throughout the empirical observations of sessions, raters reached an informal consensus regarding client markers of SI (Table 3), emotion schemes that were observed, emotional processing difficulties that appeared, in-session tasks (such as chair work for self-criticism or unfinished business) that were performed, the quality of the alliance with therapist that appeared in the session, and therapists' responses to the client that appeared relevant. Raters were vigilant for new or unexpected aspects that might be relevant to task resolution.

The raters first observed and analyzed one resolution case and then one non-resolution case. Following this, the raters observed two resolution cases and then two non-resolution cases. After each observed session, an overall case conceptualization of client SI was revisited, and a continually evolving understanding of how a particular client resolved their social inhibition was conjectured. Following each client's final session, all these components were examined together to form a tentative overarching model of the observed resolution of SI, which was revised with each additional client.

Following this, the non-resolvers were compared and contrasted to the group of resolvers, which helped to clarify which components of the emerging model appeared to be essential to the process of resolution. The findings obtained by comparing unresolved to resolved cases led to further refinement of the empirical model. Eventually, detailed lower-order observations were grouped into higher-order categories until the raters determined that saturation was reached, and the empirical analysis was concluded.

Step 6. Synthesize the Rational Empirical Model

Compared and contrasted to the empirical observations, the final synthesized rational-empirical model will be presented in Chapter Four.

Step 7. Explaining the Model: Theoretical Analysis

The rational-empirical model will be considered in relation to its application among current theory and its theoretical implications in Chapter Five.

Chapter Three: The Rational Model

In this chapter, the hypotheses formed throughout the literature review on social inhibition (SI), depression, and EFT (in Chapter One) are synthesized with clinical experience to rationally model how clients resolve their SI during EFT for depression. The hypotheses generated throughout the literature review were used to rationally conceptualize SI. A list of rationally derived client markers of SI is then provided. Finally, the hypothesized model of the resolution of SI is presented.

Markers of Social Inhibition

As mentioned above, individuals are likely to enter therapy implicitly or explicitly complaining about secondary, symptomatic, emotional reactions (e.g., worry/anxiety, self-criticism and perfectionism, self-interruption, etc.). As such, these secondary, observable, symptoms may potentially serve as client markers indicating a problem with SI. In a task analysis, it is imperative to identify SI markers that would signal the start of the model of resolution.

The hypothesized markers of SI were derived from multiple sources. One source was the *Inventory of Interpersonal Problems* (IIP; Horowitz et al., 1988), one of the most widely used measures to assess interpersonal problems. This was used in the current study to identify clients with problematic levels of SI. It can be assumed, that clients who have reported these issues on the IIP, would manifest complaints about being socially inhibited in therapy. These complaints or problems included the eight items from the SI subscale. These would mean narratives of clients with SI would have complaints about (1) joining in on groups; (2) introducing myself to new people; (3) socializing with other people; (4) expressing my feelings to other people

directly: (5) asking other people to get together socially with me; (6) opening up and telling my feelings to another person; (7) being too afraid of other people; and (8) feeling embarrassed in front of other people too much.

Another source of hypothesized markers of SI, the validated *15-Item Social Inhibition Questionnaire* (SIQ15; Denollet & Duijndam, 2019) was not used as an outcome measure in the original York Depression Studies. The SIQ15 model is based on the notion that adult SI is a broad personality disposition. This suggests that narratives of individuals with SI would indicate having an inhibited temperamental underpinning that evolved into a prototypical pattern of behavioural, cognitive and affective characteristics of SI. Specifically, these behavioural characteristics could include a client narrative of someone who: (9) felt inhibited in social interactions; (10) found it hard to start a conversation; (11) did not find the right things to talk about; (12) had difficulty making contact; and (13) had difficulty talking with other people. The cognitive characteristics might be narrative reports of being a client who: (14) worried that others may disapprove of him/her; (15) felt insecure when not knowing another's thoughts; (16) expected negative reactions from others; (17) inhibited self-expression for fear of being rejected; and (18) thought that others may find fault with him/her. Other affective characteristics in the narratives could include reports of being someone who: (19) avoided getting close to other people; (20) was a closed kind of person; (21) hid his/her feelings; (22) kept other people at a distance; and (23) avoided personal ties with other people.

Other client markers were based on both the literature review as well as the hypothesized conceptualization of SI from an EFT framework include. These were: (24) increased hypervigilance; (25) self-critical evaluation; (26) post-event rumination; (27) perfectionistic standards; (28) non-assertion of self or needs; and (29) self-interruption of emotional experience.

The above sources resulted in a total of 29 hypothesized markers of SI. These are presented in Table 2. It was thought that the presence of one marker alone would not signify problematic SI. However, a constellation of these cognitive, affective, and behavioural symptoms would point to clients expressing features of this problem. The presence of these markers was analyzed during the empirical phase of this study. The markers are organized into behavioural, cognitive, and affective aspects (Denollet & Duijndam, 2019) with the hope of adding more clarity and specificity to any observed manifestations of SI.

Table 2

Rationally Derived Markers of Social Inhibition

Behavioural Aspects	Cognitive Aspects	Affective Aspects
❖ Does not join in on groups	† Worries others may disapprove	❖ Is too afraid of other people
❖ Does not introduce self to new people	† Insecure when not knowing another's thoughts	❖ Feels embarrassed in front of other people too much
❖ Does not socialize	† Expects negative reactions from others	❖ Does not express feelings directly for fear of being rejected
❖ Does not ask other people to get together socially	† Thinks others may find fault with them	❖ Does not open up and tell feelings to another person
† Feels inhibited in social interactions	● Increased hypervigilance	† Avoids getting close to others
† Finds it hard to start a conversation	● Engages in self-critical evaluation	† Is a closed kind of person
† Does not find the right things to talk about	● Engages in post-event rumination	† Hides feelings
† Has difficulty making contact	● Expresses perfectionistic standards	† Keeps other people at a distance
† Has difficulty talking with others		† Avoids personal ties with other people
		● Does not assert self or needs
		● Self-interrupts emotional experience

Note.❖ =Markers from IIP Items (Horowitz et al., 2004); †=Markers from SIQ15 Items (Denollet & Duijndam, 2019); • = Markers from other literature review sources.

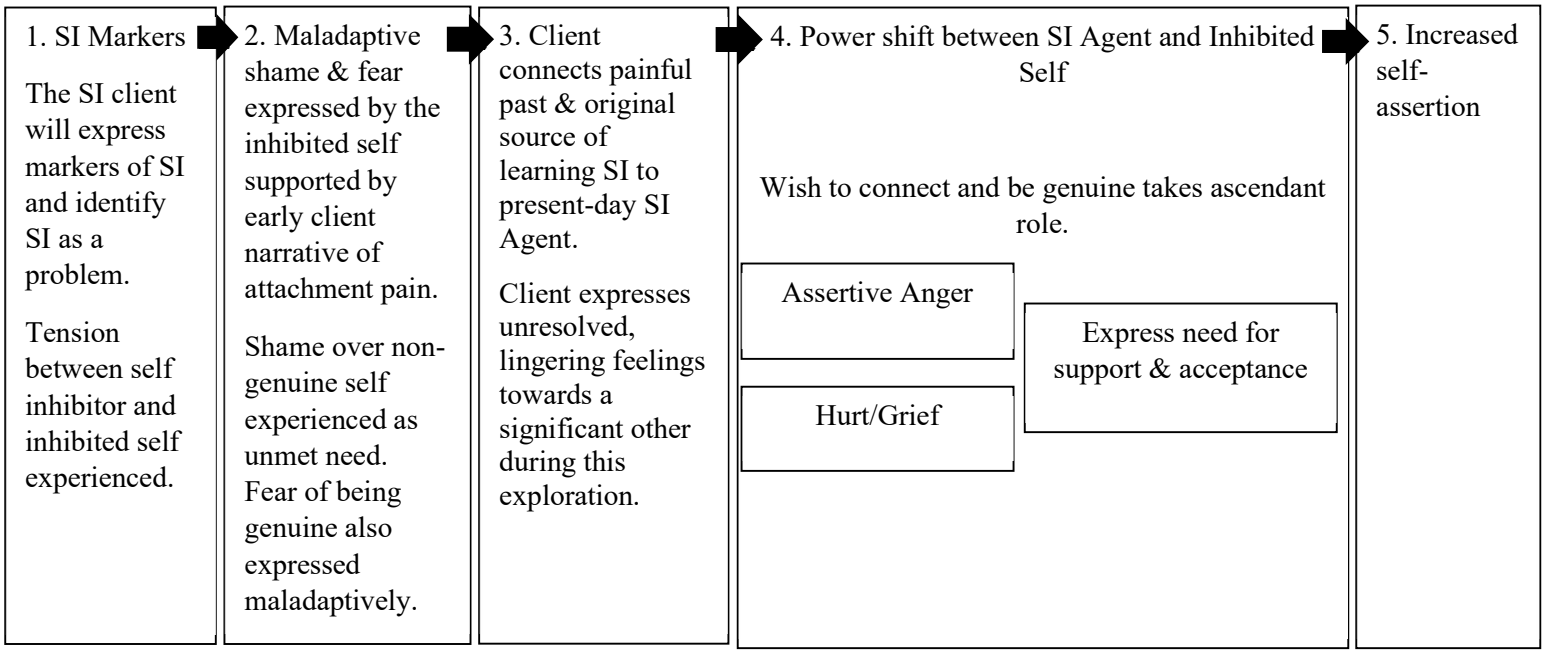
Hypothesized Resolution of Social Inhibition: The Rational Model

Given that SI was resolved for some clients over the course of EFT treatment for depression, it was logical to hypothesize that the resolution of SI would generally follow the change process of resolution of depression achieved by EFT treatment. The difference between EFT for depression and EFT for the long-term resolution of SI is that the model for resolving SI would likely be a more specific, content rich model. In essence, in the treatment of depression (Greenberg et al., 1993) EFT involves exploring secondary emotions in order to access maladaptive emotions of deep shame, sadness or anxiety, so that they can be transformed to more adaptive emotions. This is generally considered to be accomplished in three EFT phases: (1) the *bonding and awareness phase* which involves establishing a trusting relational bond, promoting client's emotional awareness, and collaboratively establishing initial focus for treatment, (2) the *evocation and exploration phase* of core difficulties of emotional processing involves helping clients experience their core pain by attending, arousing, and exploring their maladaptive emotion schemes. This core pain is then regulated, symbolized, and reflected on, and later transformed in the (3) *emotion transformation phase*, which involves the construction of alternatives by producing new emotions and building new alternatives and meanings (Angus & Greenberg, 2011; Greenberg, 2017).

The hypothesized model of resolving social SI during EFT for depression initially follows this process pattern and is presented in Figure 1. Each component in the rational model is described in more detail below.

Figure 1

Rational Model of the Resolution of Social Inhibition (SI)



Description of Components in Rational Model

A major tenet of EFT is to hold an early client-centered relationship. Therefore, it is hypothesized that all clients (resolvers and non-resolvers of SI) will have received EFT treatment in the context of having received a trusting, empathic, client-centered relational bond. Thus, the relationship will be a necessary but not sufficient element in resolving SI. The client centered relationship conditions offered during treatment by the EFT therapist (Elliott et al, 2004) may in the long run provide a corrective emotional experience (CEE; Alexander & French, 1946). It is assumed that the therapy relationship will meet unmet needs in the SI-resolving client for support and unconditional regard and connection, which the client will require to be more assertive. A description of the process and content that is expected to occur in each component of the resolution of SI in the rational model will now be provided below.

Component 1. SI Markers

The first component of the model will involve the communication or display of SI Markers that signal problematic SI. Clients may present to therapy complaining about symptoms, or secondary emotions, of SI that were hypothesized above in Table 2. The markers suggest that SI will manifest in a variety of secondary symptoms. These may include feeling anxious or embarrassed in the presence of others or inhibiting one's emotions and/or behaviours, self-scaring, perfectionism and self-criticism, interrupting emotions and needs, to name a few. Again, a constellation of cognitive, affective, and behavioural symptoms pointed to clients expressing features of the SI problem are expected.

Self-criticism and self-interruption are specifically hypothesized to be expressed markers of SI. This is because SI is related to the self-critical subtype of depression, and as such, it is expected that clients will express issues with self-criticism. Also, because one of the key features of SI is the inhibited expression of oneself, because the SI suffering individual views self as inferior and to be judged (APA, 2013), it is expected that clients will present with issues involving self-interruption, of assertive anger in particular. Within EFT, self-criticism and self-interruption are conceptualized as self-split conflicts. That is, within a client, there are parts of self that are in conflict (e.g., in this case of SI, it is assumed that there is a dominant "*SI Agent*" who expresses the need to be socially inhibited and the subdominant part of self who will suffer the consequences of being told to be inhibited by the SI Agent).

It is expected that the SI Agent will express harsh criticism often expressed by a critical voice within the context of a self-critical split (Greenberg et al., 1993). The SI Agent's rules for 'how to be perfect' will be articulated. Criticisms may be explicitly intended by the SI agent to protect the client from potential shame, humiliation, and rejection. It is assumed that secondary

angry criticism will generate maladaptive fear and shame in the subdominant self whenever a wish to assert occurs in the subdominant self. It is also expected that the SI Agent narrative may express the need to interrupt, block, or constrict the experience and expression of feelings or needs of the subdominant part of self.

Within this first component there will be communication of these secondary symptoms and exploration of the conflicting parts of self. It is also expected that at the initial stage there will be a clear differentiation between the currently more dominant part of self that is perpetuating SI (i.e., SI Agent) and the oppressed, subdominant part of self.

Component 2. Maladaptive Shame and Fear Expressed by the Inhibited Self

Typically, while exploring the secondary, more symptomatic, emotional processes (e.g., self-criticism, self-interruption), the underlying primary maladaptive emotions will be revealed. It will become apparent that the self-criticism and self-interruption (as well as other markers) are secondary to deeper and more difficult feelings of shame and fear. Shame will be by the subdominant self for not being able to follow rules expressed with a sense of shrinking away and hiding the self (Greenberg, 2015). There may also be expression of deep shame of not being genuine as well as fear of being genuine, considered clients' core pain (Goldman & Greenberg, 2015). As such, a second component involved in the resolution of SI will involve the therapist accessing the client's primary maladaptive shame of both not following rules and also the pain of not being able to express true feelings and the client's maladaptive fear of the consequences of being genuine. Given that SI is related to self-critical depression (i.e., a 'bad self' emotion scheme), it is expected that clients will also experience, or potentially express, maladaptive shame related to a sense of worthlessness or being "not good enough" because of not being able to be genuine emotionally.

Component 3. Client Connects SI Agent to Painful Past and Original Source

It is expected that exploring primary maladaptive emotions will ultimately lead to an exploration of the interpersonal origins of both the unmet needs related to the client's shame of not being genuine and also the fear of not being genuine that are activated and contribute to present-day SI. Thus, it is hypothesized that this component will consist of content related to clients making a connection between their painful past experiences and their present-day SI Agent. It is expected that to resolve SI, the client narratives will involve painful past experiences that will involve insecure attachment relationships in which the client did not receive support (e.g., encouragement, help, reliable other) from significant others. As such, if the client expresses unresolved, lingering feelings towards a significant other during this exploration, these feelings are expected to be explored within an unfinished business (UFB) intervention (Greenberg et al., 1993; Malcolm, 1999). Those who do not resolve SI will not express as rich attachment narratives.

Component 4. Power Shift Between SI Agent and Previously Inhibited Self

The fulcrum of change within the resolution of SI is expected to be a transformed power dynamic between the previously conflicting parts of self. That is, the SI Agent will lose its dominance and control on the submissive, assumed to be adaptive, part of self that has been yearning to not be inhibited. The previously submissive aspect of self may feel supported and valued by the SI Agent who may now acquiesce to the self's wishes to connect. However, the shift in power of the SI Agent and the rising power of the previously subdominant self is expected to occur through the experience and expression of adaptive emotions and the heartfelt needs that will be expressed by the previously submissive self. In terms of the expression of emotions, it is expected that expression of adaptive assertive anger and hurt/grief will both be

particularly important for this power shift with the SI agent to occur. However, it is expected that the experience and expression of assertive anger will be most transformative for SI clients because individuals with SI have known difficulties with asserting their feelings and needs. Assertive anger is used here to refer both to assertiveness against the SI Agent (e.g., pushing back against the critic) and to expressions of anger that sets boundaries with others or holds others accountable for past violations (Sharbanee et al., 2019).

Based on research pointing to the importance of accessing hurt and grief in SI (Heinonen & Pos, 2020) it is also expected that resolved clients will experience and express their adaptive hurt and grief. In terms of the expression of heartfelt needs, it is also expected that clients will express unmet needs around the specific themes of needing support and acceptance. The expressed hurt or pain of not having had needs met is expected to help mobilize the later expression of adaptive assertive anger against the SI agent (Greenberg, 2021).

It is generally hypothesized that the power shift will occur because the submissive part of self will somehow experience a crime being committed against the submissive self and this experienced crime will engender assertive self protection (adaptive anger). The need for protection from the SI Agent will therefore not be experienced by the subdominant self. This will allow the SI to dissolve, as new options or even needs for self protection are explored. This may occur within the context of exploration with therapist, or within interventions, such as self-critical splits, self interruptive splits, or unfinished business.

Component 5. Increased Expression of Self-Assertion

The fifth and final component in the model would be the display of desired increased self-assertion, or the confident expression of one's feelings, needs, or desires. The

communication of self-assertive expression and behaviour will signal that emotional transformation has occurred during the previous component. The expression of self-assertion is assumed to be a process marker of the resolution of social inhibition.

Behaviourally, self-assertion is displayed as expressing oneself with strength and having a sense of being freely expressed without hopelessness (Sharbanee et al., 2019). In essence, self-assertion is the expression of a feeling that "I matter" (Miller & Greenberg, 2016). The client's self-assertive expression may be directed to the internal SI Agent, as well as can be directed to people in their lives. It is expected that resolver clients will express content related to setting boundaries and choosing their own adaptive needs over the demands or rules of the SI Agent or others. An increase in self-assertion will suggest that the client is no longer willing to inhibit themselves in social contexts and is now empowered to express themselves more authentically. An increase in self-assertion therefore represents an antidote to many of the markers of SI. As such, an increase in self-assertion will signal the resolution of problematic SI at therapy termination. However, since the aim of this study is to identify processes and content involved in the long-term resolution of SI, only those clients who maintain a resolution of SI at 18-month follow-up will be considered resolved.

Chapter Four: The Final Rational-Empirical Model

In this chapter, an overview of the markers of social inhibition (SI) that were empirically observed is first provided. Then, the final synthesized rational-empirical model is presented. Finally, additional qualitative observations noted during the empirical analysis will be shared.

Client Markers of Social Inhibition

In Chapter Three, client markers of SI were hypothesized based on several literature sources, including the *Inventory of Interpersonal Problems* (IIP; Horowitz et al., 1988), the *15-Item Social Inhibition Questionnaire* (SIQ15; Denollet & Duijndam, 2019), and other literatures reviewed in Chapter One. Table 3 lists the empirical observation of client markers which were empirically observed.

All the hypothesized markers were observed during the empirical observation phase. Furthermore, all clients displayed no less than 12 markers of SI. This provided qualitative support for the notion that social inhibition is presently viewed as a multifaceted construct consisting of behavioural, cognitive, and affective manifestations (Denollet & Duijndam, 2019). Specifically, out of the 29 possible markers, Client 1 (Resolver) endorsed 27 markers, Client 2 (Resolver) endorsed 23 markers, Client 3 (Resolver) endorsed 12 markers, Client 4 (Non-Resolver) endorsed 25 markers, Client 5 (Non-Resolver) endorsed 14 markers, and Client 6 (Non-Resolver) endorsed 17 markers. Based on the empirical observation and the literature reviewed on SI, an individual presenting to therapy with problematic social inhibition may show a constellation and breadth of markers.

Markers were observed across all six clients. These were both cognitive and affective markers: (1) worrying that others may disapprove; (2) expecting negative reactions from others;

(3) inhibiting self-expression for fear of being rejected; (4) thinking that others may find fault with the client; (5) engaging in self-critical evaluation; (6) engaging in post-event rumination; (7) expressing perfectionistic standards; (8) not expressing feelings directly; (9) not opening up and telling feelings to another person; (10) hiding feelings; (11) not asserting self or needs; and, (12) self-interrupting emotional experience.

Client markers that were observed in half, or less than half, of all clients were: (1) not joining in on groups; (2) not introducing self to new people; (3) not socializing; (4) not asking other people to get together socially; (5) finding it hard to start a conversation; (6) not finding the right things to talk about; (7) difficulty talking with others; (8) keeping other people at a distance; and (9) avoiding personal ties with other people.

Both resolver and non-resolver clients endorsed many of the same SI markers. No pattern of resolver or non-resolver clients endorsing uniquely specific markers was noted. Four clients, including two resolvers and two non-resolvers, endorsed behavioural, cognitive, and affective markers. Two clients, one resolver and one non-resolver, endorsed cognitive and emotional aspects only. Many of the cognitive and the emotional markers of SI were endorsed by all six clients. The behavioural markers were less widely endorsed, with two of the six clients not endorsing any of the behavioural items listed in Table 3.

Table 3

Empirically Observed Markers of Social Inhibition

Behavioural Aspects	Cognitive Aspects	Affective Aspects
❖ Does not join in on groups (**1**, 4)	† Worries others may disapprove (**All clients**)	❖ Is too afraid of other people (**1**, 4, 5, 6)
❖ Does not introduce self to new people (**1**, 4)	† Insecure when not knowing another's thoughts (**2, 3,** 4, 6)	❖ Feels embarrassed in front of other people too much (**1, 2,** 4, 6)
❖ Does not socialize (**1**)	† Expects negative reactions from others (**All clients**)	❖ Does not express feelings directly for fear of being rejected (**All clients**)
❖ Does not ask other people to get together socially (**1, 2,** 4)	† Thinks others may find fault with them (**All clients**)	❖ Does not open up and tell feelings to another person (**All clients**)
† Inhibited in social interactions (**1, 2,** 4, 6)	• Increased hypervigilance (**1, 2,** 4, 6)	† Avoids getting close to others (**1, 2,** 4, 5)
† Finds it hard to start a conversation (**1, 2,** 4)	• Engages in self-critical evaluation (**All clients**)	† Is a closed kind of person (**1, 2,** 4, 5)
† Does not find the right things to talk about (**1, 2,** 4)	• Engages in post-event rumination (**All clients**)	† Hides feelings (**All clients**)
† Has difficulty making contact (**1, 2,** 4, 6)	• Expresses perfectionistic standards (**All clients**)	† Keeps other people at a distance (**1, 2**)
† Has difficulty talking with others (**1**, 4)		† Avoids personal ties with other people (**1, 2**)
		• Does not assert self or needs (**All clients**)
		• Self-interrupts emotional experience (**All clients**)

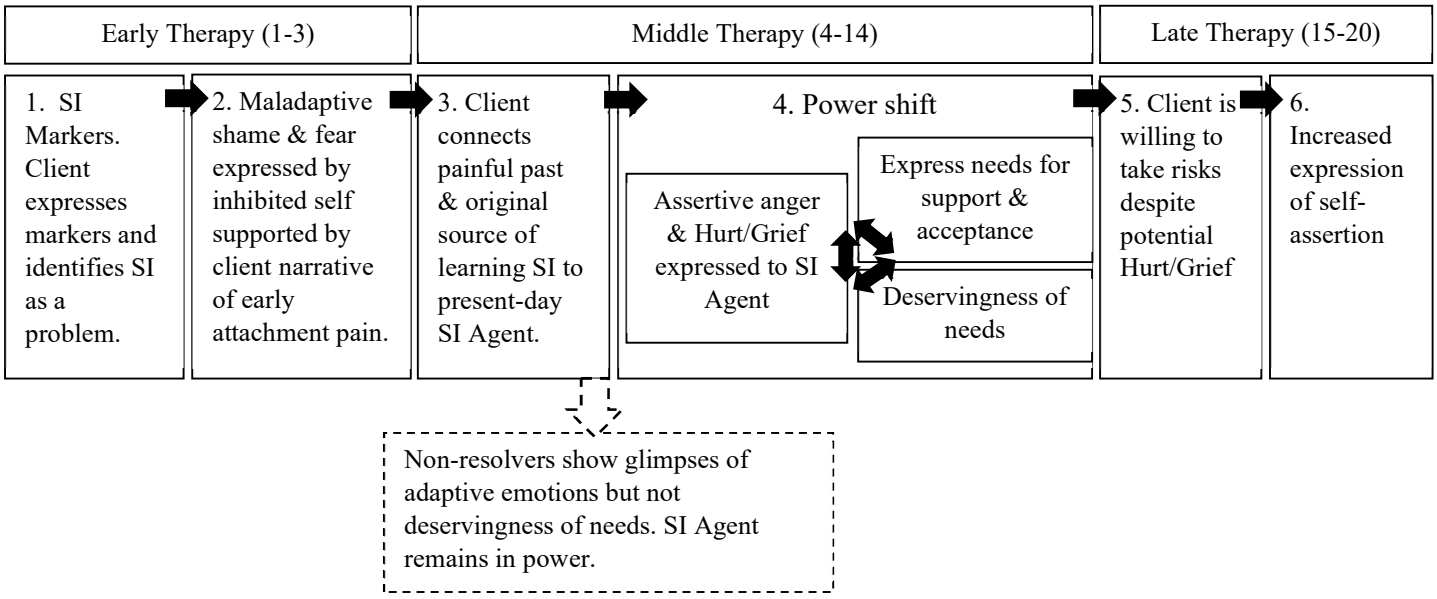
Note. N=6. Numbers in parentheses represent client IDs. Bolded client numbers = resolvers, unbolded client numbers = non-resolvers; ❖ =Markers from IIP Items (Horowitz et al., 2004); †=Markers from SIQ15 Items (Denollet & Duijndam, 2019); • = Markers from other relevant literature review sources.

The Final Rational-Empirical Model

Through an iterative process of moving between the rational model and the empirical data provided from the observation of session videos, a final synthesized refined rational-empirical model of the resolution of SI was created (Figure 2). This model involves six components representing the process and content involved in the resolution of SI over a course of therapy that ranged from 16 to 20 sessions. The estimated range of sessions in which the components were observed is also specified (e.g., early, middle, and late therapy). While the model outlines a sequence of linear, progressive steps, the process of resolving SI is believed to occur in a cyclical manner wherein components occurring earlier in the therapy may be repeated later in a similar or more complete form. The dotted arrow and dotted text box represent the point at which the non-resolvers differed from the resolvers.

Figure 2

Final Rational-Empirical Model of the Resolution of Social Inhibition (SI)



In the following sections, the ways in which the final rational-empirical model accommodated the rational model are outlined. Then, descriptions of the components of the final model and client excerpts are provided. Finally, differences between resolver and non-resolver clients that were observed during empirical analysis are noted.

How the Final Rational-Empirical Model Accommodated the Rational Model

Following empirical observation, the rational model accommodated empirical observation in the following ways. Although no conjectures related to timelines were made in the rational model, during observation it became apparent that clients followed a generally similar progression through the components. While there was some variability in the timeline (e.g., some clients arrived at a component earlier or later than others), there were times in therapy (i.e., early, middle, late) in which specific components were more prominent for clients. Thus, the timeline provides an estimate of sessions in which clients were noted to spend a majority of time within a model component. This was added to the final model to further organize and discern the process involved in the resolution of SI.

During the early sessions (one to three), considered the bonding and awareness phase, the client-centered relationship was formed. Given that resolving SI requires taking social risks, it is essential for clients to feel safe within the therapeutic relationship.

The power shift between the inhibited self and the SI Agent was also modified in the final model as well. First, deservingness of needs was added because resolvers were observed to express a felt deservingness of having their needs met. This appeared to be one significant difference between resolvers and non-resolvers. The importance of the therapist is again highlighted here. This is because the therapist must validate the SI clients' needs at an early stage

of therapy. Even in the cases where non-resolvers made some utterances about deservingness, they quickly reverted to maladaptive feelings of un-worthiness that appeared to negate a genuine sense of deservingness.

Another addition to the final model was the component in which resolver clients were observed to be willing to take social risks between therapy sessions despite hurt/grief being potentially experienced. After the power shift occurred, resolver clients expressed that in order to live authentically and in an uninhibited fashion, they were willing to accept and tolerate the risk of potential hurt/grief involved in resolving their SI. That is, resolver clients accepted that in showing their authentic selves, they risked losing others. Additionally, they were willing to take risks in order to be freer from being socially inhibited and to get what they needed from others. Thus, resolvers of SI appeared to show a willingness to expose oneself to risk. They also appeared to know they could and would survive this experience of potential pain.

Description of Components of Final Rational-Empirical Model

The six components in the rational-empirical model of the resolution of SI are described in greater detail below, along with excerpts from client transcripts to illustrate how the components manifested in actual client sessions. Only exemplary excerpts from a resolver and non-resolver client are provided for each component below. Appendix B provides excerpts for each component for each client case.

Component 1. SI Markers. The rational-empirical model began in early therapy (sessions 1 to 3) with the first component, SI Markers (self-criticism, self-interruption*)*. All six clients displayed or communicated several markers pointing to a problem with SI, which were listed above in Table 3. Each of the six clients communicated a problem involving a part of themself

that inhibits their experience and/or expression. Furthermore, all six clients displayed or communicated the markers of self-criticism and self-interruption. During this early session component, all clients also differentiated their more adaptive, subdominant part of self from the SI Agent part of self.

All six clients displayed markers of self-criticism and self-interruption. While not all clients engaged in self-critical or self-interruptive split interventions per se, all six clients did explore self-criticism and self-interruption during early sessions. While all clients were observed to express some adaptive emotions during this early exploration, there was no sustainable "resolution" at this stage of therapy. Within this early stage of therapy, all clients displayed an understanding that they were restricting the expression of a part of themselves.

Client 1 (Resolver)

Description: In her first session, Client 1 described markers of SI, which included social avoidance and withdrawal ("hiding away"), difficulty interacting with others, ruminating, and self-criticism.

Excerpt:

Therapist: how, how would you describe having a hard time what's it like for you?
Client: um - - it's almost like hiding away, and like I don't want, uh, I can't face people and deal with, you know social things or anything, I feel like I can't anyway with the kids, I have their interviews, you know their teacher interviews and I had a really hard time with that and, afterwards I just analyze every little thing and I just – I just, you know I think I just put myself through hell
Therapist: right. Okay, so you're actually experienced yourself, kind of with all these self-doubts and these criticisms
Client: yeah. Yeah. Mm-hm.

Description: Later in session one, Client 1 described other markers of SI, including inhibiting the expression of her boundaries (e.g., non-assertiveness) to keep others "happy".

Excerpt:

Client: I think it's that I want to keep them happy and
Therapist: what would happen if you were to say at the onset "no, I'm busy today, don't call me today"
Client: I don't, I don't think anything would happen, I've
Therapist: what happened to you? How would it, how would
Client: I would never be able to say it so I don't know what would happen to me, I would never be able to say
Therapist: can you, can you talk from that, from the never being able to say, like what, what is it feeling like as you even think about this
Client: it's, it's just I feel like, I feel like a, like a real pushover and like why am I like that? I don't know like, how I get into this, I don't know how this happens all the time

Client 4 (Non-Resolver)

Description: In his second session, while doing a self-interruption intervention, Client 4 also expressed markers of SI, such as self-criticism, worrying that others may disapprove of him, and how he also was inhibiting his anger.

Excerpt:

Client: you're not allowed to be angry at anyone except yourself because if you were angry at other people and other people saw that, then they might think badly of you and then that just makes your life worse than it already is
Therapist: so, it's not beneficial to be angry and if you do that, you're going to make things even worse, what happens as you say that
Client: I just don't like letting people know that I get angry, like I go to extreme lengths to hide

Component 2. Maladaptive Shame and Fear Expressed by the Socially Inhibited Self.

The next early therapy component involved accessing and exploring maladaptive shame and fear experienced by the inhibited (interrupted/blocked) part of self**.** All six clients accessed and explored feelings of primary maladaptive shame and fear. Specifically, all six clients expressed shame related to a sense of worthlessness or being "not good enough" and fear related to being rejected, negatively evaluated, or abandoned by others.

Both resolvers and non-resolvers expressed the second component in the model which involved accessing and communicating primary maladaptive shame and fear related to SI. Maladaptive shame and fear were expressed by the socially inhibited self as the felt consequence of SI in the form of being "not good enough", being wrong or bad, worthless, defective, powerless, helpless, hopeless and the anxiety of 'failing' to meet a standard, either from internal or external (and introjected) pressures.

Client 1 (Resolver)

Description: In her first session, Client 1 articulated primary maladaptive emotions related to her markers of SI (e.g., ruminating, and self-criticism), including feeling "wrong" and "really bad" about herself.

Excerpt:

Client: uh, uh, it's just um, like that's when I analyze and come up with "oh I did this I did that I shouldn't have," I'm very, just really, really going over things again and again and just feeling really - - you know, just feeling really bad about myself, guilty, um, and um, with the kids, like I, I'm constantly thinking what I, what I should do, what I have to do, what I've done that was wrong - - I'm, I'm just obsessed with them I guess, I'm just like that's my whole thing is like, what am I doing wrong with them, how I can change it, how can I fix it, it's like, you know.

Client 6 (Non-Resolver)

Description: In her second session, Client 6 described the maladaptive feeling of being small in response to the SI Agent part of her that imposed perfectionistic standards.

Therapist: the part of you that's scared and terrified, what happens when you hear this part say "I expect you to be brilliant, I'm not going to tolerate any failure" what does it feel like inside?
Client: small
Therapist: um hum, tell me about this
Client: I can't do it
Therapist: um hum, tell me, what is it

Client: because its too much**,** because I'm not allowed to fail even just a little bit, I mean it has to be absolute brilliance or nothing

Component 3. Client Connects SI Agent to Painful Past and Original Source. Then, in the middle of therapy (sessions 4 to 14), all six clients explored past painful experiences. All clients connected their painful past to how their present-day 'SI Agent' had emerged to keep them socially inhibited. Five clients expressed lingering painful feelings related to their social inhibition and as such, engaged in unfinished business (UFB) interventions with the significant other(s) from whom they had learned to be socially inhibited. One client did not engage in an UFB intervention, however this client engaged in interventions related to her painful past by using an empty chair to make contact with a younger version of herself.

Both resolvers and non-resolvers of SI expressed this third component. All clients reported painful past experiences that involved insecure attachment relationships which related to experiences of shame, humiliation, rejection, or fear and a lack of support (e.g., connection, help, encouragement, reliable other).

Client 3 (Resolver)

Description: In session seven, Client 3 explored her painful past of not being able to speak freely and learning rules around inhibiting the expression of her feelings and needs. She connected her past experiences to her present-day SI Agent, or the part of her that interrupts her from expressing her feelings and heartfelt needs to her partner and family.

Excerpt:

Client: this is what I was taught, you did this little dance, but you never said what you felt or wanted
Therapist: so you were taught somehow this is not okay
Client: no, that's not the way I was brought up, I learned the other way which was you sort of hinted and danced around until the other person figured it out

Therapist: it's almost this sense that it wouldn't be okay to just say it
Client: not at all, when I was a child, you were under the impression that you're seen and not heard, and you definitely don't speak unless you're spoken to, so you wouldn't make an opinion of your own, and you'd never ask, you would hint around, you never came out and said 'can I get this for Christmas?', if someone asked you bluntly, that was okay
Therapist: almost a sense that if you said it directly, what would happen?
Client: you would be rejected, either laughed at or made to feel selfish, it was confusing as a child because I never asked for anything, so even when I asked for one thing, the response that I got was, it's 'too much', I had to hope and pray that someone would ask me what I want, because then I could actually say what I wanted
Therapist: and now, with your boyfriend, some of that still lingers
Client: oh, of course

Client 4 (Non-Resolver)

Description: In session eleven, Client 4 explored painful past experiences and unmet needs in an unfinished business intervention with his parents. Client 4 made connections between his parents' neglect of his emotional world and how he self-interrupts in the present-day.

Excerpt:

Therapist: mm-hm, tell them what you needed from them, tell them what you wanted from them
Client: I needed to know that you cared about me no matter what I did or if I was unsuccessful with something that it would be okay and, but I never heard any of that from you, instead you either ignored when I was upset, or you would just lecture me
Therapist: mm-hm I didn't need your lectures
Client: I didn't need your lectures, I needed your support
Therapist: (p:00:00:06) What's happening to you now?
Client: (p:00:00:07) I guess uh, I guess they upset me more than I realized

Component 4. Power Shift between SI Agent and Socially Inhibited Self. The three resolver clients then progressed through this next component, which involved a power shift between SI Agent and the previously socially inhibited self. This component consisted of several elements that occurred in a cyclical process over the course of the middle stages of therapy.

These elements did not occur in a similar stepwise fashion for resolver clients but were all observed at some point during this stage of resolution. This consisted of expressing *assertive anger* and *hurt/grief* to the SI Agent, as well as the expression of *needs for support and acceptance* and the expression of *deservingness of having needs*, more generally, met. It is during this component that the non-resolvers began to diverge from the path of resolution that was observed in the resolver client cases. While the non-resolvers did show glimpses of adaptive emotions and expressed needs for support, they did not express any felt deservingness of having their needs met. As such, the non-resolvers did not fully express this component of the model and therefore did not progress further.

Only resolvers displayed all elements included in this fourth component. As such, only the resolver excerpts will be provided. While non-resolvers showed glimpses of the expression of adaptive emotions and needs for support, they ultimately slipped back into and got "stuck" in secondary and maladaptive emotions. For example, in her fourteenth session, a non-resolver (Client 6) expressed "it was better a week before but then I found that this week I was just slipping into the same old thought patterns and same, you know, being critical".

Furthermore, unlike resolvers, the non-resolvers did not express deservingness of having their needs met. Only the resolvers expressed deservingness around having their needs met, which included their need for support as well as other needs that were expressed (e.g., to be accepted, to be heard, to be seen). Deservingness implied that they were worthy of having their needs met. This increased sense of worthiness likely also transformed, or made it easier to transform, the underlying sense of shame seen in SI and the "bad self" depressive emotion scheme.

This component included elements of the expression of genuine assertive anger, hurt/grief, as well as the expression of their needs for support acceptance and the deservingness of having their needs met (in general) occurring in a cyclical process over the course of the middle stage of therapy. Resolvers displayed each of the elements involved in this component, though the elements did not follow a similar pattern across clients. That is, each resolver client displayed these elements in varying order.

Client 3 (Resolver)

Assertive Anger

Description: In session seven, Client 3 engaged in a self-split chair intervention, with the SI Agent part of self that imposed expectations to meet her family's needs and the part of client who wanted to express herself genuinely. Client 3 expressed assertive anger in the form of taking the risk of setting boundaries with her family by refusing to do what they expected of her.

Excerpt:

Client: (*speaking as her family)* you're selfish, why are you doing your stuff for you, we're a family, we're expected to do stuff together, you're expected to be there no matter what our needs come before yours, you're expected to pull up the slack, we expect you to be there because you're the one who can keep the peace among us, I'll have a lousy Christmas if you don't come
Therapist: can you switch, how do you feel inside?
Client: I used to feel guilty but now I feel torn, like you'll have a lousy Christmas but that's not my problem
Therapist: so I don't want to? It's not my job?
Client: I'm saying you can't expect me to make your Christmas okay, you're going to have to do it yourself

Expression of Need for Support and Acceptance

Description: In session nine, Client 3 expressed unmet needs for her family to accept her for her genuine self.

Excerpt:

Therapist: mm-hm can you tell them what you want from them?
Client: [speaking to imagined family in chair] I just want you to accept me for who I am, I don't want any flak, you can ask me all the questions you want about something, but I refuse to defend my actions anymore
Therapist: so I want you to accept me for who I am
Client: mm-hm, for who I am

Description: In her eleventh session, within the context of UFB chair work with her father,

Client 3 expressed her unmet needs for support from her father.

Excerpt:

Client: I was determined, <u>all I needed was support or information</u>, that's all I needed as a kid, support in what I was doing and information in what I was doing wrong, but not to be told what I can or cannot do, I was constantly told how I should feel about things
Therapist: so, I just needed some support, I really could've flowered
Client: yeah, <u>all I wanted was to be me</u>
Therapist: can you tell him what would've done with the support
Client: with the jazz class, I was doing fine, then I got moved up to my sister's group and you told me that I'm making my sister feel bad because she's older, so I quit

<u>Deservingness of Needs</u>

Description: In Session 11, in addition to assertive anger, Client 3 expressed that, as a child, she

deserved to be treated much better than she was by her father.

Excerpt:

Client: all you did was manipulate me and use me, and it's like it's terrible it's disgusting, how can you do that to a human being?
Therapist: how dare you use me, can you say that to him? How dare you use me
Client: <u>how dare you use me and discard me.</u> It's like's how can you do that to somebody?
Therapist: I don't deserve this?
Client: <u>no, I don't deserve this at all, it's like I'm a human being and I deserve,</u> if you didn't like me that much, it would probably have been better if you had just abandoned me as a child, it's like why?
Therapist: I deserved more

Client: I deserved much more, it's like, I deserved a life, I deserved a mother, if you couldn't do it, you should have just left then, I think you're the most spineless person I've ever met

Hurt/Grief

Description: In session eleven, Client 3 expressed hurt/grief around having to inhibit herself, and not having her needs for support and acceptance met, during her childhood.

Excerpt:

Therapist: what are your tears saying? Can you speak from the tears? I just feel such pain and sadness?
Client: pain and sadness, and I'm just so tired, it's like is this battle ever going to end, it seems like such a battle, and is it ever going to end
Therapist: it's been such a struggle, what do you want?
Client: some relief from this childhood pain, I can't get it back, but I also don't want it haunting me, it seems to haunt me constantly
Therapist: so, some kind of release from this childhood pain that just haunts you
Client: and to figure out who I am, I still haven't figured out who exactly I am, my family still thinks I'm the person that they want, but I'm confused because I don't know if they know that I want and need to change

Component 5. Client is Willing to Take Risk Despite Potential Hurt/Grief. Within the later sessions of therapy (for most resolved clients, sessions 15 to 20), the next component for the three resolver clients involved an acceptance and willingness to take social risks that could potentially lead to hurt/grief. Resolver clients accepted that no longer inhibiting themselves (i.e., asserting themselves) and expressing themselves authentically inherently involved a risk of potential hurt/grief and then began to take these risks in their lives between therapy sessions. Therefore, openness to potential future pain was noted in resolved SI clients.

Following the power shift with their SI Agent, resolver clients expressed an awareness that to meet their need for support and acceptance (from a part of themselves or from others), they would have to take the risk of no longer inhibiting themselves. All resolver clients

expressed a willingness to express themselves authentically despite the risk of potential hurt/grief. There appeared to be a knowing that hurt would be possibly experienced, but also a willingness to tolerate the hurt, as well a sense that pain would be survived. It was this narrated experience that indicated that a power shift between the SI agent and the self had occurred. That is, clients expressed that they had, or they intended to, assert themselves despite the possibility that they might lose others or be hurt by others' rejection or disapproval. It appeared that resolver clients wanted connection more than they feared hurt. It would be important for the EFT therapist to underline the loss of connection as a more painful experienced loss than the fear of hurt, and relief found from avoiding the hurt might be. This way this component could be facilitated. It also appeared that resolver clients felt that they would be able to survive experiencing this. As such, again, there was a willingness to tolerate experiences of hurt/grief. Though this component was focused on mostly within sessions 15 to 20, the resolver below (Client 3) began to experience this in her thirteenth session.

Client 3 (Resolver)

Description: In her thirteenth session, Client 3 displayed an acceptance of the risk by when she decided that she would share her previously inhibited feelings with her sister, regardless of the potentially painful consequence that her sister may not respond.

Excerpt:

Client: I really feel like I need to talk to my sister about the fact that we're not close and why is that, and this is how I'm feeling how are you feeling? Like it feels like I'm ready to have that conversation if I could get her alone by myself and just so I can make her aware of how I feel and what I'm going through. I don't know if it will do any good but I'm open for a try, I don't know if she'll respond but at least it's something I feel, and I'm quite prepared for the fact that she may not respond at all.

***Component 6. Increased Expression of Self-Assertion*.** The final component for the three resolver clients involved increased self-assertion. This is when clients began to assert their own feelings, needs, and boundaries to both what they experienced as their SI Agent and to actual significant others in their lives. All three resolver clients expressed narratives during the late stages of therapy in which they had taken an assertive action that they would have previously inhibited.

All resolver clients experienced and expressed increased self-assertion towards the later and final stages of therapy. In terms of their self-assertion, the resolver clients expressed a sense of strength and/or confidence about expressing their feelings, setting boundaries, and having their needs met. After clients had accepted the potential risk of hurt/grief, they began to stand their ground and express a refusal to continue allowing the SI Agent to inhibit the adaptive part of themselves. As such, resolver clients became much more empowered and self-oriented rather than other-oriented. Resolver clients were also observed to start taking adaptive action to meet their needs. This included taking social risks, ending maladaptive relationships, and prioritizing their needs over the needs of actual or introjected others.

Client 2 (Resolver)

Description: In his sixteenth Client 2 communicated a resolution of his SI, which involved self-assertion and adaptive action, in prioritizing his need for joy and pleasure over others' judgments.

Excerpt:

Client: I think that was, that was decided that if I said if I started doing certain things
Therapist: mm-hm
Client: I don't care what other people will say or think
Therapist: mm-hm
Client: if whatever I'm doing is gives me some type of pleasure

Therapist: once you make a resolution
Client: that's right
Therapist: then everything is already in process
Client: yeah, it's already in motion

Description: Also in the final session, Client 2 reported that his "logic" part of self (i.e., SI Agent) no longer had the power to control him, which further supported the resolution of SI.

Excerpt:

Client: right now, logic is there, it's not disappeared
Therapist: right
Client: but doesn't have the power to tell me you know do it or not do it, it's there but it doesn't have any more of that power

Observed Qualitative Differences Between Resolver and Non-Resolver Cases

Differences between resolvers and non-resolvers were observed during empirical analysis. These differences were not assessed using validated measures, but the below discussion on observed differences provides directions for future studies.

Interruption of Experience

Resolvers and non-resolvers showed qualitative differences in the interruption of emotional experience. Although all clients showed issues with inhibiting their feelings in social situations, non-resolvers had more difficulties with self-interruption than resolver clients. Specifically, non-resolvers expressed more inhibition and self-interruption of assertive anger than did resolvers. All non-resolver clients expressed strongly held beliefs that expressing or displaying anger was "bad". As such, it could be that non-resolvers feared anger more vehemently and were more rational or cognitively organized. It may be important for therapists

to assess for this bias towards rationality and to not assume that experience is valued more than reason by non-resolvers.

Both resolvers and non-resolvers were observed to interrupt or inhibit their emotional expression to avoid damage to their identity and to avoid increased interpersonal conflict. All clients reported silencing themselves in social situations to protect their relationships or to avoid embarrassment/shame. Non-resolvers appeared to be additionally motivated to self-interrupt because of fear of emotional overwhelm. For instance, two non-resolvers frequently became highly distressed in sessions, which was invariably followed by self-interruption. It appeared that non-resolvers had more difficulty with not only expressing their feelings outwardly and being seen to have them, but also inwardly allowing the experience of their feelings. Global fear of emotion appeared to be indicated (Weston, 2018). Conversely, resolvers engaged in more *soft* self-interruptions, in which it appeared that they allowed the experience of their feelings, but at first inhibited the outward expression of their feelings and needs (Elliot et al., 2004). Again, the role of the therapist in said hard or soft interruptions is unknown and is an important area of future research.

It is possible that non-resolvers feared emotional overwhelm because, as a group, they had more difficulty with emotional regulation than the resolvers. This may have related to the emotional content to be regulated. The need for assessing emotional regulation must be noted in order to observe a potential non-resolving SI client. Probes of emotional arousal and the client's ability to regulate this may be needed (Knight et al., 2002). For instance, one of the non-resolvers had complex trauma, which likely contributed to difficulties with containing his emotional experience. Another non-resolver disclosed in the final session, for the first time, that he used alcohol to cope in social situations. On the one hand, the client may have disclosed genuinely to

the therapist, yet on the other hand, the last session could have provided safety to disclose. In any event, the use of alcohol likely signaled some form of emotion dysregulation or the need to use alcohol to regulate emotion (Kassel, 2010). Avoiding emotion through drinking is common. Linehan (1993) has noted that the means in which one avoids emotion (e.g., drinking, drugs) is not as essential to know as is knowing that any avoiding of emotion is a chosen path. Approaching and tolerating emotion may be essential learning (Linehan. 2015) for non-resolving clients.

Because resolvers allowed the experience of their emotion, they were likely able to use this inner experience to solve problems and ultimately move towards meeting their needs. That is, resolvers were able to march to their own internal drum, and felt experience informed their problem solving (Klein et al., 1986). Conversely, non-resolvers interrupted their emotional experience and as such, searched for external referents to inform problem solving (Klein et al., 1986). This may have manifested in the form of non-resolvers expressing the need to follow external rules and habitually search outside of themselves for rules to live by. Two of three non-resolvers explicitly stated that without rules, there would be “anarchy” within themselves. No resolvers expressed a need to follow or have external rules. This again points to having a preference for rationality and the ‘mental’ being potentially problematic for non-resolvers. Identifying instances when rules have been problematic will help. This will also be a productive area of future research.

Maladaptive Emotion Schemes

All clients expressed both maladaptive shame and maladaptive fear. However, as a group, resolvers and non-resolvers appeared to differ in terms of their more preponderant emotion scheme. While resolvers indeed experienced fear and insecurity, their core issue revolved around

them gaining their sense of worth and esteem. These clients needed support from others who could accept them for who they genuinely were. As such, the resolver clients displayed more core shame-based self-organization. Non-resolvers similarly expressed feelings of shame but appeared to have a preponderant core fear-based self-organization, in which they displayed more of a shaky, anxiety-based insecurity. That is, non-resolvers appeared to be more fragile and dependent than the resolver clients. This was an important difference for several reasons. First, because non-resolvers were shakier and more fragile, they had more difficulty organizing themselves in the manner needed to express self-assertion. Resolver clients had awareness that they had strength and thus were better able to feel empowered to express assertive anger. Second, the shakier and more fragile sense of self made it more difficult for non-resolvers to tolerate emotions and they consequently interrupted experience more frequently. Third, resolvers who were not as shaky and fragile were more willing and better able to tolerate the risk of potential pain involved in exhibiting their authentic selves. This appears to point to the possibility that subtypes of SI may exist. This will be discussed further below.

Therapists and Case Formulation

There were also therapist differences observed during empirical analysis. First, the therapists of resolver clients provided more explicit orientation to the purpose of therapy tasks and provided ongoing case formulation. It is important to note that any therapy is more effective once treatment rational is provided to the client. This will include therapy tasks or goals of treatment for the client (Crits-Christoph et al., 1988.; Eells, 2022; Godoy & Haynes, 2011; Jennissen et al., 2021; King et al., 2022; Persons & Hong, 2016). Explicit articulation of the purpose of therapy tasks to the client's broader goals of targeting SI is particularly needed for the non-resolver of SI. For one non-resolver, it was especially apparent that there was a lack of

explicit orientation and case formulation. This client on several occasions, requested from the therapist more structure and orientation to the therapy, which was ultimately not provided by the therapist. Future research is needed to more systematically compare instances of explicit case formulation between resolver and non-resolver cases.

Another notable difference was that one non-resolver therapist appeared to be more of a novice to EFT than the other therapists in the sample. Although all therapists received a minimum of 48 hours of training in EFT and had their tapes regularly reviewed to ensure adherence to the treatment model, it is possible that being new to the model impacted the effective delivery of EFT therapy. Future research should compare novice and experienced EFT therapists in the resolution or non-resolution of SI.

Culture

Another important observation was the element of culture. All six therapists were female and Caucasian, five clients were also Caucasian, and one client was East Asian. Culture played an important role in the narratives and formulation of two clients, one resolver and one non-resolver. The resolver was a Caucasian man who emigrated to Canada from an Eastern European country that had a history of war and socialism. This client had explicitly stated that part of his difficulty in trusting others stemmed from distrust of government in general, which appeared to be culturally informed. The non-resolver was a man who described how his SI was related to his upbringing in a traditional Chinese family. He reported that growing up in a traditional Chinese family, education and success were prioritized with little emotional support and warmth. Though, there were no explicit issues raised related to culture within the therapist-client dyads, it is still important to consider the role of cultural sensitivity in the delivery of therapy. Future validation studies should pay closer attention to the role of culture in SI.

Chapter Five: Discussion

This was the first known study to examine the resolution of social inhibition (SI) during emotion-focused therapy for depression (EFT; Greenberg et al., 1993). Therefore, this study has added to the previously scant research on adult SI (Denollet & Duijndam, 2019) and to the long-standing confusion regarding the operationalization of 'social inhibition' (APA, 2013; Rubin & Asendorpf, 1993). Providing a list of empirically observed markers of SI in an adult clinical population has helped this issue.

There has been a gap in the literature regarding how psychological treatments for depression address certain interpersonal problems (McFarquhar et al., 2018). The current study provides empirical research on in-session resolution of the interpersonal problem of social inhibition (SI) during psychological treatment for depression. By employing steps involved in the discovery phase of a task analysis (Greenberg, 2007) a rational model of the resolution of SI was proposed based on existing literature and clinical experience. Client markers of SI were rationally conjectured and actual performances of the resolution and non-resolution of SI over a course of therapy were empirically observed using videotaped client sessions from clinical trials of EFT for depression (Greenberg & Watson, 1998; Goldman et al., 2006). The conjectured client markers of SI were observed and recorded. Finally, through an iterative process of comparing and contrasting the rational model with the empirical observations, the final rational-empirical model of the resolution of SI was constructed.

In this chapter, results of the final rational-empirical model are considered within the context of existing literature on EFT and psychotherapy. Then, implications for clinical practice are discussed. Finally, limitations of the study and directions for future research are presented.

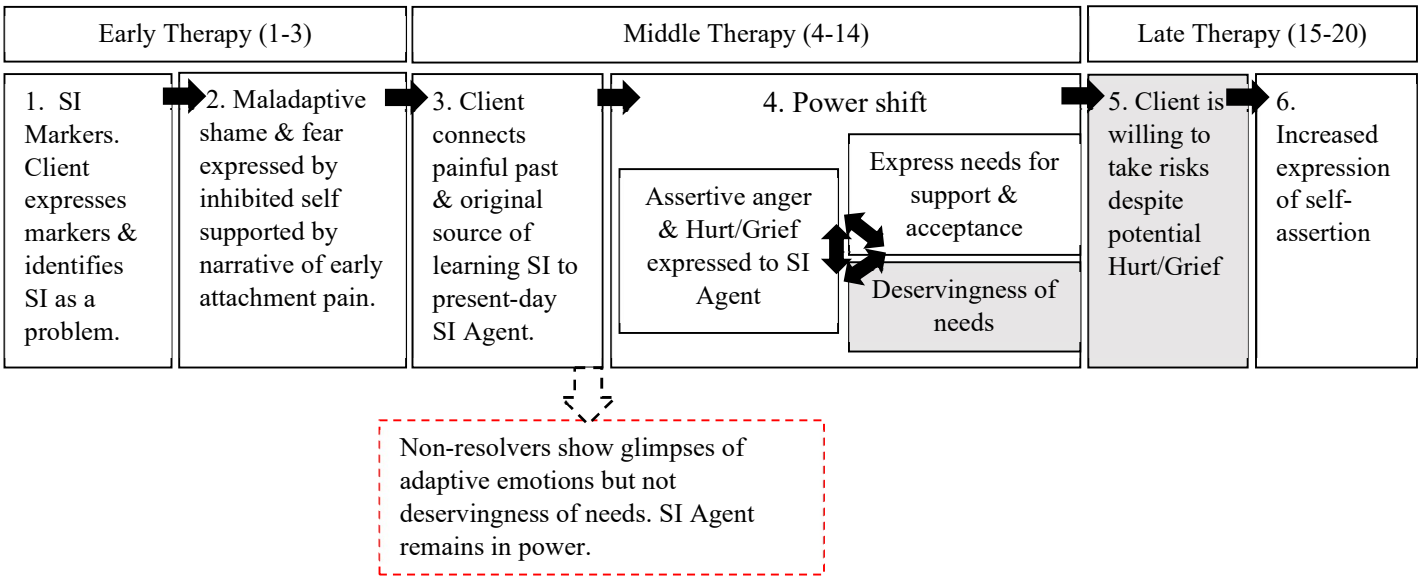
A Model of the Resolution of Social Inhibition

The model is displayed in Figure 2, is repeated below for ease of reference. The model identified 6 components involved in the resolution of SI. These components are: (1) SI Markers; (2) Maladaptive shame and fear expressed by the inhibited self; (3) A client who connects their SI Agent to a painful past and original source; (4) A power shift between the client's SI Agent and their previously inhibited self (involving the expression of assertive anger, hurt/grief, needs for support and acceptance, and the deservingness of needs); (5) A client who is willing to take risk despite potential hurt/grief; and (6) Increased expression of self-assertion. During the empirical analysis, the first the first three components were observed among all clients, while the last three were observed only among resolver clients.

The model outlines a sequence of linear, progressive steps. However, the process of resolving SI is believed to occur in a cyclical manner wherein components occurring earlier in the therapy may be repeated later in a similar or more complete form. The grey boxes represent components added to the model as a result of empirical observation. The red dotted box indicates where non-resolvers faltered in their resolution of SI.

Figure 2

Final Rational-Empirical Model of the Resolution of Social Inhibition (SI)



Overall Change Process, Content, and Themes

Given previous research showing that SI was resolved over the course of EFT treatment for depression, the current study assumed that the resolution of SI would follow the general EFT change process proposed by Greenberg and colleagues (Greenberg et al., 1993). Specifically, the model supports EFT's theory of change in depression for the most part. Transdiagnostically, this involves first exploring secondary emotions (e.g., helplessness, diffuse anxiety) in order to access maladaptive emotions of deep shame or fear, which can then be transformed into more adaptive emotions, such as sadness, hurt/grief, pride, assertive anger, joy, self-soothing, or compassion. It appears that it is the accessing and processing of important adaptive emotions which non-resolving SI clients were not able to maintain (Greenberg, 2015). The model constructed in the current study can be considered a 'more specified model' of the EFT treatment of depression that articulates the process, content, and themes expected to be displayed or

communicated at different stages of the specific resolution of SI within depression. Two non-resolving SI clients reported good BDI outcomes at therapy termination that later appeared to relapse at follow-up. It remains unclear whether the BDI scores at termination were inflated to please researchers (and were a manifestation of SI) or were truly experienced. Much work parsing SI and depression is therefore needed.

In EFT research, psychotherapy process has been traditionally privileged over content (Greenberg & Watson, 2006). However, the current study and others (e.g., Choi, 2018; Ferreira, 2017; Goldman, 1997; Goldman et al., 2005) have highlighted the importance of researching not only process, but themes and content within EFT for depression. For example, Goldman and colleagues (Goldman, 1997; Goldman et al., 2005) parsed depressed clients' narratives into core themes or foci of treatment (e.g., working on unfinished feelings towards mother or difficulties attending to feelings). Core themes are thought to be the particular client narrative content or themes that become clients' focus of therapy. Goldman and colleagues (2005) suggested that deviating from core themes of therapy may increase a client's tendency to process emotion at a superficial level. This may have been the process involved in non-resolving clients who may have required themes related to SI to be more fully explicated. Reciprocally, superficial emotional processing may increase a client's tendency to deviate from core themes of therapy and may indicate a marker of a non-resolving SI client.

The continued investigations of client content within EFT sessions for depression can increase understanding of important information imbedded within clients' emotional experiences that are essential to their well-being (e.g., Frijda, 1987). The current study may also contribute to the existing literature of content within EFT sessions by providing a more refined and nuanced understanding of not only psychotherapy processes, but also specific content articulated by

clients during the resolution of SI. Each stage of resolution within the context of existing literature is further discussed below.

All Clients Expressed SI Markers

The current study hypothesized several markers of SI based on several literature sources, including the IIP (Horowitz et al., 1988), the *15-Item Social Inhibition Questionnaire* (SIQ15; Denollet & Duijndam, 2019), and other literatures reviewed in Chapter One. During the empirical observation stage, all 29 rationally derived markers were observed. There were no differences between the types of client markers expressed by resolvers compared to non-resolvers. This suggests that resolvers and non-resolvers are at the very least, entering therapy presenting with similar symptoms related to SI.

All clients articulated more than one marker of SI, providing further validation for the notion that SI is viewed as a multifaceted construct (Denollet & Duijndam, 2019). All six clients endorsed both cognitive and affective markers. Several possible explanations are possible for the lack of endorsed behavioural items stemming from the SI scale of the IIP. First, it is a possibility that markers of SI are felt as more salient in the domains of cognition and affect. It is also possible that behavioural markers were not as widely observed because of EFT's focus on emotion. Thus, it is conceivable that, in a behaviour-oriented therapy approach, clients would have naturally expressed more behavioural markers of SI. Also given that these markers were observed post-hoc, it is also conceivable that clients did indeed have issues with behavioural SI markers but did not demonstrate or articulate these specific markers in their sessions. As such, it is not assumed here that the observed markers represent a full range of the issues that clients might have been dealing with outside of therapy or the appraised behavioral meaning these

markers may have had for some SI clients. Markers may differ depending on the therapy approach offered. However, the offered list appears to be exhaustive.

Self-interruption was endorsed by all clients. This was expected because SI is essentially self-interruption. Socially inhibited clients inhibit, interrupt, or silence themselves in social situations. Previous research has noted motivations for interrupting emotional experience as fear of damage to identity and/or attachment, and/or fear of overwhelm (Vrana, 2021; Weston, 2018). However, non-resolvers displayed more reliance on self-interruption to avoid emotional overwhelm (Weston, 2018). It has been suggested that the degree to which interpersonal desires are blocked may account for varying patterns of symptom severity (Horowitz, 2004). Indeed, the non-resolvers appeared to have more severe symptoms regarding substance use and trauma (Harwood & Beutler, 2009). Thus, perhaps non-resolvers engaged in hard interruption for good reason, and these clients were not best served by short-term EFT as it is presently defined (i.e., 16 to 20 sessions). This may also suggest that clients who engage in hard self-interruptions during treatment for depression may be suffering from more extreme SI and that assessment of trauma and substance use may be required with these clients. Hard self-interruption may parse substance use and depression more successfully in the future.

The hypothesis that all clients would display markers of self-criticism was also supported. All six clients expressed self-criticism and perfectionism. That sufferers of SI would be helped by EFT for MDD makes sense given that there is an abundance of research pointing to perfectionism and self-critical processes in both SI and depression (Ahrens & Alloy, 1997; Beck, 1983; Blatt, 1974; Buunk & Brenninkmeijer, 2000; Swallow & Kuiper, 1988; Choi, 2018; Thomson & Zuroff, 2004; Whelton & Greenberg, 2005). Moreover, self-criticism and perfectionism were expected to be particularly prominent in individuals with problematic SI

because of the intensive self-scrutiny and censuring of behaviour to avoid rejection, humiliation, disapproval, or criticism from others.

The list of markers may be a valuable tool for clinicians assessing a client's SI based on complaints shared early in therapy. Indeed, all clients in the current study expressed the above markers of SI within the early stages of therapy (i.e., first three sessions). The early identification of problematic SI may add considerable value to the clinical practice of resolving SI, especially when providing a time-limited therapy.

All Clients Had Maladaptive Shame and Fear Expressed by Socially Inhibited Self

This modeled component is in line with previous research showing that clients with SI, compared to other interpersonal problems, express more shame and fear during EFT treatment for depression (Heinonen & Pos, 2020). Based on qualitative observations of resolvers and non-resolvers, it appeared that resolvers were more characteristic of shame-based, self-critical depression, whereas non-resolvers were more fear-based. A discussion of EFT's distinction between shame-and fear-based depressogenic self-organizations is warranted here. The shame-based, self-critical depression is the 'bad self' subtype that has been highlighted through the current study. The 'bad self' subtype is marked by self-criticism, self-coercion and a preponderance of maladaptive core-shame that is activated when processing failures, mistakes, personal defects, or social mishaps.

The other type of depression is the dependent 'weak self' type, dominated by a core maladaptive attachment-related fear. Individuals with this vulnerability often have an impaired sense of protection and are dominated by an intense and maladaptive fear and avoidant tendencies of imagined future pain/hurt/grief. This anxiety-based insecurity leads an individual

to feel weak and fearful of abandonment. Compared to the self-critical depression, the 'weak self', or dependent depression, is viewed as a more 'child-like' depression (Blatt, 1974, 2004). As such, a dependently depressed individual is thought to be less individuated than the individual who is self-critically depressed (Blatt & Levy, 2003; Blatt et al., 1976). With more 'child-like' depression, also comes less evolved emotion regulation capacities. Perhaps the non-resolvers of SI were of this more anxious and child-like and dependent subtype. Indeed, the non-resolvers appeared more dysregulated and emotionally overwhelmed by secondary and maladaptive emotions. Again, it is possible that the non-resolvers required emotion coaching and emotion regulation skills in early therapy prior to engaging in more emotionally evocative work.

All Clients Connected Their SI Agent to a Painful Original Source

This component involved exploring painful past experiences in which clients made connections between their past painful interpersonal experiences and their present-day SI Agent. Exploration of painful past experiences are an important part of discovering how the client's present day emotional reactions are informed by early unmet needs. A basic gestalt principle posits that significant unmet needs do not fully recede from awareness but remain in awareness (Perls et al., 1951). Therefore, when specific emotion schemes associated with these early unmet needs are triggered, individuals re-experience the unresolved painful emotions related to never having these needs met (Greenberg et al., 1993).

While all six clients reported painful past experiences within relationships involving experiences of shame, humiliation, rejection, or fear and a lack of support, five of the six clients shared early life experiences with parents who were either critical, dominant, abandoning, neglectful, and/or dismissive. The sixth client shared a history involving loving and supportive parents who represented the standard of unobtainable perfection. As such, all six clients

connected the voice of their SI Agents as the voice of early parental figures. This supports the current study's hypothesis, as well as the abundance of existing research, that socially inhibited tendencies are formed within the context of early interpersonal attachments (Bartholomew & Horowitz, 1991; Bowlby, 1977; Haggerty et al., 2009; Horowitz et al., 2003; Elliott & Shahar, 2019; Greenberg et al., 1993; Pos & Paolone, 2019).

Resolvers Expressed a Power Shift between SI Agent and Inhibited Self

This component differentiated the resolvers from the non-resolvers. Resolver clients expressed adaptive assertive anger and hurt/grief to the part of themselves that represented their SI Agent, as well as the need for support and the deservingness of having their need for support met. Non-resolvers ultimately got "stuck" in secondary and maladaptive emotions.

Assertive Anger Expressed to SI Agent

Resolver clients expressed assertive anger to their SI Agent. This is particularly impressive when we consider how challenging self-assertion can be for socially inhibited individuals (Ludwig & Lazarus, 1972). Expressing assertive anger involves the expression of a boundary that promotes one's self-respect or one's objective. Self-assertion, therefore, can sever a relationship or attachment (Linehan, 1993). With self-assertion comes the capacity to let go of attachments and stand on one's own. Resolver clients appeared to have the internal resources and capacity to stand on their own. Non-resolver clients, on the other hand, appeared to have more (maladaptive) dependent needs. This may be another indication that dependency should be assessed carefully when dealing with SI clients.

Resolver clients were observed to eventually choose their own needs over the needs of others. Previous research (Ferreira, 2017) has shown that clients who do not resolve their

depression in EFT enter therapy with more conflicting needs than those who resolve their depression. Internal struggles often involve conflicts among self-related needs (e.g., growth, esteem) in the service of maintaining either other-related needs (e.g., connection, support) and/or emotion regulation needs (e.g., need to get rid of uncomfortable or difficult feelings). Thus, it is possible that non-resolvers could not assert themselves because they experienced too many other conflicting needs that obscured access to their own adaptive emotion and needs. If non-resolvers are more dependent, they would have issues with asserting anger, boundaries, and the emotion regulation needed to withstand 'standing on their own' (Blatt & Levy, 2003; Pos & Paolone, 2019).

Hurt/Grief Expressed to SI Agent

Resolver clients expressed hurt/grief to their SI Agent. Hurt/grief captures a client's experiences of sadness, loss, and pain. This is in line with previous research showing that the expression of hurt/grief within EFT for depression is associated with reduced SI (Heinonen & Pos, 2020). Therapeutic work in EFT for depression often involves helping clients let go of getting a need met by people in their past who disappointed them. This requires that a therapist make a distinction between needing and targeting an appropriate other. Just because another does not meet a need does not mean the need is undeserved (see below). Processing the pain of hurt/grief related to what was previously lost and what is being let go of currently, is a vital part of moving forward with life (Worden, 2009). It appeared that once resolvers processed their hurt and grief, they were able to re-own and validate their needs and they also redirected their efforts to have their need met by alternative sources, including by themselves and by their therapist (Greenberg, 2021).

Expression of Needs for Support and Acceptance

The original hypothesis that clients would express both a need for support and a need for acceptance during the power shift was partially supported. That is, all three resolver clients expressed a need for support whereas two (of three) of these clients also expressed a need for acceptance. Given that two thirds of the resolvers expressed the need for acceptance, this was also included in the model. It is possible that the need for support and acceptance are not mutually exclusive. For instance, the need for support could be a higher order category that includes the subcategory of acceptance, in the sense that clients need others' support of their individuality. That is, if another person supports a client's individuality, there is an implied message that the other accepts me as the individual that I am.

The existing literature on SI and attachment points consistently to the unmet need for support experienced by socially inhibited individuals (Bartholomew & Horowitz, 1991; Bowlby, 1977; Haggerty et al., 2009; Horowitz et al., 2003; Elliott & Shahar, 2019; Greenberg et al., 1993; Pos & Paolone, 2019). Specifically, socially inhibited individuals with insecure attachment histories may learn early in life that others are unreliable, unhelpful, or unsupportive. When the need for support is unmet consistently by significant others, the individual starts to either consciously or unconsciously inhibit/interrupt/block the need, because the continued activation of the unmet need is otherwise too painful to experience. These individuals ultimately become over-reliant on independence and avoid requesting support from others. Consequently, the antidote for this problem likely involves learning how to ask for support and to trust that others can be relied upon. It is possible that having an interpersonal focus on obtaining support versus having an individual imposed need to be self-reliant may be an important consideration in being able to resolve SI.

Ferreira (2017) found that compared to clients who did not resolve their depression, clients who did resolve their depression more often expressed the need for support and guidance from their EFT therapist. Indeed, in the current study, a resolver client (Client 2) explicitly stated that the support and guidance from the therapist allowed him to open up in sessions. This resolved client expressed that because of having received support, he was able to trust the therapist and could take the risk of showing his authentic self. This pointed to the client's interpersonal need for support and to the occurrence of an interpersonal corrective emotional experience in the context of the therapeutic relationship. This was a remarkable change in behaviour for this client who had SI themes around avoidance of risk and relationships.

It is also possible that resolvers and non-resolvers may be struggling with different levels of Maslow's (1943) need hierarchy. Resolvers appeared able to express their need for support and eventually move towards self-actualization by prioritizing their own assertion, need satisfaction, and growth. It is possible that non-resolvers, on the other hand, were obtaining lower-level needs for basic safety needs, which might include the need to remain (problematically) attached and the need to regulate "dangerous" emotions (Weston, 2018). Future research may clarify this.

Deservingness of Needs

All resolvers expressed their deservingness to have their needs met. Feeling deserving of having a need met is part of the basic gestalt cycle of need satisfaction (Perls et al., 1951; Perls, 1969). A client must first have full awareness of a need and must tolerate the painful experience of having an unmet need activated before he/she can know that they are deserving of having said need met. Then, a client must feel deserving to have an unmet need met and must believe that having this need met is possible. Resolver clients were able to complete this gestalt cycle of need

satisfaction. They expressed unmet needs and their entitlement to having their needs met, by others or by meeting their own needs. The EFT therapist can also play an important role here by helping SI clients to build a sense of deservingness. The therapist can do this by providing the client with a safe, empathic, and emotionally attuned other, as well as expressing that the client is deserving of having needs met. The therapists' role of validating needs in resolving SI cases is noted as essential future research in this area.

Non-resolvers tended to avoid their internal experience (through self-interruption, avoidance), possibly because having activated unmet needs was too painful, especially when there is no sense of deservingness.

Resolvers Were Willing to Take Risks Despite Potential Hurt/Grief

At this later point in the model, resolvers appeared to have the resilience and strength needed to tolerate and to take the risk of choosing happiness (i.e., living uninhibitedly) over "safety" (i.e., inhibiting self to avoid pain). Indeed, all resolvers reported taking social risks between therapy sessions, despite the potential for hurt/grief (i.e., being rejected, not accepted, not supported, abandoned, etc.). This may be a micro-marker of SI resolution.

EFT theory assumes that resolver clients transform their feelings of hurt/grief in the previous component of the model. EFT theory also posits that emotional transformation does not change as a function of extinction. Yet, EFT acknowledges that change in behavior (and a client's willingness to behave differently) is needed to solidify a transformation. In the previous component, resolvers accessed and expressed adaptive hurt and grief combined with the experiences of adaptive anger, expression of unmet needs, and the experience of deservingness. Somehow resolvers accepted two simultaneous truths: that taking interpersonal risks might lead

to pain *and* that my happiness is worth the risk. Happiness trumped the fear of risk. This again points to affect processing differences that may occur between SI resolvers and non-resolvers and again may indicate that emotion education or longer treatment may be called for in non-resolving SI clients.

Behaviourally oriented therapeutic approaches and techniques, such as Acceptance and Commitment Therapy (ACT; Hayes et al., 1999), Behavioral Activation (Jacobson et al., 2001), DBT (Linehan, 1993), emphasize 'feeling the fear and doing it anyways' (Jeffers, 1987). Though in these approaches, a lack of anxiety is not the goal, an extinguishing of fear is assumed to be inherently involved in exposure to the feared outcome. In these exposure-based approaches, clients accept the risks involved, feel the fear, and move toward valued and desired ends, such as forming relationships or feeling self-respect or esteem. In the current study, resolvers were able tolerate the required exposure to risk that appears to be needed to resolve SI. Resolvers accepted the risk, behaved in uninhibited ways, and extinguished fear of future pain. This suggests that an adaptive spiraling effect may have occurred in exposure to the risk involved in overcoming SI. The role of the alliance and the therapist expressing confidence of the SI client's right to, validation of, and ability to tolerate exposures may provide affective fuel for clients engaging in these exposures.

Resolvers Expressed Increased Expression of Self-Assertion

Resolvers were observed taking adaptive action to meet their needs. This included taking social risks, ending maladaptive relationships, and prioritizing their needs over the needs of actual or introjected others. These 'powerful' moves are in line with previous research. The movement from a sense of empowerment into taking actual action has been well-documented. Pike and Galinsky (2020) described that power leads to action because it releases the

psychological brakes on action in three ways. First, power increases *feelings* of control and *actual* control, making failure seem improbable and less painful. Thus, a sense of power reduces the anticipated pain of action. Indeed, as resolvers became increasingly empowered, they became even more accepting and less afraid of potential painful hurt/grief related to taking social risks. Taking action also leads to power, so that power and action exist in a self-reinforcing cycle (Pike & Galinsky, 2020). This was displayed by resolvers who began taking action in their lives during the course of therapy and consequently reported feeling better and more empowered by taking risks. The importance of the experienced power shift between the SI agent and client's self is thus highlighted. The work of achieving adaptive emotion such as hurt/grief and assertive anger is also pointed to as essential with these SI clients, as is the provision of support and expressed validation of the client's needs. This will be a constant demand on the EFT therapist working with SI.

Second, power shrouds the perspectives and feelings of others, diminishing the anticipated social costs of action (Pike & Galinsky, 2020). Within interpersonal relationships, power and SI have been found to have an inverse relationship (Keltner et al., 2003). Specifically, having a sense of power impacts the inhibition or disinhibition of the expression of emotion (Kraus et al., 2011). Individuals with a higher sense of empowerment exhibit greater consistency between their internal feelings and outward expressions because of a reduced need to conform to what is deemed acceptable or approved by others. As such, again, it appears that achieving this sense of power is essential to resolving SI. Resolvers stopped prioritizing the need to be accepted and approved by others, and instead turned their focus inward towards being accepting and approving of themselves. Third, power filters out goal-irrelevant and goal-inhibiting information, which focuses the mind on action, and as a result, leads to action (Pike & Galinsky, 2020). It is

possible that resolvers arrived at therapy more ready and focused on making changes and taking action. As such they may have been more prepared to resolve their SI. Whereas non-resolvers may have been in the contemplation or preparation stages of change when they entered therapy (Prochaska et al., 2008).

Long-term Resolution of Social Inhibition and Depression

Resolver clients maintained the resolution of both SI and depression at 18-month follow-up. All non-resolvers reported problematic SI at 18-month follow-up, but two of three non-resolvers did not meet criteria for depression (BDI score below 10), though they were approaching criteria (e.g., score of 8 and 9) at 18-month follow-up. The third non-resolver met criteria for depression at 18-month follow-up, though there was an 11-point drop on the BDI from pre-treatment. In terms of the whole sample, five out of six clients resolved their depression. Therefore, it appears that EFT for depression was effective in decreasing or resolving depression for all clients. However, for some clients, their SI was also resolved whereas for others, it was not. There are several possibilities for this finding.

The first possibility is that SI resolvers were depressed *because* they were socially inhibited. For these clients, it is possible that improving their SI helped to ameliorate their depressive symptoms (i.e., lifting the SI lifted the depression). Conversely, for two non-resolvers, improving their depression did not seem to improve their SI. Thus, it could be that these two non-resolvers had a more stable disposition to be socially inhibited that was either co-morbid with or independent of episodes of depression (i.e., lifting the depression did not change the SI). This speaks once more to the importance of parsing comorbid depression and social anxiety (Tsuchiya et al., 2009).

Also, for non-resolvers, high scores on the IIP may have signaled a co-morbid underlying anxiety disorder. Anxiety did appear to be more prominent for non-resolvers than for resolvers, however, no direct measure of anxiety in the current study allowed for a test of this. Within EFT theory, social anxiety is conceptualized as primary maladaptive shame with secondary anxiety, self-criticism, avoidance, and emotion dysregulation (Elliot & Shahar, 2019). This conceptualization fits the profiles of the non-resolvers who showed more avoidance (e.g., self-interruption and avoidance of risk) and emotion dysregulation (e.g., shaky, panicky). EFT for anxiety treatment emphasizes the importance of providing guidance and structure to anxious clients, as this orientation to treatment can have a soothing and emotionally regulating effect (Watson & Greenberg, 2017). This, in addition to the current study's observations around less explicit case formulation in the non-resolver group, suggests that non-resolvers may have fared better in an EFT for anxiety protocol (Elliott & Shahar, 2019; Watson & Greenberg, 2017).

The possibility of depression *because* of SI is also supported by developmental research on a socially inhibited temperament preceding, and perhaps contributing to the onset of, depression, (Dyson et al., 2011; Essex et al., 2010; Gest, 1997; Kagan et al., 1988; Rubin & Asendorpf, 1993). Another possibility is that there are subtypes of SI in depression. Specifically, resolvers may be prototypical of self-critical depression, whereas the non-resolvers may be prototypical of dependent depression. If this were the case, then the current model of the resolution of SI might be best suited for clients who are more characteristic of a self-critical and independent type of depression ("bad self") rather than the dependent, insecure type of depression (e.g., "weak self").

Two of the three resolvers continued to improve long after therapy ended. On the other hand, all non-resolver clients increased their SI and depression from therapy termination to 18-

month follow-up. It appears that non-resolvers gained some symptomatic relief while in therapy but lost these gains over time (presuming they were not seeking therapy elsewhere). The continued improvement of SI and depression for resolvers, however, speaks to the power of adaptive emotion and behaviour to transform emotions over time (Choi et al, 2015; Rinaldi, 2015; Wong, 2016).

Clinical Implications

This study closely examined the components involved in the resolution of SI during EFT for depression. The final synthesized model provides a valuable framework for clinicians working with individuals with SI. While this model does not prescribe specific interventions, it can help organize and guide a clinician's therapeutic observations to better discern "where is my client right now?" and "what emotional experiences and content should we be optimally working toward?" (Pascual-Leone, 2017).

Phases of Therapy

The phases of therapy in the current model (e.g., early, middle, late) naturally overlap with the three phases of EFT therapy (Angus & Greenberg, 2011; Greenberg, 2017). In early therapy (sessions 1 to 3), the early assessment of SI markers may be important to observe. Within this phase, clinicians might focus on establishing a trusting relational bond, promoting client's emotional regulation capacities and awareness, and on collaboratively establishing an initial SI focus for treatment (e.g., *bonding and awareness phase*). A clearly articulated case formulation may orient clients towards resolving SI more explicitly. Then, the clinician might help the client become aware of the maladaptive shame and fear that is expressed by the inhibited part of self and how this connects to their painful past and original source of learning SI

that will be explored in the later phases of therapy. Clinicians may also support their clients further by explicitly validating clients' needs and entitlement to having needs met during this relationship phase of therapy.

As mentioned above, non-resolvers may be more rational or cognitively organized. That is, non-resolvers expressed more rules to live by. These clients may need more help moving from a cognitive framework into emotional experiencing. Clinicians may need to evoke emotional experience in these clients. However, if these clients are not able to tolerate emotional experience, it may be important for clinicians to first engage in emotion coaching and emotion regulation skills training before this phase of therapy can be successfully approached.

In middle therapy (sessions 4 to 14), clinicians may continue to help clients evoke and explore their emotional experience. Then, clinicians might help clients connect painful past & original source of learning SI to present-day SI Agent. It will be important will for the EFT therapist to support the expression of assertive anger and hurt/grief, the expression of needs for support and guidance, and the deservingness of having their needs met. Given the importance of power in resolving SI, clinicians might also consider ways to help empower their clients during the resolution of SI.

During late therapy (session 15 to 20), clinicians may help clients take risks by continuing to build capacity to accept the risk of future pain (hurt/grief). This might be accomplished by the clinician suggesting and encouraging behavioural exposures between sessions. Of course, a client's willingness to behave differently and to tolerate the anxiety of risk taking will be essential. The therapist's confidence in the client's ability to tolerate or endure anxiety might play an important and constant role. During this phase, new adaptive emotional

experiences and building new meanings may support the client's continued expression of self-assertion.

Therapeutic Relationship & Corrective Emotional Experiences

Given the interpersonal nature of SI, it is likely that providing a safe therapeutic relationship will be an important condition for treatment. Within the current study, all components occurred within the context of a client-centered EFT relationship. Moreover, qualitative observations highlighted the importance of clinicians offering a corrective emotional experience (CEE; Alexander & French, 1946) of providing support to socially inhibited individuals. The therapeutic relationship can serve as a CEE that might move clients closer to the resolution of SI. The EFT therapist may do this by providing a safe foundation while supporting the client's agency and their expression of core pain (fear/shame) and adaptive emotions (Elliott et al., 2004). It is possible that non-resolvers in the current study required more relationship tending before moving on to other components of the model.

Case Formulation

Another clinical implication of the current study is the qualitative observation related to the explicit articulation of case formulation during resolution cases. In EFT, case formulation is based on client processes, rather than specific content of client narratives (Goldman & Greenberg, 1997). Case formulation is also helpful in facilitating the development of a focus and fitting the therapeutic tasks to the client's goals to establish a productive working alliance (Elliott et al., 2004). Thus, explicitly sharing of case formulation helps to build a strong therapeutic alliance, in which both clinician and client have a consensus on therapy bond, tasks, and goals (Horvath & Greenberg, 1989). In EFT, case formulation also has an orienting function that helps

to structure sessions (Greenberg & Watson, 2006). The benefits of providing rationale for therapy tasks in the context of the broader case formulation and therapy goals is well-supported across theoretical orientations in the existing literature (Crits-Christoph et al., 1988.; Eells, 2022; Godoy & Haynes, 2011; Jennissen et al., 2021; King et al., 2022; Persons & Hong, 2016). Alternatively, research has found that client-centered therapists who are unable to help clients structure their sessions are more likely to have poor outcomes (Watson et al., 1998).

In the current study, qualitative observations suggested that therapists of resolver clients provided more explicit case formulation to their clients. This finding has several important clinical implications. First, it is possible that sharing case formulation allowed for more collaboration around the understanding of the client's painful SI issues and the tasks required to facilitate the resolution of SI. As such, clients may have been more willing to engage in experiential tasks if they understood the rationale for doing so. Second, it is possible that explicit case formulation provided structure and orientation that may have been soothing and emotionally regulating for resolving SI clients. If this was the case, these clients may have had less secondary anxiety obscuring their primary maladaptive emotions and as such, were able to more effectively work on emotionally salient issues throughout therapy. This finding speaks to the importance of continued research in the area of case formulation in EFT with socially inhibited individuals.

Emotion Coaching & Emotion Regulation Skills Training

Non-resolvers appeared to have more difficulties with emotion regulation, complex trauma, and substance use. This suggests that it may important to start therapy with a careful assessment of these issues. If complex trauma and/or substance use are indicated and interfere with trauma, it may be appropriate to start with treatment of these issues. If emotion regulation difficulties are noted, clinicians may consider first providing clients with emotion regulation

skills training prior to engaging in deeper emotional work. This suggests that some SI clients will need longer courses of EFT treatment.

Culture

Also, clinicians ought to take into account the cultural norms of all clients with whom they work. Social inhibition is a culturally bound problem based on Western ideology that views SI as a maladaptive, unhelpful, or unhealthy tendency. In Western culture, extraversion is socially preferable and thus introversion and inhibition feel less desirable (Cain, 2013). Moreover, culture dictates the display rules that are learned early in childhood that help individuals manage and modify their emotional expressions, depending on social circumstances (Ekman & Friesen, 1969). Western, individualistic cultures appear to foster greater emotional expression compared to Eastern, collectivistic cultures more generally (Matsumoto et al., 2005). However, Western cultures tend to display negative emotions to in-group members, whereas Eastern collectivistic cultures may foster greater expression of positive emotions toward in-groups and negative emotions toward out-groups (Matsumoto et al., 2005). Thus, the consideration of cultural norms is important in understanding the nuances of a client's intercultural and intracultural interactions.

Client Versus Therapist Factors

It is clear that both client and therapist factors of change are being pointed to here. Both the client's potential difficulties and the therapist's ability to respond to these difficulties may play a role in the successful resolution of SI during depression. The client factors may be their readiness to change, their individuation stage, their emotion regulation abilities, their

vulnerability to anxiety, their culture. whether they are ‘dependently’ or ‘independently’ organized, and their trauma history.

For the therapist, factors may be a willingness to assess substance abuse and emotional avoidance early in therapy, to be ready to explicitly point to the problem of SI in a clear case formulation, and a readiness to view the importance of the relationship in providing safety for emotional work, validation of needs, and confidence that the client will be able to survive any risk taking that will be finally required. As such, both the client’s potential difficulties and the therapist’s ability to respond to these difficulties may both play a role in the successful resolution of SI in depression.

Limitations of the Study and Future Research Directions

Like all research, this study has its limitations. These limitations are outlined here with suggestions for improvement in future research. First, because task analysis involves exploratory and qualitative components, some findings may be vulnerable to biases by the investigator and observer-raters. While the investigator declared her own assumptions to ensure that the current findings are understood within the context of the investigator’s cognitive framework, the vulnerability to bias in the discovery phase of a task analysis is meant to be best addressed within the next phase of the task analysis, the validation phase. Future research should conduct the validation phase of the current findings using validated process-outcome measures.

One limitation was that this study did not assess the presence of emotion types using empirically validated measures. Therefore, it would be helpful for future research to systematically code emotion types and compare resolvers to non-resolvers. This could potentially be accomplished using the Classification of Affective-Meaning States (CAMS; Pascual-Leone &

Greenberg, 2005), a measure that assesses the presence of emotion states. However, because the CAMS combines maladaptive fear and shame into one category, future research might further differentiate the Fear/Shame category to help add sensitivity to this measure.

Furthermore, it would be helpful for future research to further assess the expression of different types of needs during the resolution of SI. The current study found that all resolvers explicitly expressed the need for support, whereas two of the three resolvers also expressed the need for acceptance. Thus, it is likely that the need for acceptance is an important need contained within a need for support, but this remains an empirical question within socially inhibited depressed individuals. Future studies using larger sample sizes may qualitatively examine the types of needs expressed in the resolution of SI.

Another limitation of this study is the small sample size, which limits the generalizability of the findings. The intense empirical observation of a full course of therapy for six clients is a time-consuming and laborious undertaking. As such, the current study used the recommended sample size of three cases exemplifying resolution and three cases exemplifying non-resolution cases (Greenberg, 1984) to begin the construction of the final model. Future research should conduct further empirical observation on resolver cases to ensure saturation has been reached.

The cultural homogeneity of therapist and clients is also considered a limitation in this study. Specifically, five of six clients were Caucasian, and all therapists were female and Caucasian. Although control was enhanced, future research should consider inclusion of various groups and cultures to explore differences in beliefs, values, traditions, practices, and fundamental assumptions among various groups that may play a role in the resolution or non-resolution of SI. This inclusion would help expand the generalizability of the current study's findings. Furthermore, and perhaps more importantly given the established inverse relationship

between power and SI, inclusion of various groups and cultures could invariably help highlight larger social issues of justice and inequality.

Conclusion

In summary, this is the first study that attempted to answer the question: How do clients resolve the interpersonal problem of social inhibition during EFT for depression? The Discovery Phase of a task analysis was completed, which involved first creating a theory-based model of the resolution of SI, followed by the rigorous observation of actual client performances. This led to a final model of the resolution of SI. The model adds to the literature as it provides novel and meaningful insight into the close-up processes involved in this psychotherapeutic change. The model also has clinically relevant implications and can potentially be used as a guide for clinicians supporting clients through the resolution of SI. The current study includes findings that can be used to guide future research, which may ultimately include a Validation Phase of the current model.

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Appendix A: Social Inhibition IIP Scale Items

Clients rate the distress associated with the below problems on a 5-point Likert scale ranging from 0- *not distressed at all by this problem* to 4- *extremely distressed by this problem*.

1. Join in on groups
2. Introduce myself to new people
3. Socialize with other people
4. Express my feelings to other people directly
5. Ask other people to get together socially with me
6. Open up and tell my feelings to another person
7. I am too afraid of other people
8. I feel embarrassed in front of other people too much

Appendix B: Client Excerpts

Client 1 (Resolver)

SI Markers

Description: In her first session, Client 1 described markers of SI, which included social avoidance and withdrawal ("hiding away"), difficulty interacting with others, ruminating, and self-criticism.

Excerpt:

Therapist: how, how would you describe having a hard time what's it like for you?
Client: um - - it's almost like hiding away, and like I don't want, uh, I can't face people and deal with, you know social things or anything, I feel like I can't anyway with the kids, I have their interviews, you know their teacher interviews and I had a really hard time with that and, afterwards I just analyze every little thing and I just - I just, you know I think I just put myself through hell
Therapist: right. okay, so you're actually experienced yourself, kind of with all these self-doubts and these criticisms
Client: yeah. yeah. mm-hm.

Description: Later in session one, Client 1 described other markers of SI, including inhibiting the expression of her boundaries (e.g., non-assertiveness) to keep others "happy".

Excerpt:

Client: I think it's that I want to keep them happy and
Therapist: what would happen if you were to say at the onset "no, I'm busy today, don't call me today"
Client: I don't, I don't think anything would happen, I've
Therapist: what happened to you? how would it, how would
Client: I would never be able to say it so I don't know what would happen to me, I would never be able to say
Therapist: can you, can you talk from that, from the never being able to say, like what, what is it feeling like as you even think about this
Client: it's, it's just I feel like, I feel like a, like a real pushover and like why am I like that? I don't know like, how I get into this, I don't know how this happens all the time

Maladaptive Shame and Fear

Description: Also in her first session, Client 1 articulated primary maladaptive emotions related to her markers of SI (e.g., ruminating, and self-criticism), including feeling "wrong" and "really bad" about herself.

Excerpt:

Client: uh, uh, it's just um, like that's when I analyze and come up with "oh I did this I did that I shouldn't have," I'm very, just really, really going over things again and again and just feeling really - - you know, just feeling really bad about myself, guilty, um, and um, with the kids, like I, I'm constantly thinking what I, what I should do, what I have to do, what I've done that was wrong - - I'm, I'm just obsessed with them I guess, I'm just like that's my whole thing is like, what am I doing wrong with them, how I can change it, how can I fix it, it's like, you know.

Connect to Painful Past

Description: In session four, Client 1 connected her SI Agent, the part of her that inhibits her, to previous painful experiences with a dominant employer who mistreated her.

Excerpt:

Client: I think it's the same deal with these other bad experiences that I've had, like rationally I think "Dr S. wasn't a nice person, there are people like that in the world", now the next time I try to make a plan for when I meet someone like that, I'm going to get out of it right away, like I'm not going to waste time, people like this exist in the world and you have to deal with them, I didn't deal with it the last time and next time I will deal with it, I rationally try to tell myself, try to talk to myself about it but the fact is, that I still carry that, and I'm angry about it, I'm really timid, like that's going to happen again

Description: Later in the eleventh session, on the topic of *why* she inhibits herself and does not assert herself, client begins exploring painful past experiences in which her mother was critical of her. Client connected her self-critical SI Agent to the introjected voice of her mother:

Client: I wonder like, was it, like my childhood and just, you know, I don't know
Therapist: yeah, that somehow that affected your self esteem
Client: yeah

Therapist: that you were being told things
Client: yeah
Therapist: that you couldn't or you shouldn't
Client: mm-hm
Therapist: or you're not good enough
Client: or just negative things like you know, like for instance, like when you would be, getting ready to go out, and this happens, it still happens all the time now, you'd be all dressed up and ready to go somewhere and like that and mom would come in and like give her, uh, like just make a statement, ohhhh, like your hair, or (laugh) uh, she's just very blunt that way, and she will say all the time, I'm just trying to help you now, I'm just trying to, you know, no one other than your mother would point these things out to you, but it's very dem-, it's not demeaning but it's
Therapist: the word that came to mind is cruel
Client: yeah, it does, like it takes the wind right out of your sails

Softening SI Agent

Expression of Need for Support and Acceptance

Description: In session eight, during a self-critical split chair work, Client 1 expressed to her critic her need for encouragement (i.e., support).

Excerpt:

Client: [to critical part of self] it's taking the air out of me, you're deflating me, suffocating me
Therapist: she's really grinding you down
Client: yeah, and then I have to run to catch up
Therapist: you're trying to catch up
Client: but I'm always behind
Therapist: is it possible to say right now what you need to not feel so deflated
Client: I need encouragement, I must need encouragement, I've just never gotten that internally
Therapist: from yourself
Client: no
Therapist: I'm wondering if we can try to ask this side who's telling you about how you look, can you tell this side what you need
Client: yeah, I think it would be helpful if I got positive feelings from you, even if it's not encouragement, if the feelings and thoughts were positive
Therapist: can you give her an example
Client: tell me that I have a brain, and I can figure it out, and I will

Assertive Anger

Description: In session eleven, Client 1 expressed the consequences of her having expressed assertive anger in the form of feeling "powerful" and "conquering" the steps needed to meet her needs.

Excerpt:

Client: I'm happy about that because I feel that I, that's another level that I've come to really, I guess I kind of feel that I'm conquering different steps so I'm feeling better about it
Therapist: mm-hm
Client: and feeling that yes, ok I'm on my way, I can do this
Therapist: yeah, that you're, you know even when you put it in that, in those terms of sort of conquering, I mean that's, that's pretty powerful
Client: yeah
Therapist: I get the feeling of, of you taking, kind of taking charge and actually
Client: yeah

Hurt/Grief & Deservingness of Needs

Description: In session twelve, during a dialogue with a younger version of herself, Client 1 explored and expressed heartfelt needs to be carefree as she once was a young girl. She expressed adaptive grief about the loss of her carefree and fun self and expressed the deservingness of having her needs met to feel playful again.

Excerpt:

Client: I just long to have fun too, it's been so long since I've just been playful (breaks up in tears)
Therapist: can you say more about that?
Client: I just really, that part of me just wants to, I'm easily contented, easily happy person and I long for, to be able to just have fun and be carefree, that feeling
Therapist: yeah, there's that part of you that's just
Client: and I think I deserve it, I think I should reward myself, but I don't know how to do it, I just haven't found how to do that
Therapist: It doesn't have to be all at once, step by step (C: yeah) I'm wondering if you could come over, we're almost out of time here - if you could just imagine that, that that is something, you're the, she's there saying that she wants to have fun - can you give her a little bit of, what can you offer her right now

Client: I don't know. All I can think of is like, the closest I can come is like in my garden and nature and putting my hands in the earth

Willing to Take Risk Despite Hurt/Grief

Description: In her sixteenth and final session, Client 1 also expressed her acceptance around taking the risk of ending her marriage.

Excerpt:

Client: I almost feel like, when you said strength, it's a feeling of a quiet and calm strength, I don't know why I feel like that but it's almost like uh (voice quivering) like I've reached a place that I'm more accepting of yes, this is what has to be done, this is what I have to do

Therapist: yeah, so it's a sadness that's kind of like yes, it's sad that it's come this far, it's not a sadness of I'm scared, don't make me do it, it's a sadness of it's come to this point, and I know what I have to do

Client: yeah, that's what's like

Increased Self-Assertion

Description: Later in her final session, Client 1 expressed self-assertion in choosing herself over others, especially choosing her own needs over those of her problematic husband. She had previously either avoided thinking about the marriage or focused on her husband's and children's needs over her own. At the end of therapy, she was focused on meeting her own needs, which involved taking adaptive action to seek more therapy and support around separating from her husband.

Excerpt:

Therapist: I'm wondering how you're feeling about therapy ending now that this is all coming up for you?

Client: I'd like it to continue. At first when you said therapy could continue, I first thought of marriage counseling but now I'm thinking more along the lines of what you just said, if I'm going to go through something, maybe it would be better to just focus on my mental state. I see couples counseling as a waste of time in this scenario

Therapist: right, you were really on the fence before and now you're not off the fence yet, but you're leaning far more on the side of separating or divorcing?

Client: yeah, I think so. I do know

Client 2 (Resolver)

SI Markers

Description: In his first session, Client 2 communicated markers of SI, including retreating from others (e.g., social avoidance), self-criticism, and not taking social risks.

Excerpt:

Client: It makes you very selfish which I don't like, I'm basically being a selfish person
Therapist: like you're just retreating into your corner and build walls
Client: I did build walls a long time ago, this is why I'm here, the walls are up a long time ago, I'm trying to take them down
Therapist: yeah, now that the walls are built, and they go up and up and up, how do you get out?
Client: I don't see any escape from that

Maladaptive Shame and Fear

Description: In his first session, Client 2 expressed maladaptive emotions related to SI, such as feelings of powerlessness and helplessness and a wish to avoid the pain of being hurt.

Excerpt:

Therapist: if you get hurt enough, why would you want to take that risk again?
Client: that's right, because nothing changes. It's nice to take a risk and to see something different, but it's always the same, you always end up being hurt one way or another
Therapist: yeah, so why would you go and beat your head against a wall? It's still going to be brick and it's still going to hurt
Client: yeah, don't hit the wall, try to avoid it if you can but then again, all this trying to avoid or avoiding makes you depressed
Therapist: if you don't take risks, don't try things, if you don't go out and give it another shot, then you're left sitting with no place to go, nothing to do, no hope
Client: that's right, which means you're living just to make money, have food, survive

Connect to Painful Past

Description: In his seventh session, Client 2 referred to the painful past experiences of being hurt in relationships. Throughout therapy, Client 2 indicated that his early life consisted of a close and secure relationship with his parents, which he viewed as the ideal. In this way, his present SI

Agent represents the idealistic (perfect) expectations that were formed in his early life that did not prepare him for relationships later in life. Specifically, Client 2's previous marriage failed, and this led him to avoid making future connections in an effort to avoid potential pain.

Excerpt:

Client: being yourself, you can't do that, you can't go outside and be yourself
Therapist: what would happen if you were to go out and just be yourself
Client: you lose
Therapist: it's kind of like, if I let people know what I'm really like
Client: she'll take advantage, you see if you completely open to person, you have to put all your barriers down and you're completely vulnerable, which means that person can hurt you or do whatever they want
Therapist: when did that happen to you
Client: it happened a couple of times, had a couple of relationships that finished and my marriage same thing, you know you completely open yourself and be honest
Therapist: so your marriage is a time when you let yourself be completely vulnerable and you got taken advantage of?
Client: well, you need only a couple of times, for certain people, only once to get badly hurt, emotionally hurt, and that's it, never happen again, and this is why people are playing these games

Softening SI Agent

Hurt/Grief

Description: In Session 14, within the context of a self-split chair work with the SI Agent who stops him from taking "social risks", Client 2 expressed his hurt/grief about missing chances or opportunities to have a relationship, something that he deeply wants.

Excerpt:

Client: I feel missed things
Therapist: tell him, tell him about that
Client: well I missed things
Therapist: tell him what you missed, tell him what you dream of what you want and wish for, if I do what you tell me I'll never
Client: (p00:00:08) hm, well it depends on the again on the context of the situation,
Therapist: mm-hm there are things that you missed, what are they?
Client: well it's a chance right, it's uh due to the circumstances whatever is a chance or a chance to meet somebody and to create something from that

Therapist: if I do what you tell me to do I'll miss out on a chance at a relationship, I'll miss out on the possibility of the kind of love and caring that I want, tell him that
Client: well I'll miss the chance to meet somebody and maybe to have a relationship and uh to have things which I would like to have

Assertive Anger, Expression of Need for Support

Description: In session fourteen, within the context of an UFB intervention with his ex-wife, who partly represented the voice of his SI Agent, Client 2 expressed assertive anger about his ex-wife's unrealistic expectations and for not supporting him. He expressed his unmet need for support within the marriage.

Excerpt:

Therapist: can you express some of that resentment, say I resent
Client: I did so many times, through my marriage, I said listen you're expecting too much
Therapist: put your ex-wife here and tell her what you resent
Client: I resent the fact that you're never satisfied, whatever I do is not enough, or it isn't good enough, and I resent that I never heard thank you
Therapist: I wanted, I needed from you
Client: the basic support which gives you confidence or strength to go through, you know some words of encouragement

Deservingness of Needs

Description: Also in the fourteenth session, after exploring unmet needs, Client 2 communicated the occurrence of an interpersonal corrective emotional experience in the genuine relationship between himself and the therapist. He expressed that he did not feel alone and trusted the therapist. The Client displayed self-assertion by taking the risk of sharing his authentic self with the therapist and by allowing himself to form the relationship with the therapist which implied that he felt deserving to receive support and acceptance from her. While not expressly stated, the client's deservingness around having his needs for support and connection is implied by him allowing the relationship to occur.

Excerpt:

Client: well, it brought change in the fact that I'm talking to you, I'm telling you what I'm thinking, I'm telling you what's my problem according to my conclusions
Therapist: mm-hm, and what has that done, how has that changed you?
Client: well, change in some way that somehow, I feel a little better you know in, uh
Therapist: not quite so alone?
Client: yes, okay lots of things are missing you know but uh - purely on uhm, on an emotional basis uh somehow, I don't feel alone- I don't know, to tell you the truth I don't know, that's the big step, you know to help somebody, to trust in the way I'm trusting you.

Willing to Take Risk Despite Hurt/Grief

Description: In session 15, Client 2 expressed that he had accepted that if others do not approve of his dancing (an activity he enjoyed), then he would be willing to lose/let go of those friends. He shared that he had recently danced in public, an activity that he had not done in a long time.

Excerpt:

Client: I was thinking on the way over here, the part of me that is scared to be silly, to lose something and then on the other hand I was thinking 'so what'
Therapist: somehow it didn't seem like such an awful thing
Client: that's right, because if anybody is appreciating you, they will accept you as is, doesn't mean that if you do something silly, that they will say 'oh you're stupid', they will accept this as part of fun
Therapist: so if you made a mistake, people could take that in stride, maybe think about times they have done it themselves
Client: well I was thinking, like who is more important, it is important what I'm thinking,
Therapist: so it doesn't really matter what other people
Client: well it matters because you are human being, it's nice if somebody tells you not nice things about you, but it doesn't matter in that capacity to affect me
Therapist: it doesn't matter enough that it should stop you
Client: from doing it, that's right, if I want to keep your friendship, it's not important anymore
Therapist: it's like I need to make me first, instead of what everyone else will think
Client: well if I like to dance, I will dance, if you don't like my dancing, good, if you like my dancing, good but I will start doing things that I like doing for myself

Increased Self-Assertion

Description: In his sixteenth session, Client 2 communicated a resolution of his SI, which involved self-assertion and adaptive action, in prioritizing his need for joy and pleasure over others' judgments.

Excerpt:

Client: I think that was, that was decided that if I said if I started doing certain things
Therapist: mm-hm
Client: I don't care what other people will say or think
Therapist: mm-hm
Client: if whatever I'm doing is gives me some type of pleasure
Therapist: once you make a resolution
Client: that's right
Therapist: then everything is already in process
Client: yeah, it's already in motion

Description: In his eighteenth, and final session, Client 2 reported that his "logic" part of self (i.e., SI Agent) no longer had the power to control him, which further supported the resolution of SI.

Excerpt:

Client: right now, logic is there, it's not disappeared
Therapist: right
Client: but doesn't have the power to tell me you know do it or not do it, it's there but it doesn't have any more of that power

Client 3 (Resolver)

SI Markers

Description: In her third session, Client 3 expressed markers of SI related to worrying that others will disapprove of her, ruminating, and difficulty asserting herself or her needs.

Excerpt:

Client: yes, but I didn't feel anything wrong with it, but then if I let society
Therapist: who, who is society, who actually is questioning you
Client: people that I work with, people, my friends, you know, my sister even, and uh
Therapist: it's almost as if you're put on the spot, like you have to justify, you have to defend
Client: put on the spot and I have to defend, you got it, got to justify or defend myself on this, and uh, and then I start to doubt, maybe what I'm doing isn't right because all these other people say it isn't, but I was ok with it when I started but now, I let society nag at me
Therapist: so, then this niggling doubt
Client: yeah
Therapist: it's, kind of like turns into self-doubt
Client: that's right

Maladaptive Shame and Fear

Description: In her third session, Client 3 described primary maladaptive emotions related to fears of being abandoned by her partner, which perpetuated her SI markers (e.g., by her having difficulty asserting herself or her needs, that she could not survive the separation, and her worrying that others will disapprove of her).

Excerpt:

Client: try and get myself up as much as I can before he leaves and see if that can, you know, sustain me through
Therapist: so, you're really anticipating that this is going to be a very hard time to deal with
Client: I'm not sure, I'm not sure, I just know in the past it has been, and the insecurities certainly come out
Therapist: so, you're afraid, you start becoming insecure and nervous
Client: very insecure and afraid, and generally it usually happens before the person leaves and once they leave, the reality of there's not much I can do usually sets in anyway
Therapist: there's certain things that you're particularly afraid of, that you imagine?

Client: well, you know, leaving and he's not coming back

Connect to Painful Past

Description: In session seven, Client 3 explored how her painful past of not being able to speak freely and learning rules around inhibiting the expression of her feelings and needs. She connected her past experiences to her present-day SI Agent, or the part of her that interrupts her from expressing her feelings and heartfelt needs to her partner and family.

Excerpt:

Client: this is what I was taught, you did this little dance, but you never said what you felt or wanted
Therapist: so you were taught somehow this is not okay
Client: no, that's not the way I was brought up, I learned the other way which was you sort of hinted and danced around until the other person figured it out
Therapist: it's almost this sense that it wouldn't be okay to just say it
Client: not at all, when I was a child, you were under the impression that you're seen and not heard, and you definitely don't speak unless you're spoken to, so you wouldn't make an opinion of your own, and you'd never ask, you would hint around, you never came out and said 'can I get this for Christmas?', if someone asked you bluntly, that was okay
Therapist: almost a sense that if you said it directly, what would happen?
Client: you would be rejected, either laughed at or made to feel selfish, it was confusing as a child because I never asked for anything, so even when I asked for one thing, the response that I got was, it's 'too much', I had to hope and pray that someone would ask me what I want, because then I could actually say what I wanted
Therapist: and now, with your boyfriend, some of that still lingers
Client: oh, of course

Softening SI Agent

Assertive Anger

Description: In session seven, Client 3 engaged in a self-split chair intervention, with the SI Agent part of self that imposed expectations to meet her family's needs and the part of client who wanted to express herself genuinely. Client 3 expressed assertive anger in the form of taking the risk of setting boundaries with her family by refusing to do what they expected of her.

Excerpt:

Client: you're selfish, why are you doing your stuff for you, we're a family, we're expected to do stuff together, you're expected to be there no matter what our needs come before yours, you're expected to pull up the slack, we expect you to be there because you're the one who can keep the peace among us, I'll have a lousy Christmas if you don't come
Therapist: can you switch, how do you feel inside?
Client: I used to feel guilty but now I feel torn, like you'll have a lousy Christmas but that's not my problem
Therapist: so I don't want to? It's not my job?
Client: I'm saying you can't expect me to make your Christmas okay, you're going to have to do it yourself

Expression of Need for Support and Acceptance

Description: In session nine, Client 3 expressed unmet needs for her family to accept her for her genuine self.

Excerpt:

Therapist: mm-hm can you tell them what you want from them?
Client: [speaking to imagined family in chair] I just want you to accept me for who I am, I don't want any flak, you can ask me all the questions you want about something, but I refuse to defend my actions anymore
Therapist: so I want you to accept me for who I am
Client: mm-hm, for who I am

Description: In her eleventh session, within the context of unfinished business chair work with her father, Client 3 expressed her unmet needs for support from her father.

Excerpt:

Client: I was determined, all I needed was support or information, that's all I needed as a kid, support in what I was doing and information in what I was doing wrong, but not to be told what I can or cannot do, I was constantly told how I should feel about things
Therapist: so, I just needed some support, I really could've flowered
Client: yeah, all I wanted was to be me
Therapist: can you tell him what would've done with the support
Client: with the jazz class, I was doing fine, then I got moved up to my sister's group and you told me that I'm making my sister feel bad because she's older, so I quit,

Deservingness of Needs

Description: In Session 11, in addition to assertive anger, Client 3 expressed that, as a child, she deserved to be treated much better than she was by her father.

Excerpt:

Client: all you did was manipulate me and use me, and it's like it's terrible it's disgusting, how can you do that to a human being?
Therapist: how dare you use me, can you say that to him? how dare you use me
Client: how dare you use me and discard me. It's like's how can you do that to somebody?
Therapist: I don't deserve this?
Client: no, I don't deserve this at all, it's like I'm a human being and I deserve, if you didn't like me that much, it would probably have been better if you had just abandoned me as a child, it's like why?
Therapist: I deserved more
Client: I deserved much more, it's like, I deserved a life, I deserved a father, if you couldn't do it, you should have just left then, I think you're the most spineless person I've ever met

Hurt/Grief

Description: In session eleven, Client 3 expressed hurt/grief around having to inhibit herself, and not having her needs for support and acceptance met, during her childhood.

Excerpt:

Therapist: what are your tears saying? Can you speak from the tears? I just feel such pain and sadness?
Client: pain and sadness, and I'm just so tired, it's like is this battle ever going to end, it seems like such a battle, and is it ever going to end
Therapist: it's been such a struggle, what do you want?
Client: some relief from this childhood pain, I can't get it back, but I also don't want it haunting me, it seems to haunt me constantly
Therapist: so, some kind of release from this childhood pain that just haunts you
Client: and to figure out who I am, I still haven't figured out who exactly I am, my family still thinks I'm the person that they want, but I'm confused because I don't know if they know that I want and need to change

Willing to Take Risk Despite Hurt/Grief

Description: In her thirteenth session, Client 3 displayed a willingness to take of hurt/grief by deciding to share her previously inhibited feelings with her sister, regardless of the potentially painful consequence that her sister may not respond. In later sessions, she shared that she had shared her feelings with sister between sessions.

Excerpt:

Client: I really feel like I need to talk to my sister about the fact that we're not close and why is that, and this is how I'm feeling how are you feeling? Like it feels like I'm ready to have that conversation if I could get her alone by myself and just so I can make her aware of how I feel and what I'm going through. I don't know if it will do any good but I'm open for a try, I don't know if she'll respond but at least it's something I feel, and I'm quite prepared for the fact that she may not respond at all

Increased Self-Assertion

Description: In her eighteenth session, Client 3 reported feeling more empowered. She expressed self-assertion and adaptive action by also prioritizing her needs over her partner's needs and setting boundaries with him.

Excerpt:

Client: my confidence in the last few weeks has been going up, because I've been getting up and going places, even though it's in conflict with the only time he and I have to spend together, and it's sort of like I'm sorry I've already made these plans, I made you aware that I was going to be busy, last week it was Tuesday and Thursday and then he didn't come home on the Wednesday night when we were supposed to go out, and he said well we'll go out Thursday, and I said no, I'm going out and I refuse to change my plan to accommodate time for us at my expense

Therapist: so that felt good to do that?

Client: yeah, it did, I said it more for my purpose, I'm not going to do that anymore

Client 4 (Non-Resolver)

SI Markers

Description: In his second session, while doing a self-interruption intervention, Client 4 expressed markers of SI, such as self-criticism, worrying that others may disapprove of him, and inhibiting his anger.

Excerpt:

Client: you're not allowed to be angry at anyone except yourself because if you were angry at other people and other people saw that, then they might think badly of you and then that just makes your life worse than it already is

Therapist: so, it's not beneficial to be angry and if you do that, you're going to make things even worse, what happens as you say that

Client: I just don't like letting people know that I get angry, like I go to extreme lengths to hide

Maladaptive Shame and Fear

Description: In his second session, within the context of chair-work intervention with the part of him that socially inhibits him (SI Agent), Client 4 expressed his core maladaptive hopelessness and powerlessness as a result of the SI agent continuously imprisoning him.

Excerpt:

Client: I just feel like nobody really understands me, they don't understand my pain, they don't understand what I'm going through, how angry I always am, how sad I always am, you stick me in a room and basically I can't talk to anyone…I've had to carry this pain for so long, it just feels like there's no end in sight, that I can never get rid of it, I feel really stuck and because of you I feel I haven't gone anywhere in the last how many years in my life, I'm 23 and I feel I like I can be 14, you have an idea of how I should be, so you keep me stuck

Connect to Painful Past

Description: In session eleven, Client 4 explored painful past experiences and unmet needs in an unfinished business intervention with his parents. Client 4 made connections between his parents' neglect of his emotional world and how he self-interrupts in the present-day.

Excerpt:

Therapist: mm-hm, tell them what you needed from them, tell them what you wanted from them

Client: I needed to know that you cared about me no matter what I did or if I was unsuccessful with something that it would be okay and, but I never heard any of that from you, instead you either ignored when I was upset, or you would just lecture me

Therapist: mm-hm I didn't need your lectures

Client: I didn't need your lectures, I needed your support

Therapist: (p:00:00:06) What's happening to you now?

Client: (p:00:00:07) I guess uh, I guess they upset me more than I realized

Client 5 (Non-Resolver)

SI Markers

Description: In his first session, Client 5 reported markers of SI, such as inhibiting and interrupting his experience of anger.

Excerpt:

Client: what I tend to do in situations that arouse anger, is I somehow turn off and I'm not sure how I do it, I'll get into an intellectual pursuit, I'll watch television
Therapist: so, sort of tuning out, numbing yourself
Client: yeah

Description: Later in his first session, Client 5 described SI markers related to hypervigilance and not asserting his own feelings and needs. He described searching for external rules to live by.

Excerpt:

Therapist: you've been trying to process it but somehow, you're stuck
Client: I intellectualize the whole world, I carry around a big model, a moral model of the world in my head, and I keep adjusting it and changing it and living within it, and I look for the rules to follow, in every situation I look for the actual rule to follow…I live my life in the second person or the third person

Maladaptive Shame and Fear

Description: In his first session, Client 5 expressed his current core maladaptive feeling of powerlessness which originated in childhood and which he also related to his markers of SI (e.g., inhibiting and interrupting his anger).

Client: in my childhood, I was only aware of power relationships as in interpersonal kinds of relationships
Therapist: so, this person has power over me, or I have power over them, that's how you would evaluate things?
Client: and I never have power over anything

Connect to Painful Past

Description: In the tenth session, Client 5 explored painful past experiences and unmet needs in the context of unfinished business with his neglectful father. Client 5 made connections between the way his father made him feel worthless and his present-day non-assertiveness.

Excerpt:

Client: I can barely tolerate the sight of you and going back to the house where all of this happened only makes me sadder and sadder and sadder and makes me feel worthless, this is where I learned how to be a doormat and a and a whipping boy

Therapist: yeah so, it's just you were so helpless it was like nothing you could have done

Client 6 (Non-Resolver)

SI Markers

Description: In her second session, Client 6 communicated markers of SI, such as self-criticism, worrying what others will think of her, perfectionism, rumination, and inhibiting her feelings, especially anger.

Excerpt:

Client: yeah, I'm having doubts about the way I'm approaching things
Therapist: and how previous mistakes, does that mean you're not good enough or
Client: yeah, yeah
Therapist: what is that about?
Client: I don't know, believe me I go over it and over it in my own head and that's sort of like I get really tired of hearing it, because I don't know, I don't know why I'm doing this except that there's expectations on me to do really well, I have a tendency to not to, I have a tendency to really freeze up
Therapist: so, you see this as freezing you or
Client: yeah, it's just, you know and if I fail really spectacularly then that, I mean that gives me an out, that gives me, you know I don't have to do it and I don't have, all the pressures and expectations are gone

Maladaptive Shame and Fear

Description: In her second session, Client 6 described the maladaptive feeling of being small in response to the SI Agent part of her that imposed perfectionistic standards.

Excerpt

Therapist: the part of you that's scared and terrified, what happens when you hear this part say "I expect you to be brilliant, I'm not going to tolerate any failure" what does it feel like inside?
Client: small
Therapist: um hum, tell me about this
Client: I can't do it
Therapist: um hum, tell me, what is it
Client: because its too much**,** because I'm not allowed to fail even just a little bit, I mean it has to be absolute brilliance or nothing

Connect to Painful Past

Description: In her twelfth session, Client 6 explored painful past experiences with her father that are related to her SI related core maladaptive feeling of failing and being inadequate. Client 6 made connections between her father and her SI Agent. She expressed, as her SI Agent, her father's high standards and expectations.

Excerpt:

Client: I loved you so much and I wanted you to be so proud of me, and I knew you weren't

Therapist: Can you come over here *(to father's chair)*? What happens when you hear her say that?

Client: *(As father)* I'm hurt but part of me knows that if I was really in this chair, I would deliver another lecture

Therapist: okay, so lecture her

Client: about how irresponsible you've been and if you wanted me to be proud why did you do all those things that were ridiculous and why didn't you live up to your potential, and why didn't you do the things you wanted to do