School of Psychological Sciences and Health

Counselling Unit

Decoding Negative Treatment of Self

Comprehensive Measurement and Diverse Presentations in Socially Anxious Clients

by

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This thesis is the result of the author's original research. It has been composed by the author and has not been previously submitted for examination, which has led to the award of a degree.

All data supporting this Thesis will be available from the University of Strathclyde PURE repository (see Appendix Q), following the cessation of an embargo period. Further details relating to the data and the embargo can be requested using the contact details available on the portal-landing page.

Signed: 

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Abstract

Navigating the landscape of self and emotion, and bridging the experience of self in relation to others, emotion-focused therapy (EFT) is a humanistic-experiential psychotherapy that has demonstrated efficacy in treating depression (Greenberg et al., 1990; 1998) and social anxiety (SA; Elliott et al., 2013). At the heart of social anxiety lie numerous conflicting self-identities, rooted in enduring feelings of inadequacy and shame. Adopting a deleterious self-critical stance, the array and complexity of inimical self-actions underscores the debilitating nature and therapeutic challenges of SA. While existing literature on the self-relationship has examined the global self-concept and constructs such as perfectionism and self-criticism, there remains a significant gap in comprehensively understanding and effectively measuring negative treatment of self (NTS).

Drawing on archival data from SA clients undergoing EFT, this three-part mixed-method study aimed to achieve several objectives: (a) evaluating the reliability and validity of the Self-Relationship Questionnaire (SRQ; Faur & Elliott, 2007); (b) comprehensively mapping the manifestations of NTS within-therapy discourse; (c) testing and validating the rational-empirical model of NTS proposed by Capaldi and Elliott (2023); and (d) exploring the amelioration of NTS observed by the conclusion of therapy.

The findings confirmed the SRQ as a reliable and valid instrument for assessing the self-relationship. The analysis extended beyond mapping the nuances of NTS therapy discourse, exploring its multifaceted dimensions, including self-dislike, detrimental self-actions, and their emotional effects, providing comprehensive insights into NTS. The empirical validation of the rational-empirical model of NTS was supported and expanded upon. The observed decrease in NTS by therapy's end further enhanced the model, highlighting significant improvements in client discourse about the self-relationship.

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Chapter 1: Exploring, Understanding and Measuring the Self-Relationship and Negative Treatment of Self

Introduction

Informed by the theory and practice of EFT, this research is grounded in a neo-humanistic approach to therapy (Elliott et al., 2004) that upholds the role of emotion as a core element in psychotherapeutic change. Comprising various strands from different humanistic approaches such as the relational aspects of person-centred therapy, and the experiential components of gestalt and focusing (Greenberg et al., 1993), EFT aims to strengthen the self-relationship by supporting meaning making and affect regulation processes. Recognising all emotion as containing innately adaptive potential, the process of accessing painful or unwanted self-experiences is understood to support the movement from problematic emotional states to more adaptive ways of being (Greenberg, 2017).

Representing a profound connection with oneself, the state of a person's self-relationship has far reaching consequences that greatly influence their life and experiencing (Ociskova et al., 2019). Central to the practice of EFT, the unfolding self-relationship and its development, involving emotional, cognitive, behavioural and somatic experiencing, lies at the heart of this humanistic-experiential therapy (Elliott et al., 2004; Elliott & Greenberg, 1997; 2021). It is widely understood that negative treatment of self (NTS; Capaldi & Elliott, 2023) in the form of self-critical and inimical self-processes is integral to the formation of psychopathology (Greenberg, 1979), and a core component of an individual's experience of emotional distress and pain (Greenberg et al., 2003). Demonstrating the connection between the self-relationship and emotional dysregulation, Greenberg et al. (1990; 1998), formulated a model that is '*centred on the vulnerability of a disempowered self*' (Whelton & Greenberg, 2005, p. 1584). Conceptualising depression as '*an emotional disorder of the self*', Greenberg et al. (1998, p.231) described an emotion-based self that experiences itself as

incompetent and helpless, thus descending into collapsed self-experiencing as a result of current life difficulties and past trauma.

Elaborating the impact of these core experiences, Stinckens et al. (2013) explored the resulting secondary effects on the self-relationship in the form of the inner-critic and its ensuing distress. Acknowledging that the inner critic requires more active engagement if it is to reach resolution, Stinkens and colleagues highlighted the need for therapy to more effectively address issues of self-organisation as well as promote self-acceptance and trust. Improvement in the self-relationship requires contact and processing of these harmful-to-self processes, thus supporting transformation toward a more adaptive self-aspect by replacing self-criticism with a more self-compassionate way of being (Stinckens et al., 2013). Developing an active and integrated self involves collaboration and cooperation between the various voices or facets of self. Such interactions aim to transform or remove blocks to experiencing, mobilising and strengthening the integral sense of 'I' (Elliott et al., 2004) toward a greater sense of unity. Of central importance to the therapeutic process, this ability to work with and effect change in the self-relationship directly correlates with successful outcomes in psychotherapy (Arnold et al., 2000), and as such, is a relevant and important topic for practice and research.

According to Cooper (2017), the movement from psychological distress to greater levels of psychological well-being requires the ability to relate to self (and others) in accordance with Buber's (1958) *I-thou* relational stance. This movement from fragmented self-objectification towards an attitude of totality or wholeness in embodied self-to-self relating was reconceptualised as *I-Me* and *I-I* (as opposed to Buber's I-It and I-Thou) intrapersonal attitudes, to depict the internal dialogues and styles of self-relating being observed in therapy. Connecting fractured I-Me positions to intrapersonal discordance, Cooper highlighted the plurality of varying *I-positions* and their myriad of constructs and defences. Well established in the humanistic-experiential field, these interacting voices or parts are understood to contribute to the

organised whole self of the person and their moment-to-moment lived experiencing (Cooper, 1999; Cooper et al., 2004; Elliott & Greenberg, 1997; Mearns & Thorne, 2000; Stiles et al., 1990).

Emphasising the need for greater dialogue between the various facets of self, Cooper and Rowan (1999, p.8) acknowledged that dominant or disowned parts of self result in a '*cacophony of monologues*' requiring a co-operative type of working together to enhance self-awareness, and to move towards greater coherence, understanding and integration. Associating positive or self-affiliative feelings such as harmonious openness and acceptance towards oneself with the I-I relational stance, and harsher self-rejecting and derogatory attitudes with the I-Me position (Cooper, 2017), evidence points to the importance of enhancing one's ability to integrate the various aspects of self as a means of reducing inner-conflict and dysfunction (Elliott & Greenberg, 1997; Greenberg et al., 2003). Highlighting the levels of distress caused by conflicted self-aspects whilst acknowledging their changeable dynamic structures, Elliott and Greenberg (1997) asserted the need for therapists to facilitate '*constructive dialogues*' (p.225) between these internal voices of the client. As these disowned or silenced self-aspects often operate unconsciously, appearing undifferentiated and implied, Elliott et al. (2004) stressed that people are not always aware of the ways in which they might habitually beat themselves up (Elliott et al., 2004).

This antagonistic tendency to denigrate and attack oneself has long been recognised in psychotherapy research and practice as a pivotal characteristic in the myriad of psychological difficulties (Shahar et al., 2012). A fundamental imperative for successful outcomes in therapy, the ability to discern, explore and understand the phenomenological nature of negative self-treatment in its array of manifestations and forms, aids the therapist in navigating and working with these inner *conflict splits* (Elliott et al., 2004). Necessitating the need for more comprehensive understanding and awareness of these intrapersonal self-damaging activities, Kramer and Pascual-Leone (2015) highlighted the challenges to effective observation and measurement of

hostile self-relating due to its often subtle and implied presentations. These frequently undisclosed and somewhat restricted self-to-self processes highlight the complexities of NTS, and point to the usefulness of utilising a combination of in-session observation alongside the client's self-report measure. Suggesting the need for greater clarity in their study of self-criticism, Shahar et al. (2011) proposed that therapeutic outcomes may be better addressed by considering the client's implicit processes and patterns of emotional processing, viewed in association with their self-appraisal. Recognition of the relevance of implied client-process indicators, and this difficulty in quantifying and classifying the multitude of NTS presentations forms the basis for this PhD thesis, which aims to contribute to existing research on measuring and understanding the self-relationship, particularly as it relates to deleterious forms of self-relating.

Much of the research to date involving the self-relationship has emphasised particular attributes such as the process and features of the inner critic (Stinckens et al., 2002a; 2002b; 2013a; 2013b); the impact of self-criticism on the therapeutic relationship (Whelton et al., 2007); dialogues with the inner critic (Vahrenkamp & Behr, 2004); self-criticism and depression (Mosher et al., 2008); conceptualising healthy self-attitudes (Neff, 2003); and therapies for shame and self-attack (Gilbert & Irons, 2005), to name but a few. Furthermore, researchers involved in the psychometric measurement of aspects of self-relating have often focused on themes such as depressive experiences (Blatt et al., 1976); self-esteem (Rosenberg, 1965); self-compassion (Neff, 2003); and psychological distress (Evans et al., 2000). In contrast, focus is given here, first to the effective psychometric measurement of the broader concept of the self-relationship and its proposed underlying constructs of self-attack, self-control, self-neglect, and self-affiliation, and secondly to the mapping of negative treatment of self in its multifarious presentations as expressed by clients through in-therapy discourse. Finally, empirical model construction of the taxonomy of NTS was applied in the explication and widening of our understanding of harmful self-relating. Differing from previous research that has focused solely on a distinct feature or

characteristic of the self-relationship such as self-compassion or the inner critic, the empirical framework incorporated both obvious and subtle client process indicators of varying aspects of NTS: *Objects* (what I dislike about myself) within the domains of *Being*, *Doing*, & *Having*; *Directness* (the strategies I use for my self-dislike) within the domains of *Direct* vs *Indirect*; *Modes* (what I do that is bad for me) within the domains of *Self-Attack*, *Hostile Control*, *Hostile Neglect*, & *Hostile Freedom or Separation from Others*; and *Emotional Effects* (what I feel preceding or in reaction to my self-dislike and inimical self-actions) within the domains of *Fear*, *Sadness*, *Anger*, *Shame*, *Guilt*, & *Despair*. In addition to mapping the nuances of negative treatment of self, the varying and elaborated dimensions were further incorporated to create a more comprehensive definition.

Definition of Negative Treatment of Self: An Integrative Summary

Building upon and empirically testing, validating and elaborating the preliminary research conducted by Capaldi and Elliott (2023), the definition of negative treatment of self that has underpinned this series of studies (and will be further refined in Chapter 6) is based upon the integrative summary of their findings as outlined below:

Negative Treatment of Self was understood to be a '*synergistic activity comprising the dimensions of objects of NTS, inimical self-actions and their emotional effects*'. Functioning as a cyclical and interconnected system, each aspect '*appeared to directly affect and sustain the others*' in the creation of problems and interference with personal goals.

(A) Objects of Negative Treatment of Self '*exhibited varying forms and degrees of intensity, whereby a person deemed an aspect of self as flawed in terms of who they are, what they do, or what they possess. It resulted in preoccupation with how others might perceive or judge one's flaws together with how one may obtain an acceptable or worthy sense of self. Self-dislike or self-criticism was expressed through inflated demands and idealistic expectations of self, together with a tendency towards*

belligerent self-derogation, abasement or rejection when such standards were unmet'. Strategies for carrying out the self-dislike or self-criticism included direct (through self) or indirect (through others) action, the effect impacting both behaviour and emotional states, and often leading to the adoption of avoidance strategies that appeared protective by intent and yet were harmful by effect.

(B) Modes of Negative Treatment of Self '*appeared most often as self-critical process, understood as a behavioural reaction to, or enactment of NTS, exhibiting varying forms and degrees of intensity, whereby an action was taken either momentarily or habitually, that was consciously or unconsciously obstructive or detrimental to self, whether by attacking, distancing, controlling or neglecting. Appearing to negatively affect emotional experiencing and sustain the self-critical process, strategies for carrying out the behavioural reactions included direct (through self) or indirect (through others) action*'.

(C) Emotional Effects of the Negative Treatment of Self '*involved a bodily feeling that was activated due to the effect, or as an enactment of the NTS actions that negatively impacted a persons' homeostasis or experiencing, sustaining pessimistic thinking and detrimental behaviour or action whilst causing multiple forms of emotional pain*'.

Extracted from Capaldi and Elliott (2023, p.116).

Overview and Rationale for the Series of Studies

Study 1: My first study was intended to evaluate the quality of a person's relationship with self, using the Self-Relationship Questionnaire (SRQ; Faur & Elliott, 2007 – see Appendix D), an experimental measurement tool whose reliability and validity required further assessment. Designed to measure key aspects of the self-relationship specifically within the domains of self-affiliation, self-attack, self-control and self-neglect, the instrument required empirical validation by way of psychometric investigation to test its accuracy and effectiveness. Whilst the SRQ had been

repeatedly tested and modified since its original construction in the late 1990's, it is still an unpublished experimental measure, requiring further psychometric testing and development.

Utilised within the Strathclyde Counselling & Psychotherapy Research Clinic to gauge the self-relationship of socially anxious clients who received emotion-focused therapy (EFT-SA), the SRQ required further investigation of its scale structure (items measuring the same focal variable); construct validity (the degree to which it measures the constructs that it was designed to measure); and test-retest reliability (to explore the consistency and stability of the measure over time). While prior SRQ outcome data was able to capture significant movement from self-attack to self-affiliation for EFT-SA clients during their engagement with this 20-session therapy (Elliott et al., 2014), combining this original sample with a larger data set (incorporating a subsequent training study) and comparing with a newly collated normative non-clinical sample would provide more rigorous psychometric data. Contributing to the existing body of clinical archival data, it was expected that the addition of these further analyses with this wider clinical data set and normative non-clinical sample would allow for the calculation of clinical cut-off and reliable change indices. Furthermore, it was anticipated that these developments would support the scientific publication of the SRQ in a relevant journal for wider use within the clinical psychotherapy and research communities. To this end it was identified that the SRQ would benefit from further examination as follows:

1. Conceptual clarification and refinement of its construct validity by way of exploratory factor analyses to ensure that the instrument is capturing elements of the construct under investigation, i.e. the self-relationship, in all of its forms.
2. Investigation of the test-retest reliability of the instrument to explore its consistency and stability over time. Aiming to establish a Reliable Change Index (RCI) value and the clinical cut-off points of the measure will enable researchers and mental health professionals to make effective use of the SRQ, evidencing

significant change and clinical vs non-clinical states within therapy.

3. Validating the consistency and reliability of the SRQ and its constructs to support the clinical assessment of the client change processes in EFT-SA, and provide more solid grounding for the subsequent studies of this thesis that have utilised SRQ outcome data to inform their selection criteria.

Studies 2 and 3: Building upon earlier preliminary research and rational-empirical model construction of negative treatment of self (Capaldi & Elliott, 2023), the second and third studies sought to not only challenge the original model but to reproduce a more elaborated and refined version based upon these further set of analyses. Whilst investigation into harmful self-treatment is often reduced to the exploration of self-critical processes, these studies assumed that the inner critic is only part of a wider spectrum of forms of negative self-treatment that affect a person's experiencing. Contemporary investigations into the qualitative analysis of the self and its multivoiced nature, has not only highlighted the influential importance of this theoretical concept for psychotherapy research and practice, but also underscored the challenges in precisely discerning and distinguishing the diverse *I-positions* (Kay et al., 2021). Recognising that the primary challenge resides in the procedural task of *'identifying and naming I-positions'* (p.12), it was acknowledged that the subjective nature inherent in interpreting phenomenological experiencing and dialogue poses a risk of inaccuracies and potential oversight of reality or intended meaning. Acknowledging the complexity of effectively distinguishing and categorising the self-damaging narratives that are expressed in the counselling room, the latter investigations of this thesis sought to describe and classify the variety of presentations, whilst holding an open curiosity about the ways in which they developed or eased across the duration of the therapy.

In accordance with Elliott and Greenberg's (1997) assertion that dialectically constructive change requires distinct separation between the various voices or self-aspects in order to facilitate their interactive dialogue, it appeared evident that

attempting to perceive, understand and describe the array of possibilities of NTS can support the practitioner in more effectively engaging with the client's process. Grounded in Rogers' (1961) concept of movement towards growth and optimal functioning, these studies aimed to enhance awareness of NTS by expanding the taxonomy of negative self-dialogues, inimical self-actions, and their emotional effects. The emphasis was on fostering the assimilation and accommodation of various self-aspects to attain a coherent sense of wholeness, as outlined by Elliott and Greenberg (1997). Ultimately, the aim was to widen the practitioner's, and therefore the client's, awareness of the array of negative self-treatment narratives, behaviours and affects, thus creating more fertile ground for the assimilation and integration of these conflicted self-aspects.

Working initially with the beginning stage therapy sessions for six clients (study 2) who received emotion-focused therapy for social phobia, the aim of these qualitative case examinations was to better understand the evolving self-relationship in its array and intensity of harmful-to-self discourse, the corresponding harmful-to-self activities and their impact on the emotional state of the person. Operating incrementally, this second study formed the basis for the third and final study of this thesis, whereby ending phase sessions were analysed for each of the six participants to further test the model, and to provide insight into the ways in which expressions of negative treatment of self evolved and changed during the course of therapy.

Epistemological and Methodological Framework

The combined quantitative and qualitative approaches utilised in this series of studies reflects the researcher's alignment with multiple ontological and epistemological viewpoints to aid the exploration of phenomenological reality and knowing. Reality in the context of this research is aligned with Rogers' (1951) proposition that all a person experiences or perceives in any given moment is reality for them. Rather than positing any notion of absolute reality, psychological phenomena

can be understood as the individual's private world of perceptions and hypotheses, both tested and untested against those of others and offering varying levels of predictability and security through the process of socialization. Used to investigate what is real in the world and how best to apply understanding and knowledge, the mixed methods employed in this thesis are underpinned by the researcher's reflexivity in relation to their lived experiencing and understanding.

More specifically, this research bridges the territories spanning from positivism to the critically challenging, underpinned by the self-reflective, degrees of interpretation involved in the descriptive-interpretative approach (Elliott & Timulak, 2005; 2021). Long established within social science, psychological and psychotherapeutic research, this type of methodological pluralism has gained much traction widening the scope for multiple approaches to the testing and classification of data, thus providing a richer context for understanding (Roth, 1987; Slife & Gantt, 1999; Klein & Elliott, 2006; Frost & Nolas, 2011). Rejecting *methodological exclusivism* in the interpretation of human behaviour, Roth (1987) advocated that no individual theory carries precedence, rebuffing the established norms of social enquiry. Furthermore, arguing that no single approach to research can be considered superior over another due to the varying and useful gains obtained from each, Klein and Elliott (2006) asserted that pluralistic approaches offer more nuanced outcomes than the traditional dichotomy of quantitative vs qualitative dictates. Both exploratory and confirmatory by nature, the three interrelated studies followed a discovery-orientated approach involving deductive and inductive reasoning, aimed at testing and developing the existing measure of the self-relationship and rational-empirical model of negative treatment of self.

Contemporary Measurement Theory

Underpinned by a positivist position that aims to bring psychological research in line with physical scientific methods of enquiry, psychometric theory is central to the ways in which quantitative measures and their properties can be understood and

conceptualised. Incorporating *classical test theory* for evaluating psychometric instruments, the core concepts of reliability (involving an exploration of the measure's internal consistency and test-retest stability) and content and construct validity concern the reproducibility and meaning of any measurement (Barker et al., 2016, p.58). According to Furr (2018), just as the tests themselves measure a person's psychological attributes, the science of psychometrics measures the psychological or mathematical attributes of the test. Psychometrics has often been viewed by contemporary authors as being primarily concerned with *differential psychology*, the study of individual differences between people, believing that the study of *experimental* or *general psychology*, which places its focus on the average individual, is of less concern. Furr emphatically disagrees with this assertion believing that the psychometric measurement of psychological and behavioural attributes are relevant regardless of any specific branch of practice and research, thus placing importance in being able to '*identify and quantify variability in human behaviour*' (p.17) irrespective of area of interest. It is therefore anticipated that by validating the SRQ (Faur & Elliott, 2007) for future scientific publication, the instrument will support both individual (or differential) quantification of the self-relationship, as well as offering a useful research measurement to ascertain group averages.

In their review of the developments relevant to measurement in psychotherapy, Margison et al. (2000) asserted that modern methods support psychological treatments through both *evidence-based practice* (clinical practice based upon a combination of robust scientific evidence and patient preferences and care data) and *practice-based evidence* (the gathering of quality clinical data from routine patient care). In considering the uniqueness of each therapist and client dyad, the ability to '*measure personally relevant change*' (p.124) is crucial to Barkham and Mellor-Clark's (2000) strategy for incorporating testing and measurement in practice. They advocate for a comprehensive approach, proposing a three-phased strategy that includes theory and treatment generation, efficacy testing and validation, and effectiveness measurement

and dissemination. However, Margison et al. (2000) argued that, while logical, this strategy lacks emphasis on replication during efficacy testing and does not adequately address the slow transfer of research outcome knowledge for treatment modification and development. In their broader critique of routine outcome measurement in psychotherapy, Margison et al. (2000) highlighted challenges relating to a number of conceptual and methodological issues, namely difficulties with comparability due to limitation of applied settings; aiming to enhance the reliability of instruments by including too many items per construct or domain; and a general lack of testing for acceptability and validity across different languages and cultural or ethnic groups.

Reflecting on Jacobson and Truax's (1991) complementary method for calculating change that incorporates both the clinical significance and statistical reliability of any change in therapy, Margison et al. (2000) stated that whilst this may represent evidence of pre and post treatment change, a substantial normative dataset is imperative to provide a robust baseline for comparing expected individual outcomes. Arguing that baselines tend to be limited in their ability to accurately reflect the psychological state of a person before any intervention, Fishel and Muth (2007) proposed a comprehensive approach utilising a set of average responses for a more robust baseline comparison. Although this represents a '*norm-referenced method*' (Margison et al., 2000, p.128), which is vulnerable to fluctuations in the base reference parameters, Margison and colleagues highlight its improvement upon the alternative approach of simply measuring clinically significant change as any arbitrary increase or decrease in the measure. Endorsing Zarin et al.'s (1996) *practice research networks* that generate larger practice-based datasets from collaborating clinicians, these real world practice settings support enhanced prediction on an individual case level (Margison et al., 2000). In their overview of quantitative self-report methods, Barker et al. (2016) asserted that once a suitable measure has been developed, a reliability study should be undertaken with a large sample (which they suggest is greater than 120 respondents), which was one of the aims of the first study of this thesis.

Whilst the original version of the SRQ was designed as an *idiographic measurement* which avoids comparing an individual's results against others, the current development of the instrument will bring it in line with the majority of other psychological tests which fall within the *nomothetic* category, i.e. norm-referenced by way of comparison to the rest of a population (Barker et al., 2016, p.59). This development required analysis of the test-retest reliability of the measure in a non-clinical population, and the subsequent calculation of its clinical cut-off point. These steps will enhance the instrument's clinical applicability and broaden its overall usefulness. Furthermore, testing the *dimensionality* of the measure through exploratory factor analysis will clarify the number of constructs that the SRQ is measuring, what these dimensions are, and whether they correlate sufficiently to reflect a higher-order factor of self-relationship. '*Considered a multidimensional test with uncorrelated dimensions*' (cf. Furr, 2018, p.80), the SRQ was developed to measure four different constructs of self-relating. In developing the clinical cut-off points for the measure, each subtest score will be considered in isolation rather than cumulatively to produce a *total test score*. This is in line with the NEO-FFI-3 (McCrae & Costa, 2010), a five-factor measure of personality, which is multidimensional with theoretically uncorrelated dimensions, thus relying on individual scores for each subset rather than computing a total test score.

Philosophical Position of Study 1

Combining differing epistemological standpoints, the chosen methodology for this quantitative psychometric study was underpinned by a pluralistic philosophy and methodological framework. The quantitative data collected from participants was phenomenological in nature, as it employed a self-report method. In accordance with correspondence theory, positing that truth is whatever corresponds with reality (reality in this context being all that a person experiences or perceives as defined by Rogers, 1951), in measuring a person's self-relationship, it is suggested that the SRQ is measuring something real in the world (Barker et al., 2016). Yet according to

Greenberg et al. (2003), the symbolisation of experiencing involves the continually evolving construction of implicit and explicit processes which, although in a state of becoming, are '*always limited and incomplete*' (p.308). Therefore, due to the variables of experiencing being in constant flux, it is understood that a persons' relationship with their self is transient and continuously shifting, whereby nothing is absolute and events cannot be observed directly. While one might argue that it relates to a set of characteristics that exist in a person, any measure of a persons' self-relating is therefore reflecting their experiencing at a particular moment. Guided by emotion, and indicating that people always look for, and reconfigure meaning in new ways, experiencing in this neo-humanistic perspective posits an internal sense of complexity whereby '*more is contained at any one moment than any one explicit representation can capture*' (Greenberg et al., 2003, p.307). This is in contrast to Conway's (2005) ideas on the *working self*, which places greater emphasis on the connection between a person's memories and the ways in which they define their self, citing memory as a motivating database of self-knowledge, and cognition as being goal oriented. Thus it became relevant to incorporate a critical realist (Cook & Campbell, 1979) position that proposes temporary, rather than definitive understandings that may be considered truth at any particular moment (Barker et al., 2016). Considering that responses to questionnaires in this study will have depended on how people felt at the time of completion, I started with the assumption that participant replies corresponded with their reality as perceived by them at that time, and that their reality was subject to change.

Additionally, the hypothesised inter-item reliability and construct validity of the measurement tool is consistent with coherence theory (Joachim, 1906), which suggests that an account is true if it is internally consistent whereby an extensive group of propositions (rather than individual ones) comes closer to the whole truth. This investigation also aligned with pragmatist theory (Peirce, 1905) in that '*a belief is true if it is useful or produces practical benefits*' (Barker et al., 2016, p.10). Rather than relying

on idiosyncratic interpretation, the aim was to clarify the factors of the SRQ, and whether the instrument actually measures the constructs it was designed to measure. Validating the SRQ was therefore expected to have a functional value, and in accordance with pragmatist theory, it was anticipated that it would offer a robust tool that can be useful within both psychotherapy research and clinical practice. Adopting their recommendation for including multiple truth criteria and highlighting the relevance of this pluralistic epistemological basis, this research aligns with Barker et al.'s (2016) assertion that whilst being fallible, multiple theories of truth each have their value.

Generic Descriptive-Interpretative Approach to Qualitative Research

The investigative method employed in the second and third studies sought to scrutinise the negative treatment of self in-session dialogue of socially anxious clients. Incorporating the typical components of qualitative research, the generic descriptive-interpretive approach (GDI-QR; Elliott & Timulak, 2021, p.6) shares the common endeavour to '*describe, summarize, and classify what is present in the data*'. Involving a critically challenging and self-reflective degree of interpretation (Elliott & Timulak, 2005) to elucidate the participant harmful-to-self discourse by way of saying, doing and being, this pluralistic and pragmatic analytical methodology was considered optimal to the overall aims of these projects. Working with verbatim therapy session transcripts, GDI-QR offered a highly creative and flexible procedure for the delineation of complex communications, allowing for effective structuring and modelling of the data (Timulak & Elliott, 2019). Spanning an established range of useful qualitative procedures providing a reflexive platform for an interactive meaning construction process (Elliott & Timulak, 2021), this method aided the comprehension and classification of micro-processes in therapy (McLeod, 2013). Underpinned by a dialectical constructivist (Pascual-Leone, 1991; Greenberg & Pascual-Leone, 1995) epistemology, the rigorous inspection of the clients' discourse unearthed its numerous '*repertoires*' and '*subject positions*' (Barker et al., 2016, p.89).

Philosophical Position of Studies 2 and 3

According to Elliott et al. (2004) it is the meaningful contact and interaction of dialectical constructivism that explains human functioning, positing that the act of knowing something changes both the knower and the known. For example, to articulate a vague feeling by symbolising it verbally helps to bring the experience into further reality by defining and making sense of it. They argued that the creation of meaning comes from this process of verbalising it by '*acting on and synthesizing components of experience*' (p.37). Acknowledging that certain *reality constraints* can get in the way of full symbolisation of experiencing (difficulties with emotional processing being one of them), they pointed to the possibility of multiple plausible versions of reality as well as those that don't always appear to be a good fit with the data. Applying this dialectically constructive framework to the self, a person is understood to comprise multiple evolving parts or self-aspects, describing different voices of self that reflect the various emotion schemes of the person, affecting their experiencing and actions taken (Elliott et al., 2004; Greenberg & Pascual-Leone, 2001). Warning against reifying parts of self, Elliott et al. (2004) asserted that as with emotion schemes, self-aspects are variable constructions involving both owned and disowned parts that are in a continuous state of becoming, and are greater than any explicit identifying descriptor.

While dialectical constructivism is the '*philosophical basis for emotion-focused therapy*' (Elliott & Timulak, 2021, p.9) in that it views qualitative research dialogically, the critical realist practicalities of *replication* and *triangulation* were also relevant to this examination which adopted a comparative approach to examine more tacit communications. The critical realist epistemology (Cook & Campbell, 1979) infers that life holds recurring patterns or regularities, albeit that these can never truly be known (Barker et al., 2016). Emphasising the need for replication whether it be with other methods, client populations, or differing researchers, critical realism is underpinned by these coherence (consistency in various observations) and consensus (agreement with

other researchers) criteria (Elliott & Timulak, 2021). Starting with the earlier rational-empirical model of negative treatment of self (Capaldi & Elliott, 2023), the second and third studies sought to not only test the original model but to reproduce a more refined empirical version based upon these further set of analyses. The chosen methodology and underpinning philosophical stance allowed for a creative process of replication and discovery, unfolding the array of harmful self-to-self processes, whilst also acknowledging the therapist's part in the dialectical interplay that supported the client in attending to these various self-aspects.

The Researcher

At the time of conducting this research, I was employed as a Teaching Fellow at the University of Strathclyde, working within the Counselling Unit (School of Psychological Sciences & Health), and teaching on the MSc Counselling & Psychotherapy course. Part of my role involved coordinating the Strathclyde Counselling & Psychotherapy Research Clinic, which continues to offer free person-centred experiential psychotherapy to members of the public who are willing to take part in its research protocol. Having completed initial counselling training in 2007, I have worked in both private practice and a variety of clinical settings. Subsequently undertaking MSc Counselling & Psychotherapy studies along with advanced professional training in EFT, I have developed a strong interest in understanding and working with the self-relationship and its associated challenges. I am particularly focused on exploring, comprehending and resolving intrapersonal processes related to psychological distress.

Part of my interest in undertaking this series of studies stemmed from my own early experiences of debilitating social anxiety and the transient yet somewhat lingering feelings of unease that have remained. Having spent much of the past twenty years immersing myself in the exploration of various therapeutic approaches to personal development, fuelled by the desire to transform and release my own self-

critical and fear-based processes in order to better support others in theirs, I was immediately drawn to the process-experiential and task focused aspects of EFT. With a modus operandi that holds centrality on emotion, self and experiencing, EFT-SA offers pragmatic approaches to understanding and resolving the harsh inner-critical and shame-based processes associated with social anxiety, underpinned by an elegantly robust theoretical base.

In my role as coordinator of the research clinic, I had access to the EFT-SA archival database, a protocol that had ceased data collection prior to my joining the unit. In addition to my own personal and professional interests, it felt important to further explore the self-relationship and its role in psychological distress, particularly with this archive of socially anxious clients who, due to the nature of their difficulties, had so courageously offered their data in the pursuit of research. As I embarked on these studies, I was aware of the desire to explore and further develop the existing measure of self-relating, and to create an empirical and useful model of negative treatment of self to support therapists in their work with clients (and to support clients in better understanding their self-relationship too). That said, I was also aware that this desire in itself created an implicit bias, leading to my resolve to stay as close to the data as I could, bracketing my desires and assumptions where possible, and being transparent about my processes and methods along the way.

Aims and Expectations

Overall, the purpose of this series of mixed-method studies was to investigate the reliability and validity of the Self-Relationship Questionnaire as a useful measure of the various constructs of self-relating, to empirically validate the rational-empirical model of negative treatment of self, to further incorporate end of therapy expressions of, albeit ameliorated, harmful-to-self discourse, and consider the impact of EFT on the modelled account of the self-relationship.

In the first study, it was predicted that the SRQ would be an effective measure of the self-relationship within the constructs of self-affiliation, self-attack, self-control and self-neglect, with the first two domains listed acting as an inverse measure of each other and merging into a bipolar construct. It was however anticipated that some overlap would be found between some of the items within each domain of the questionnaire, supporting a reduction in the 36 items to a shorter, more simplified yet robust version of the instrument. As a side note, and observed in my preliminary MSc research on NTS, it was expected that the clients' appraisal of their self-relationship as measured by the SRQ would demonstrate both confirmatory and contradictory aspects when viewed in association with their moment-to-moment in-therapy discourse. This assertion builds on a previous within-case analysis (Barker et al., 2016) conducted during my MSc studies, which identified several discrepancies. Notably, participants scoring high in SRQ self-attack and self-affiliation, respectively, exhibited distinctive patterns. The former presented in a highly restricted manner, offering limited self-attacking data, while the latter presented uninhibitedly, reflecting greater levels of hostile control, hostile neglect, fear, and grief compared to other participants. These observations not only underscored the variance that can occur between the clients' self-report and their in-therapy discourse, but also highlighted the challenges in effectively capturing and measuring the self-relationship. We cannot assume that a client reporting high levels of self-attack will communicate the severity of this in therapy, or that those scoring high in self-affiliation will not also openly express high levels of NTS.

Following the earlier MSc research and subsequent creation of the rational-empirical model of negative treatment of self, I expected to find in the second and third studies both explicit and implied process indicators of different types of negative self-treatment, which would clarify, refine, and greatly elaborate the preliminary structure. Considering Kramer and Pascual-Leone's (2015) emphasis on the difficulties faced when measuring concepts such as self-contempt due to its often implicit-nature, I

brought to this research an intention to consider these more subtle processes beyond the clearly defined examples, implementing an approach of micro-analysing or deep reading of the data. This methodological strategy, enabling the close inspection of client in-session discourse, supported the nuanced elaboration and empirical validation of the map of negative treatment of self. While fully acknowledging that the person-centred approach (Rogers, 1951) does not seek to interpret clients, the aim was to conduct a deep, interpretive (but not in a psychodynamic sense) read of implicit meanings, at what is referred to as the edge of awareness (Gendlin, 1996). Underpinned by the researchers' observation and perceptual style, along with the theoretical understanding they brought to the research (Elliott & Timulak, 2021), this interpretative approach supported the deeper reading of the clients' discourse, enhancing awareness of tacit processes as they presented in the therapy.

Structure of the Thesis

Structured over six distinct chapters, the thesis begins with this initial overview presenting an introduction to the concept of the self-relationship as it relates to negative treatment of self, offering an outline of the rationale for the series of studies and the epistemological and methodological frameworks upon which they have been based. The second chapter provides a wider exploration of original and contemporary literature and research on the varying theories of self and experiencing, including the ways in which negative self-treatment manifests and can be understood and resolved. This justification of broader knowledge and understanding considers the self-relationship and NTS not only from the humanistic-experiential approach, but also from the perspectives of the more cognitive-behavioural and psychodynamic traditions. Chapter three supports the SRQ as a valid and reliable measure of self-relating by presenting the first empirical study, which explores the significance of measurement in psychotherapy, addresses the ethical and methodological challenges of quantifying the self-relationship, and examines both classical and contemporary methods used in the

validation and refinement of the SRQ. The fourth and fifth chapters empirically validate the earlier rational-empirical model of negative treatment of self, challenging, differentiating, and elaborating its structure by examining therapy sessions from the beginning and end stages, respectively. Utilising good outcome cases, the latter study, while contributing to the model, also provides an overview of the ways in which negative self-treatment softens towards the end of therapy. Each of the three studies included in this thesis concludes with a detailed, focused discussion of its findings. Chapter six provides a summary of the findings from each study, followed by a comprehensive discussion on their contributions to knowledge and their broader implications for theory, practice, and future research. This final chapter highlights the challenges in conceptualising and measuring the self-relationship, underscores the need to address the often-overlooked issue of self-neglect, differentiates self-control as a distinct form of self-relating, explores the bipolar nature of self-affiliation and self-attack, and addresses issues related to self-awareness, self-doubt, authenticity, and self-knowledge. It also emphasises the relevance of pluralism in psychotherapy research.

Chapter 2: Self, Experiencing and Negative Self-Treatment Literature Review

'The curious paradox is that when I accept myself just as I am, then I can change'.

(Rogers, 1961)

Introduction: The Humanistic-Experiential Perspective

Integrating person-centred (Rogers, 1951; 1959) and gestalt (Perls et al., 1951) approaches to therapeutic change (Greenberg et al., 1993), EFT is a humanistic-experiential approach rooted in the humanistic traditions (Greenberg et al., 1993; Greenberg et al., 1998). Concerned with the spectrum of human emotion spanning the most obvious to indistinct—from old, familiar, stuck patterns to new in-the-moment events and themes (Elliott & Greenberg, 2021)—EFT recognises that one's lived experiencing happens via this emotional interface between self and other, acknowledging both its intrapersonal and interpersonal dimensions. Understanding that emotion is central to the therapeutic change process, acting as a guide in the realisation and fulfilment of a persons' wants and needs, EFT offers a dynamic platform that aids resolution of difficulties through accessing, deepening, and thus better comprehending emotional experiencing (Elliott et al., 2004; Elliott & Greenberg, 2021). Striving to support maturity in a person's ability to create and maintain healthy relationships with themselves and others, EFT upholds the humanistic values of *'authenticity, growth, self-determination, creativity, equality, and pluralism'* (Elliott & Greenberg, 2021, p.3).

The self-structure in EFT is conceptualised as a dynamic and versatile multiplicity in constant interaction with its surroundings. Fuelled by underlying emotional processes and needs, it remains responsive, instigating actions rooted in these internal stimuli (Greenberg & Pascual-Leone, 1995; Elliott et al., 2004). Expanding this conceptual framework to embrace the motivational dimension of emotion schemes (Greenberg et al., 2003, p.305), the *'process view of functioning'* encompasses an automatic situational assessment process, positioning it as the driving

force behind all behaviours and actions (Greenberg et al., 1993). Referring to the point where the self-structure engages with the external environment, this juncture signifies the intersection of internal self-processes, such as emotional responses and needs, with the external situational context, ultimately influencing behavioural responses. Rejecting the notion of a hierarchical structure *'topped by an Executive Self or I'* (Elliott et al., 2004, p.38), the dialectically constructivist self is perceived as a dynamic organisation of multiple interacting voices or parts (Elliott & Greenberg, 1997; Mearns & Thorne, 2000). Engaging in the on-going task of constructing a *'coherent story of the self'* in each moment (Greenberg et al., 2003, p.305), this continual process of creative self-narration in the quest for meaning introduces the potential for negative or hostile intrapersonal (as well as interpersonal) relationships. As internal voices or parts conflict within the self-structure, there arises tension that may lead to maladaptive emotion schemes, resulting in psychological distress and impeding responses or actions (Elliott et al., 2004). Generating the discordance from which negative self-treatment arises, according to Stinckens et al. (2002b, p.43), as the unified self becomes obscured it '*degenerates into a rigid structure*', losing the freedom of its uninhibited flexibility and spontaneity. Acknowledging a person's multiple interacting self-aspects and tendency towards growth, the EFT neo-humanistic approach to therapy aims to strengthen growth-orientated voices by accessing more adaptive emotions to overcome problematic, rigid, and often dominant states (Elliott et al., 2004).

The task-focused process-guiding formulae of EFT were built upon the theoretically robust humanistic foundations of Carl Rogers' (1951; 1959) person-centred relational-based approach to human functioning. Rogers' (1959) personality theory was strongly underpinned by his sole motivational concept of the *actualising tendency*, an innate driving force that seeks to enhance or maintain the self-concept. He described this process of becoming as '*the tendency of the organism to maintain itself- to assimilate food, to behave defensively in the face of threat, to achieve the goal of self-maintenance even when the usual pathway to that goal is blocked*' (1951,

p.488). Indeed, from the EFT perspective, it is this tendency to self-actualise towards maturity that provides the individual with the inherent ability to adapt and respond to their environment through their emotional interface system (Greenberg et al., 1993), thus shaping behaviour by offering valuable information about the individual's needs for growth and survival (Greenberg, 2011). Referring to an '*organised, consistent, conceptual gestalt*' (Rogers, 1959, p.200) and comprising self-experiencing as the raw material on which the self-concept is formed, Rogers' notion of self was understood to involve the individual's perceptions of self, as defined by them at any given moment. Affected by the introjected values of significant others as *conditions of worth*, the self-structure was deemed vulnerable to incongruence, driven by the need for positive regard (Rogers, 1951). Giving rise to the possibility of inauthentic functioning and ensuing psychopathology, as the child adopts the values of parents and caregivers their authentic *organismic valuing* process may, or may not align with the behaviours required to obtain the desired positive regard that is either received from, or withheld by others. According to Cooper (2013, p.121), this developing process of differentiation in the experiential field, and the emergence of the regard complex, throws a '*spanner in the works*' as the child selectively seeks out worthy self-experiences. In their exploration of meaning construction in therapy, Greenberg and Pascual-Leone (2001) outlined the ways in which a child (who experiences feelings from birth) begins to construct their sense of self, in relation to the various emotion schemes experienced through their interactions with significant attachment relationships. They noted that although affect regulation develops as the child matures, it is also significantly affected by the way that parents and caregivers respond to their emotions and needs. These experiences in relation to others are understood to integrate with the child's emerging internal sense of self, forming the '*core structures of the person*' (p.178) as they grow. Whilst these meaning making configurations can provide the developing child with useful standards and values, the opinions and expectations inferred through experiencing or absorbed from others are also a major source of

psychological difficulty and pathology. Emphasising the importance of congruence between the self-concept and lived experiences, Rogers (1951; 1961) proposed that the actualization of the self entails aligning with one's authentic self and embracing genuine feelings, desires, and values. Underscoring the importance of authentic expression, free from external pressures and aligning daily life with one's core self, Rogers regarded this heightened congruence as a clear indicator of progress toward self-actualization.

Criticising Rogers' somewhat unitary sense of self, Coulson (1987) argued that these tensions of social restraint are a normal part of human functioning, representing the reasonable adjustments people make between themselves and their social environment. Acknowledging that an individual takes others into account during the course of their life, this *social mediation* according to Mearns and Thorne (2007) is the prompting of the actualising tendency inspiring resistance in a person's social milieu. Taking an increasingly relational and dialogical stance, Rogers (1963) widened his perspective by recognising that any social force carrying the risk of negative reaction or judgement could work against the individual's natural expression of their actualising tendency. Hence, acknowledging the interconnectedness of all beings underscores the constructivist shift from Rogers' (1951) individualistic perspectives on the self towards social integration. In this evolved framework, *'the self is considered as a dynamic system in which various sub-systems continuously interact in a dialectical field of tension'* (Stinckens et al., 2002a, p.41). These advancing humanistic theories on perception and experiencing reframe Rogers' notions of the developing self as a composition of internal-experiential and external-conceptual voices, each contributing to the organised whole of the individual, without any singular voice assuming ultimate authority. Within this dialectically constructive framework, the self undergoes a perpetual process of creative self-narration propelled by an interplay of internal and external motivational forces in the pursuit of meaning. The concept of a predetermined true self is discarded in favour of a dynamic understanding of the self in

constant creation. This movement away from Rogers' tendency to conceptualise personality and human development on the level of the unitary individual towards self-plurality acknowledges both the intrapersonal '*multiplicity by which the individual is constituted*' (Cooper, 2013, p.128), and the interpersonal multiplicity of which they are part. It is this theoretical basis that provides insight into the vast complexities involved in effectively capturing and classifying self-to-self and self-to-other relationships. Developing over the past thirty years, in their acknowledgement that people are made up of these multiple elements, contemporary humanistic-experiential authors have coined terms such as *configurations* (Mearns & Thorne, 2000; Mearns, 2002), *modes of being* (Cooper, 1999), *inner-persons* (Keil, 1996), *sub-selves* (Barrett-Lennard, 2005), *voices* (Stiles et al., 1990) or *parts* (Warner, 2000).

Proposing similarities between Rogers' (1959) person-centred personality theory and Deci and Ryan's (1985; 2012; Ryan & Deci, 2000; 2002) self-determination theory (SDT), Patterson and Joseph (2007) highlighted the SDT perspective that views the individual as a '*growth-oriented organism*' (p.123) seeking to actualize their potential within a dialectical interface that considers both the facilitating and inhibiting aspects of a person's social environment. Reflecting metatheoretical parallels with the person-centred approach, the person's ability to respond to both internal and external forces or influences is understood to affect their development. Patterson and Joseph (2007) further highlighted the similarities between intrinsic motivation (autonomous actions driven by inherent satisfaction) and extrinsic motivation (interpersonal actions aimed at meeting external standards and expectations) with Rogers' concepts of the organismic valuing process and conditions of worth. As well as distinguishing between intrinsic and extrinsic motivation, and recognising that people can be either supported or thwarted by their social contexts, Deci and Ryan's (1985; 2012; Ryan & Deci, 2000; 2002) self-determination theory of human motivation and personality reflected three innate psychological needs of competence, autonomy, and relatedness (all considered essential for a person's well-being and functioning). Related to competence, intrinsic

motivation and its inherent tendency towards learning, creativity and self-satisfaction is enhanced when underpinned by a sense of autonomy. Linking to relatedness, it can also be impacted by social contexts such as external rewards, interpersonal controls, and ego-involvements. On the other hand, extrinsic motivation concerning the more controlled self-regulation of relatedness refers to doing an activity in order to achieve a particular outcome, which is underpinned and affected by variable levels of autonomy as it relates to external factors. Whilst also connected to competency, these social contexts provide a continuum of internalisation, which is greatly impacted by a person's levels of autonomy (Ryan & Deci, 2000). In reviewing a wide body of literature, Deci and Ryan (2012) clearly demonstrated that greater levels of autonomous motivation better supports a person's positive functioning and growth.

Emerging Difficulties in the Self-Relationship

Suggesting that individuals continually develop new self-concepts that are consistent with their current lived experiencing (Cooper, 1999), these *configurations of self* demonstrate the ways in which multiple voices or parts can be expressed and identified within the life of a person and their narratives (Cooper, 2013). Based upon this concept of the plural self, and the conflicts that can arise between the various self-aspects, the inner critic has long been a topic of interest in the understanding and application of dialectical change processes within the humanistic psychotherapeutic disciplines (Vahrenkamp & Behr, 2004). Dependent on the individual's lived experiencing within this framework, the scope of these differing facets of self are understood to range from being in harsh conflict to working in harmony with each other. Recognising the multivoiced self as comprising numerous relatively independent 'I' positions, Hermans et al. (1993) distinguished between those that are in a contradictory or complimentary dialogical relationship. Within this pluralistic configuration, Stinckens et al. (2013a) articulated the notion of self-criticism as a distinct authority, acknowledging the diverse and often conflicting facets within an

individual's internal landscape. Emphasising the intricate interplay of these various self-positions, this depiction portrays self-criticism as a compilation of alienating and deeply ingrained negative self-attitudes and beliefs. These elements function as barriers, impeding and interrupting a person's organismic experiencing.

First introducing the term *inner critic* in client-centred/humanistic-experiential literature, Gendlin (1981; 1986; 1996) described an oppressive *superego* and particularly hostile aspect of self that attacks from within, interrupting and blocking a person's actions and preferences. Acknowledging the pervasiveness of this concept, and Gendlin's assertion that self-criticism had been well described and studied within most therapeutic modalities, Stinckens et al. (2002a, p. 40) highlighted some of its other known descriptors such as *negative beliefs*, *bad parent*, and *top dog* (Perls, 1969). Underpinned by a range of feelings such as fear, humiliation, guilt, and shame, Gendlin (1996) described a disempowering expectation that one's needs will never be met, leading to the adoption of avoidance strategies that impede oneself from taking appropriate action. Expressed through shaming and demeaning oneself in relation to unrealistic expectations and demands, Whelton et al. (2007, p.136) defined self-criticism as '*a consuming preoccupation with the establishment of a worthy sense of self*'. Similarly, when describing an intensely critical self-relationship, Shahar (2015, p.5) pointed to the '*uncompromising demand for high standards in performance*' underpinned by self-directed hostility when failing to achieve the desired result. Thus it is understood that at the core of negative treatment of self, we find an unforgiving inner critic exhibiting varying forms and degrees of intensity, from mild castigation to belligerent self-contempt and loathing.

Recognising these inner-critical voices as a task-marker whereby specific dysfunctional processes may be worked, Elliott et al. (2004) described a strong inner normative voice that seeks to evaluate, coerce, interrupt, and guard. Similarly, Stinckens et al. (2013a, p.59) stated '*the inner critic symbolizes the strict, inner normative voice that interferes with the individual's organismic experiencing*'.

Contributing to the literature on negative treatment of self, in their definition of the concept, Capaldi and Elliott (2023) proposed a synergistic and cyclical process that incorporates not only the variables of self-criticism, but also the inimical self-actions and emotional processes that are so intricately entwined. Their expanded description of NTS considered both the targets and directness of self-criticism, along with the associated harmful-to-self actions and resultant affects. Supporting this interdependent construct of negative self-treatment, according to Firestone (2010), the insidious nature of the inner critic correlates directly with patterns of self-harming behaviour. Citing her father's earlier work on the *inner voice*, Firestone (1986, p.67) described '*an internal system of destructive thoughts and attitudes, antithetical to the self and cynical towards others*'. To circumvent the psychological distress induced by the inner critic's dysfunctional processes, individuals often employ dissociative avoidance strategies, such as depersonalization and fantasy (Firestone, 1997). Acknowledging the profound psychological and emotional pain associated with confronting inner conflict and dysfunction, Firestone et al. (2013) proposed that some may find it easier to externalise and project their self-criticisms onto others, shifting the struggle from internal to external perception. While this perspective holds merit, Capaldi and Elliott's (2023) preliminary model of NTS underscored diverse modes of self-critical processes manifested through both self-to-self and self-in-relation-to-other modes.

Returning to Rogers' (1959) theory on psychological maladjustment, he described a state of threat or anxiety that occurs when a person is either conscious of the inconsistencies between their lived experiencing and self-concept (threat-based process), or are completely unaware of them (anxiety process). It is this discrepancy and state of incongruence that points to the ways in which a person might go on to distort their experiencing as a way of maintaining or enhancing their self-identity. With this in mind, it makes sense that the underlying intent of the inner critic is understood to serve a protective function, being deeply afraid, seeking to shield and guard (Cornell,

2005), yet its contemptuous and disparaging self-denigration negatively impacts emotional experiencing and is the source of much maladaptive behaviour (Kramer & Pascual-Leone, 2015). Rogers' theory pointed to the concept of an *ideal self*, which in itself emphasises the potential discrepancy between this ideal and a person's organismic experiencing, thus supporting the notion of interacting facets of self-multiplicity. Inferring the importance of authenticity for a person's congruent functioning and psychological well-being, it raises the question as to how the individual makes contact with, recognises, or knows what their authentic experiencing is. One might argue that this stance assumes self-knowledge, and yet from my own experience of working many years in clinical practice with thousands of clients, it seems evident to me that this is an area that people commonly struggle with in therapy. Apparent from the *Self-Doubt or Indecisiveness* categories in the second and third studies of this thesis, and from my clinical observations, it appears that self-doubt and uncertainty over self-awareness or knowledge is so often commonplace, and yet is frequently assumed to be the antithesis of authentic and congruent functioning (Shahar, 2015). Perhaps this notion challenges the definition, meaning, and understanding of authentic and congruent functioning, a debate described by Shahar (2015) who linked self-authenticity with vulnerability to self-criticism, a subject that will be returned to for further discussion in Chapter 6.

Resolving Conflicted Self-Aspects

Due to its resilience and the notion that it provides a sense of control over a persons' inner world, the inner critic can be stubborn and may present in varying restricted modes whereby the expression of underlying feelings are limited or interrupted (Elliott et al., 2004), making it difficult to work with and the change process therapeutically challenging (Stinckens et al., 2002; 2013). In his earlier research on intrapersonal conflict resolution and patterns of change, Greenberg (1984) asserted that the integration of conflicted self-aspects is possible when they are fully brought

into awareness, dialogue, and lively contact with each other. Proposing that therapeutic change happens through the assimilation of distressing, problematic, or distanced experiences, the assimilation model (Stiles et al., 1990; Stiles, 2001) demonstrated that reconciliation could occur between troublesome internal voices (both those that criticise and are criticised) through the creation of a *meaning bridge*. Emphasising the significance of this intrapersonal relationship between inner voices, in their reformulation of the assimilation framework, Honos-Webb and Stiles (1998) linked problematic experiencing with these conflicted self-aspects, noting that therapy involves the assimilation of '*voices that determine behaviour and attitudes*' (p.25) of which the individual may be unaware. Bearing some similarities with the person-centred approach to psychological change (Rogers, 1951; 1957), the assimilation model meaning bridge facilitates connection and understanding, thus aiding resolution of the distortion and denial associated with Rogers' conditions of worth. Applying Stiles' assimilation framework of internal voices alongside Rogers' person-centred theories in their case study of a depressed client, Mosher et al. (2008) were able to identify the various voices of the client as being representative of aspects of their early conditioning. Encouraging active contact and dialogue between harsh inner voices and the experiencing aspects of self, Elliott et al.'s (2004) two-chair dialogue for conflict splits task aims to stimulate differentiation and specificity to support the resolution of dysfunctional processes.

In considering the destructiveness of self-criticism, Gendlin (1996, p.249) suggested that the '*characteristic manner'* by which these attacks are delivered, could be more injurious than the subject matter of the criticism. Similarly, when working with the inner critic, Elliott et al. (2004) recommend being mindful of both its content and mode of enactment. Emphasising the need to support individuals in becoming more aware of their self-attacking inner-critical voices, Firestone et al., (2013, p.30) advocated the importance of differentiation to help clearly identify these often '*unconscious or barely conscious*' attacks. Instead of perceiving the inner critic as a *bad*

guy that is criticising the *whole self*, Cornell (2005) viewed it as *something* within the person that is fearful and trying to protect another self-aspect, suggesting this better supports its compassionate transformation. Acknowledging the challenges faced in offering compassion to an attacker, Cornell's (2005) view supported the process of differentiation through encouraging separation and distinction of the various self-aspects to aid their identification and resolution. Similarly, Stinckens et al. (2013a) acknowledged emerging literature highlighting the importance of this process of distinction to more effectively aid psychotherapeutic change of self-critical and self-attacking patterns.

It has been suggested that the main pathway to transform self-critical processes is the movement towards a more flexible, coherent, and adaptive self-aspect, whereby self-compassion and acceptance replace harsh self-evaluation and judgment (Stinckens et al., 2013a; Gilbert & Irons, 2005; Neff, 2003). The EFT approach to therapeutic change aims to transform difficult emotions by facilitating their full experiencing and acceptance. This action of becoming focuses on moving through old stuck maladaptive emotions to access more adaptive and empowering emotional responses (Elliott et al., 2004; Greenberg, 2017; Elliott & Greenberg, 2021). Developing a person's emotional intelligence and literacy, as well as accessing their emotional experiencing, EFT supports emotional regulation and the movement towards more positive personal meanings and narratives (Greenberg, 2017). Arguing that painful emotions do not change by simply voicing them, or knowing where they stemmed from, Greenberg and colleagues (2015; Elliott et al., 2004) emphasised the need for full experiencing and acceptance that is nourished by the adaptive underpinnings of, for example, assertive anger or connecting sadness. Suggesting that appropriate expression of emotion is an important yet often untaught and complex ability, Greenberg (2015) highlighted the need for people to learn how to understand and sensibly act upon their innate bodily signals. Elliott et al. (2004) acknowledged the deep levels of emotional pain that underlie the critic's vulnerability, demanding the therapist's careful holding and gentle

navigation towards the uncovering of any unmet needs. Distinguishing between *introjective* and *anaclitic* psychopathologies, Blatt at al. (2001) suggested the importance of therapeutic interventions that consider these aspects of the client's personality. Whilst introjective individuals may be primarily concerned with a worthy sense of self, anaclitic patients tend to place greater importance on their interpersonal relationships. Blatt and colleagues argued that ignoring the clients' leaning towards either intrapersonal or interpersonal priorities, can greatly impact upon how they receive and respond to the therapy.

Other Theoretical Frameworks of Self, Experiencing and Negative Self-Treatment

Despite many iterations and critiques, Freud's (1917) introduction to psychoanalysis including his theory of the human condition and central hypotheses of inner-conflict, distortion, and denial, was hugely influential for contemporary theorists and their subsequent conceptual developments of the self-concept and self-criticism. Laying the groundwork for more modern scholarly explorations of dysfunctional self-processes, in his study of melancholia, he noted the '*lowering of the self-regarding feelings to a degree that finds utterance in self-reproaches and self-revilings, and culminates in a delusional expectation of punishment*' (p.244). Regardless of Freud's widely critiqued postulations on the impact of the unconscious mind, his psychosexual stages of development, or somewhat sexist assertions, it remains evident from recent research on negative treatment of self (Capaldi & Elliott, 2023), that much of his early insights into inner-conflict and self-criticism remain relevant today. In fact, it could be argued that the methodological approach of EFT is built upon and supports Freud's assertion that '*unexpressed emotions will never die, they are buried alive and will come forth later in uglier ways*'. Moving beyond the psychoanalytical approach, and building on the earlier exploration of humanistic-experiential perspectives, other prominent and well-supported models of psychotherapy that address theories of self and dysfunction include the psychodynamic approach, which evolved from Freud's theories, and Beck's

(1975) cognitive-behavioural therapy. Both of these models are further examined below.

Psychodynamic Approaches to Self and Experiencing

Freud's psychoanalytical approach was the original psychodynamic theory, yet contemporary developments based upon his ideas contain multiple elaborations from Jung (1912), Klein (1921), Adler (1927), A. Freud (1936), Erikson (1950), and others. Freud's original assumptions, which continue to underpin psychodynamic therapy today, were that human behaviour arises from unconscious processes that although often inaccessible, directly impact a person's thoughts, feelings, and actions. Centring on a trifold partnership between his conceptualisations of the Id, Ego, and Superego, Freud's personality theory highlighted the tensions respectively, between the more primitive and instinctive biological components, the mediating decision maker, and the learned societal morals, values, and judgments. Conflict and anxiety, which arise from the interactions between the conscious ego (potentially leading to distortion and defence mechanisms) and the unconscious id and superego, were understood to shape personality as it develops through various childhood developmental stages and events, with aspects of personality residing in either the conscious or unconscious mind. It is surmised that these latter out of awareness processes powerfully influence motives, feelings, and decisions, and are thought to be the underlying cause of psychological difficulties. Perhaps not too dissimilar to Rogers' (1951) theories of the actualizing tendency and conditions of worth, Freud's theory of personality is shaped by the innate drives of an individual as they strive to fulfil their needs. Although Freud primarily focused on sexual motivation and aggression, he also recognised the influence of external conflicts in shaping personality. Heavily critiqued by the humanistic-experiential approach, Freud's strongly deterministic conviction that all drives are motivated by unconscious childhood remnants, leaves little space for the consideration of a person's conscious free will or personal agency over their behaviour and decision making. Although often criticised as a subjective and unscientific approach to human

behaviour—stemming from Freud's clinical observations, case studies, and personal reflections, particularly due to the empirically untestable nature of the unconscious mind and tripartite personality—cognitive and social psychology have since provided evidence for the role of unconscious processes in behaviour, including procedural memory (Tulving, 1972), implicit processing (Greenwald & Banaji, 1995), and automatic processing (Bargh & Chartrand, 1999).

Centring on the mother and infant relationship, Klein's (1921) theory of the unconscious inspired the central concepts of object relation's theory (ORT), a variation of psychoanalysis that places greater emphasis on the consistency of interpersonal relations as opposed to biological based drives. Viewing human contact and the need to form relationships as a prime motivator in the development of personality, the term *object* in this instance refers to significant others (or aspects of them including mental representations) rather than an inanimate entity. Suggesting that people unwittingly propel needs, drives, and emotions that threaten the self-concept into the unconscious mind, ORT proposes that these continue to greatly influence the conscious awareness, and impact mental representations of self, others, and self in relation to others. Combining ORT with Piagetian cognitive-developmental theory (Piaget, 1969), Blatt's (1974; 1995; 2008) psychodynamic/cognitive developmental theory examined the ways in which mental representations or schemas cognitively develop, becoming more complex or abstract over time. Blatt proposed psychological development as a continuous life long process that happens between the two polarities of relatedness (anaclitic) and self-definition (introjective), with individuals leaning towards one or the other in varying compensatory degrees of tension. Underpinning Blatt's two-configuration concept in relation to depressive experiences is the assertion that personality development and functioning can be rooted in either attachment and relational issues including loss, or alternatively, problems with the ways in which a person defines or criticises their self. Exploring the impact of intense levels of perfectionism upon the treatment for depression and pointing to the need for more

extensive longer-term therapy, Blatt (1995) highlighted the ways in which self-criticism and problematic levels of perfectionism are engendered by harshly judgemental and punishing parents.

Cognitive Behavioural Approaches to Self and Experiencing

Similar to, and influenced by Ellis's (1962) concept of *self-statements*, Beck's (1963) cognitive therapy emerged out of his exploration and elucidation of *automatic thoughts*, which he later formulated into a theory of human psychopathology. Often observing these thought processes as situational misinterpretations or exaggerations, he noticed that cognitive distortions generally fitted with the person's expectations or diagnosis, and went on to explore these processes in a caseload of depressed clients. Beck observed improvements in his patients when they were able to consider the evidence or alternative explanations, examine their beliefs, and challenge their negative cognitions. Similar to Blatt's introjective and anaclitic polarities, Beck initially proposed the dimensions of autonomy and sociotropy as being associated with a person's vulnerability to depression. Describing excessive concern with independence and personal achievement (autonomy), and investment in interpersonal relationships and the need for approval from others (sociotropy), Beck later proposed a cognitive triad associated with depressive experiences involving '*self (I am a failure), world (everyone and everything is against me), and the future (I will never be able to succeed)*' (Shahar, 2015, p.46). Developing this theory into *modes* or *schemas*, Beck moved beyond this purely cognitive approach to cluster related experiencing to incorporate their motivational, behavioural, and affective processes (Beck, 1996). Creating a more unified theory, a transdiagnostic approach was taken in order to classify the idiosyncratic beliefs associated with various psychopathologies (e.g. anxiety, depression, anger, substance abuse, schizophrenia), and to create effective measurement tools to diagnose, and treatments to modify, the maladaptive cognitions associated with each condition.

Similar to Mearns and Thorne's (2007) ideas on *social mediation*, Bandura's (2001) social cognitive theory is underpinned by the personal agency that enables a person to exercise a level of control over their self and their life. Existing in relation to the constraints of social influence, and characterised by the features of *self-regulation* and *reciprocal determinism*, Bandura distinguished the triad of *direct personal agency*, *proxy agency* (indirect in the sense that it relies upon others to secure needs), and *collective agency* (involving social coordination and interdependence). Directly challenging Freud's deterministic ideas on unconscious motivation, and acknowledging individuals as both products and creators of the social systems of which they are part, Bandura's ideas on reciprocal determinism recognised that a person's thoughts, feelings, beliefs, and environment interact and influence their actions in any given situation. Providing a link to self-criticism and self-efficacy, Bandura (1991) posited that people create and mould their social environments via the mechanism of self-regulation. By identifying three key components—the monitoring of self and behaviour, evaluating oneself and behaviour against personal values and social circumstances, and the resulting emotional responses—he asserted that each plays a crucial role in exercising personal agency.

Adopting a cognitive-evolutionary perspective, Gilbert's (2000) stance on *social mentalities* delineates how evaluative processes, integral to social relating, serve as the foundation for the diverse inner conflicts that arise through their interplay. This encompasses the strategies individuals develop and the reciprocal effects these processes exert on each other. Illustrating the ways in which this *internal social conflict* or process of self-evaluation, can be likened to the types of external conflict experienced in relation to others, Gilbert proposed varying pairs of social signals (e.g. care giver-care receiver, friendly-hostile, dominant-subordinate) that directly impact a person's behavioural responses. Similar to Elliott and Greenberg's (2021) two-chair dialogue for conflict splits and compassionate self-soothing tasks, Gilbert suggested that these self-cognitions can be treated therapeutically as if they were social

cognitions, through their interaction and dialogue by way of '*activating the patient's own self-directed inner capacities for caring, compassion, and forgiveness*' (p.118). Supporting the notion of multiplicity in the self-concept, Gilbert et al. (2001) asserted that the mental mechanisms that cause a person to act in *threatened-subordinate* or *hostile-dominant* ways, play off each other internally so as to cause a self-attacking individual to defensively react to their self-to-self attacks in a subordinate way that seeks to guard against the threat.

Challenges to Conceptualising and Measuring the Self-Relationship

Considering issues around this concept of the self-relationship and its measurement, Byrne (1996) highlighted the widely acknowledged challenges relating to its definition, and the ways in which this directly impacts subsequent psychometric measurement. She noted a number of conceptual difficulties including ambiguity between terms such as self-esteem, self-efficacy, and self-concept, similarity or overlap between terms, and a general lack of agreement or universal definition. Citing Hattie's (1992) distinction between self-esteem and self-concept, it was proposed that self-esteem is similar to terms such as self-worth, self-respect, self-regard, and self-acceptance; and self-concept similar to self, self-identity, self-awareness, and self-image. Suggesting that the self-concept more broadly involves aspects of cognition, affect, and behaviour, Byrne (1996) posited that self-esteem on the other hand reflects a narrower component that is encapsulated within a person's overall concept of their self. Acknowledging the importance of the self-concept in understanding human behaviour, Burns and Dobson (1984) distinguished between the two components of self-image or the way a person views their self (involving the beliefs formed as a result of lived experiencing which includes feedback from others), and self-esteem or the value judgements a person holds in relation to aspects of their self-image (connecting to attitudes and often involving societal evaluations and expectations). In their study of the role of self-efficacy and self-concept beliefs in problem solving, Pajares and

Miller (1994, p.194) differentiated these terms noting that self-concept tends to lack specificity, being a more global term that incorporates aspects of self-worth in relation to one's perceived competence, whilst self-efficacy '*is a context-specific assessment of competence to perform a specific task*'. Furthermore, in their exploration of the role *frame of reference* plays in self-efficacy and self-concept response modes, it was noted by Marsh et al. (1991) that those relating to self-concept were more likely to be confounded by external factors relating to the ways in which a person compares themselves to others.

Originally thought to be unidimensional by nature, contemporary researchers have since demonstrated the multifaceted construct of the self-concept (Byrne, 1996; Hattie, 1992). Highlighting multiple theoretical models of self, Byrne (1996) outlined the ways in which the generalised unitary nomothetic model has been heavily critiqued in favour of a concept of self that recognises its multidimensional structure. Differentiating between a nomothetic construct and a truly unidimensional design, she pointed to Rosenberg's (1965) Self-Esteem Scale in which he opted to focus on the measurement of this one particular aspect of self as it relates to overall or global self-esteem. While one might argue that this points more generally to a person's self-concept, it takes no account of the impact of other dimensions of the construct. Recognising that multiple aspects of self form as a result of a person's lived experiencing, including their abilities and interactions with others, Soares and Soares (1980) reported that these multiple facets of self are weakly correlated and largely independent. Contrasting this independent-factor structure, the correlated-factor model supports the view that '*multiple domain-specific self-concepts*' (Byrne, 1996, p.16) can demonstrate varying levels of correlation under the banner of global self-concept. Suggesting that within this overall self-concept we find a multitude of positively or negatively correlated bipolar constructs, Marx and Winnie (1980) proposed a compensatory model that accounts for the ways in which a person seeks to create a sense of balance within their self-structure between their high and low ranking

self-perceptions. Further considering issues of ranking, Byrne (1996, p.22) offered an exploration of Shavelson et al.'s (1976) hierarchical model whereby the self-concept is considered '*a multidimensional and hierarchically ordered structure*', incorporating both a person's general self-perceptions and their actual behaviours within an increasingly differentiated framework. Citing the Shavelson hypothesis as an extensively validated self-concept model, Byrne clarified their position on self-multidimensionality, holding that although the various facets of self-concept may be inter-correlated, they can also be considered as separate constructs. Additionally, their suggestion of hierarchy predicates that the strength of the correlation between the various facets of self varies in a systematic or methodological pattern. Considering these multiple theories of self, of which there exist many others, it is perhaps unsurprising that the result is a level of complexity within its overall structure that can be challenging to effectively capture due to its myriad of possible domains, facets, and levels. Furthermore, as set out by Byrne (1996), these difficulties are often further compounded by methodological and psychometric issues relating to the reliability and validity of instruments, the absence of normative comparative sampling and consideration of cultural or developmental differences, as well as widely acknowledged self-report biases.

Rationale for the Effective Measurement and Categorisation of the Self-Relationship

Promoted as an all important and principal focus in psychological and psychotherapeutic research and practice, the search for self awareness and knowledge in relation to a person's lived experiencing is underpinned by the question *who am I?* Related to self-identity, this perennial search encompasses experiences, relationships, memories, beliefs, thoughts, feelings, and values. Impacting a person's life and the choices they make, these identities are so often the result of internalised values of parents and significant others, which may be out of alignment with the person's authentic sense of their self. Creating the disharmony that drives people to therapy,

these inauthentic identities are the source of significant psychological pain and emotional distress that can result in various psychopathologies. This, according to Burns and Dobson (1984, p.473), provides a robust rationale for the continued exploration of the self-concept '*due to its primacy, centrality, continuity and ubiquity in all aspects of behaviour*'.

Although much has been achieved to date in the development of self-concept measurement and conceptualisation, Byrne (1996) reiterated a number of weaknesses relating to the methodological strategies applied, the absence of testing and instrumentation across different populations, and inadequate considerations of cross-cultural differences. In their Positive Self-Relation Scale (PSRS), which contains the facets of authenticity and assertiveness, self-confidence, self-acceptance, and fulfilled experience, Ociskova et al. (2019) aimed to develop a brief measure of the self-relationship for ease of use in clinical practice and research. Suggesting that the developing self-relationship comprises these four basic constructs involving the person's *ability* to treat self with care and acceptance, experience self as competent, to fully live their present life, and to do this in an autonomous and authentic way, they point to the importance of a universal scale that offers wide applicability for the measurement of this universal concept. Providing a psychometrically sound measure, one might contend that the constructs encapsulated within it tend to skew towards assessing self-efficacy concerning an individual's competence or ability to execute intended tasks. Consider, for instance, the authenticity and assertiveness subscale, which centres on a person's *ability* to embody their authentic self. Moreover, akin to self-efficacy, the self-confidence scale incorporates items such as *'I have enough skills to accomplish what I want'* and '*when I meet an obstacle, I quickly give up'*.

Conceptually differing from Ociskova et al.'s (2019) PSRS, yet also containing four varying subtypes of self-relating, the Self-Relationship Questionnaire (SRQ; Faur & Elliott, 2007) offers exploration of self-to-self relating within the domains of self-affiliation, self-attack, self-control, and self-neglect. Appearing on the surface as

theoretically disparate constructs, and highlighting the subjective use of language in the ways in which definitions are formed, it is interesting to note that PSRS self-acceptance reflects similarities with those of the SRQ self-attack and self-affiliation domains. Another instrument that measures a person's beliefs about their self and the ways in which they expect others to evaluate them is the Beck Self-Esteem Scale (BSE; Beck et al., 2001). Assessing a more cognitive element of the self-concept as core beliefs, this instrument differentiates between the overarching domains of self and other, by utilising multiple pairs of adjectives such as *lovable-unlovable*, *attractive-unattractive*, *worthwhile-worthless*, and *good-bad*. Again, regardless of structure, this instrument appears to incorporate the recognisable elements self-affiliation and self-attack, however it becomes notable that these other measures of the self-concept appear to focus less on the harmful constructs of self-control and its much over-looked counterpart, self-neglect. Similarly, Neff's (2003) Self-Compassion Scale (SCS), which aims to counteract harmful self-attitudes through promoting self-compassion, demonstrated discrimination between self-esteem and self-compassion by pointing to an accepting recognition of shortcomings rather than any esteemed adoption of inflated views of oneself. Regardless of the apparent similarities and differences between these and other measures, their findings evidence that improvement in a person's relationship with their self is synonymous with better results in therapy, supporting mental health and life satisfaction (Neff, 2003). Further dissecting the complexities of the self-relationship to enhance its understanding, description, and measurement would not only support the individual's developing self-awareness but also enable therapists to more effectively facilitate positive therapeutic outcomes.

Chapter Summary

To conclude this chapter, I began with an overview of the humanistic-experiential perspectives on the developing self, experiencing, and negative self-treatment, including an exploration of emerging difficulties in the self-relationship, and

processes involved in working with and resolving these conflicted self-aspects. Although particular focus was given to the person-centred, emotion-focused, and dialectical constructivist theories of human experiencing and psychopathology, I also provided an exploration of two other contemporary research-informed theoretical frameworks including related developments, namely the psychodynamic and cognitive-behavioural approaches to self and experiencing. The challenges faced in the effective conceptualisation and measurement of the self-relationship were outlined together with the rationale for further concerted efforts to successfully capture the quantification and categorisation of self-relating.

Chapter 3: Psychometric Evaluation and Validation of the Self-Relationship Questionnaire for Clinical Assessment

Introduction

To further investigate the validity and reliability of the SRQ, and to assess whether its content or underlying theoretical constructs require refinement, additional testing is necessary. In order to evaluate how robustly the SRQ assesses the constructs that it was designed to measure, and its stability over time, data from a nonclinical population was gathered at two data points for analysis and comparison. Alongside a battery of other measures, 150 participants completed the online administration of the SRQ, and were invited to complete another questionnaire following a two-week delay to evidence the instrument's test-retest reliability (n=42). The dimensions of the SRQ were compared to those of other similar validated psychometric instruments. Referring to the degree to which two scales that theoretically should be related are in fact related, convergent (correlation with other similar constructs) and discriminant (zero correlation with dissimilar constructs) validity tests were conducted against a variety of other self-report measures comparing participant responses to similar and dissimilar intrapersonal variables. Utilising an archival SRQ clinical sample (n=281-290), comparison was made with the nonclinical test scores to calculate the reliable change and clinical cut-off indices of the instrument. Finally the nonclinical and clinical datasets were subjected to exploratory factor analyses (EFA), to further investigate the dimensionality and internal structure of the instrument.

Literature Review and Rationale for Developing a Robust Measure of the Self-Relationship

Influenced by theories of self and emotional processing, my approach to psychotherapy is grounded in the humanistic-experiential traditions, which include both emotion-focused therapy (EFT; Elliott et al., 2004; Greenberg et al., 1994; Greenberg et al., 1998) and the person-centred approach (PCA; Rogers, 1951; 1959).

Concerned with the range of human emotion and experiencing (Elliott et al., 2004; Elliott & Greenberg, 2021), the concept and process of the self-relationship is a key tenet of humanistic-experiential therapy. The self-relationship describes and enacts how we think, feel and behave towards ourselves (Capaldi & Elliott, 2023). Referring to the attitudes and beliefs that a person holds in relation to their self, the self-relationship is an evolving, and therefore somewhat difficult to measure aspect of human experiencing. Integrating a person-centred framework (Rogers, 1951; 1959) with elements of focusing (Gendlin, 1981; 1986) and gestalt therapy (Perls et al., 1951), EFT creates a dialogue between aspects of self, describing the 'I' as *'an agent self-aspect or self-narrating voice that constructs a coherent story of the self by integrating different aspects of experience in a given situation*' (Elliott, 2012, p.113). Expressed in the form of *conflict splits* and theoretically central to the development and practice of EFT (Greenberg et al., 2003), difficulties in the self-relationship are understood to generate distress and emotional pain, as a result of self-attacking and inner-critical processes.

Since the earliest developments in humanistic-experiential psychotherapy, therapeutic personality change has depended on a person developing a healthier, more positive style of self-relating (Rogers, 1959; 1961; Perls, 1969). Highlighting the importance of *unconditional positive self-regard* (Rogers, 1959), or the degree to which a person accepts their self, research has demonstrated high correlations with intrinsic aspiration and authenticity, positively impacting overall psychological well-being (Murphy et al., 2017). Through his own practice and research, Rogers (1961) identified seven stages of process outlining marked phases that clients or individuals might experience when progressing through self-change. Ranging from initial defensiveness, remoteness from experiencing, and resistance to change, Rogers' ideas on the *fully functioning* individual reflected a more fluid, self-directing, self-trusting, and self-accepting person who is open to experiencing, with '*internal communication between various aspects of himself… free and unblocked*' (p.154). Similarly, Elliott et al. (2004)

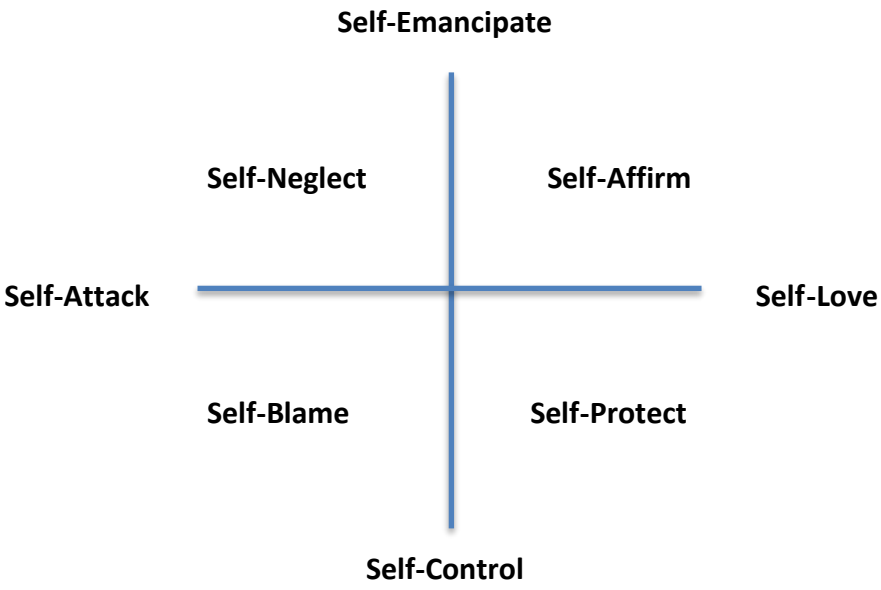
highlighted that conflict splits within the self-structure arise from blocked or conflicted aspects of the self and experiencing, where one part of the self negatively impacts another. The goal of their two-chair dialogue task for addressing conflict splits is to help the client resolve inner conflict and move toward a more adaptive and integrated sense of wholeness.

Also known as the inner critic (Gendlin, 1981; 1986), this hostile and disapproving self-treatment is associated with social anxiety (Elliott et al., 2013), an increased risk of depression (Greenberg et al., 1990), and is central to other types of anxiety, substance misuse, and compulsive behavioural difficulties. Greenberg et al. (1990) highlighted the connection between perfectionism and blocked emotional processing, which often masks intense feelings of self-disgust and hostility, particularly in cases of clinical depression. Similarly, Ehret et al. (2015) found that depressed patients exhibit low self-compassion and high self-criticism compared to healthy individuals. Connecting self-criticism to perfectionism and personal effectiveness (Whelton et al., 2007; Shahar, 2015), Powers et al. (2011) emphasised its impact on personal goal achievement. Investigating how problematic levels of perfectionism affect treatment for depression, Blatt (1995) posited that punishingly judgemental parents foster intense self-criticism and perfectionism.

The Structural Analysis of Social Behaviour (SASB; Benjamin, 1974; 1994; 1996) framework is a '*three-surface circumplex model built on two axes*', whereby each domain (assigning differing labels to each pole of each surface) reflects a horizontal axis from hate to love and a vertical axis from aspects of enmeshment to differentiation (Benjamin, 1994, p.278). A model of interpersonal and intrapsychic interactions that can be used to assess the specific ways in which a person interacts with self and others, each of the three surfaces places attention respectively on interpersonal focus on others, interpersonal focus in relation to self-reactions, and intrapsychic self-to-self focus. The model dissects these personal and social interactions into these three distinct underlying dimensions. The two interpersonal surfaces of the model describe

social interactions in terms of attentional focus, i.e. focus on other (this is about you), or focus on self in relation to other (this is about what I do in relation to you). The third type of focus, the intrapsychic surface (see Figure 1), describes intrapersonal behaviour in terms of what the self does to itself, understood to be a reflection of what others have done to me (I treat myself as others have treated me). For example, a child whose needs have been consistently neglected by significant others, will internalise this pattern as self-neglect (I neglect my needs), just as one who received nurturing and protection will experience an internalised sense of self-care and security (my needs are recognised and met, I feel safe). The intrapsychic surface of the SASB model is most relevant to this investigation into the self-relationship, its four quadrants reflecting aspects of self-relating ranging from self-hate to self-love on the horizontal axis, and self-emancipation (letting go of the self) to self-control on the vertical axis.

Figure 1: Benjamin's SASB Introject Model



Developed in parallel with, and central to EFT theory, the Intrex-introject Scale of the SASB (SASB-IS, Benjamin, 1995) is a well-validated and useful model of

intrapersonal processes (Benjamin, 1994; 1995; 1996; Critchfield & Benjamin, 2010; Monsen et al., 2007) from which the SRQ was created. While the SASB-IS has been successfully utilised in numerous research studies to measure individual self-to-self attitudes—such as Stinckens et al. (2002) investigating clients' experiences and the inner critic's change process in therapy—the introject surface and the SASB model as a whole have been criticised for being overly complex and lacking simplicity (Erickson & Pincus, 2005). In fact, Benjamin (1996) acknowledged that '*the SASB approach requires substantial effort for mastery*' (p.255). In their application of the SASB to explore the interpersonal meanings of anxiety symptoms, Erickson and Pincus (2005) demonstrated that the introject scale was sensitive to differences between anxious and nonclinical participants' self-perceptions. They found that those with anxiety difficulties reported less self-affirmation, emancipation, love, and protection, and greater self-attack, neglect, control, and blame. Validating the SASB introject surface, Monsen et al. (2007) found reasonably good construct validity in a clinical sample but less favourable results for the nonclinical group. While acceptable reliability and test-retest correlations were reported for most of the introject clusters, low internal consistency was found for the self-emancipate, self-protect, and self-neglect scales. Despite these small deviations from the ideal, Monsen and colleagues concluded that the implications for using the instrument to measure self-relatedness were minimal, supporting the validity of this measure of self-to-self relating.

Due to the relative complexity of the SASB model, its hypothesised structure, and convoluted language and scoring system, Faur and Elliott (2007) developed the SRQ as a simplified alternative, establishing a shorter, user-friendlier approach to measuring the self-relationship. Using unambiguous language and a simple method of scoring, the SRQ retained a slight variation of the four distinct SASB domains of self-treatment. Whilst Benjamin's (1996) model reflected the opposing axis of self-control as self-emancipation, the SRQ captured this fourth domain as self-neglect, which the SASB places within the quadrant that lies between self-attack and self-emancipation.

Thus, a four-factor solution closely corresponding to the four poles of the SASB model was identified as the basis of the SRQ, namely self-attack, self-management or control, self-neglect, and self-affiliation. Identifying internal reliability issues within the SASB instrument, Rasch analysis conducted by Faur et al. (2007) clarified the framework's complexity by concluding that the 11-point Likert scale of the SASB exceeded users' ability to discriminate effectively. This led to the development of the SRQ, which utilises a simplified 4-point scale.

As evidenced by Elliott et al. (2013) in their research on humanistic-experiential psychotherapies, many therapy outcome studies that utilised self-report measures have demonstrated the effectiveness of EFT. For example, Stinckens et al. (2002) employed the Self-Attitude Scale, amongst other tools, in a case study that demonstrated a statistically significant increase in the client's self-emancipation endorsements, accompanied by a corresponding decrease in self-control levels. Presenting the possibility of measuring session-to-session changes in an individual's self-relating, the SRQ offers potentially valuable information on the client's self-to-self processes. Paying closer attention to a client's self-appraisal alongside their moment-to-moment therapeutic process may provide deeper insight into the inner critic and its dysfunctional patterns, thereby enhancing therapy outcomes.

Central to the success of EFT is the two-chair dialogue for conflict splits task resolution model (Elliott & Greenberg, 2021), whereby aspects of self that are considered to be in conflict (rather than working in harmony) may be identified, brought into lively contact, and processed, working towards a resolution (Greenberg, 1984). Derived from Gestalt therapy (Perls, 1969) and based upon Moreno's (1946; 1993) psychodrama experiment, this task aims to uncover and explore internal conflict, evoke primary feelings, and negotiate a resolution that fosters a more harmonious integration of the conflicted self-aspects (Elliott & Greenberg, 2021). The development of the two-chair task has evolved over the past four decades in response to research and practice, to identify and resolve conflicts that emerge when an aspect of self

attacks, criticises, coerces, interrupts, or blocks the full expression of a more adaptive aspect of self-experiencing. Encouraging a dialogue between these conflicted self-aspects, EFT uses the two-chair task to guide clients toward more adaptive emotion schemes and experiences (Elliott et al., 2004).

Identifying conflicted self-processes is facilitated by therapy *task markers* (Elliott et al., 2004), while the SRQ self-report measure may serve as a valuable tool for anticipating such conflicts before they manifest in the counselling room. Moreover, tracking changes in the SRQ throughout sessions offers insightful client feedback on their perceived progress (Faur et al., 2007). Thus, for a comprehensive understanding of an individual and their challenges, as well as to accurately gauge their therapeutic progress, a dependable assessment of their self-relating is indispensable. Recognising how individuals harshly criticise and attack themselves versus how they nurture self-compassion, and understanding their tendencies to neglect or exert control over their experiences, becomes crucial in facilitating the adoption of a more positive self-relationship and way of being.

The Four Hypothesized Factors of the SRQ

Posited to encompass four distinct domains of self-treatment, the SRQ's four-factor model—self-attack, self-control, self-neglect, and self-affiliation—and their therapeutic implications are further explored below:

Self-Attack. Clients presenting with social anxiety difficulties commonly struggle with a hostile inner critic, a strict inner normative voice that hinders them and their development (Stinckens et al., 2002). Persistently emphasising a sense of inadequacy and worthlessness (Elliott & Shahar, 2017), this harshly disapproving and judgemental self-attitude of the individual is examined within the self-attack domain of the SRQ with statements such as: '*I harshly reject myself as worthless*' and '*I criticise myself harshly when I don't do something perfectly*' (see Table 1).

The bidirectional causal link between maladaptive perfectionism/self-criticism and depression is well evidenced, with researchers such as Ferrari et al. (2018) exploring the impact of self-compassion as a route to altering a person's relationship to their difficult thoughts, as opposed to the traditional approach of directly trying to alter patterns of negative thinking. Highlighting a correlation between increased self-compassion and a reduction in the strength of the relationship between maladaptive perfectionism and depression, it was anticipated that there would be some overlap between the measures of self-attack and depression. Linking high levels of self-criticism, emotional avoidance, and processing difficulties as core psychopathological issues in social anxiety, Shahar (2020) asserted that maladaptive emotions are more efficiently transformed by activating more adaptive emotional responses rather than through reasoning alone. Connecting the characteristic social problems associated with social anxiety to an increased risk of substance abuse, depression, and suicide, Shahar's findings support the expectation of overlap between self-attacking and depressive dimensions of the self-relationship.

In their Depressive Experiences Questionnaire (DEQ), Blatt et al. (1976) classified vulnerability to depression in two distinct ways: self-critical or perfectionistic depression, and dependency or anaclitic depression, characterised by helplessness, a need for protection from others, and a fear of abandonment or loss (Zuroff et al., 1983). Similar to self-attack, the self-criticism scale of the DEQ captures feelings of inferiority and guilt, along with the anticipation of not being liked by others or failing to meet their expectations. This is reflected in statements such as '*I tend to be very critical of myself*' and '*if I fail to live up to expectations, I feel unworthy*' (Blatt et al., 1995, p.324-325).

Table 1: SRQ Self-Attack Items (n=7)

SRQ13	I don't feel that I deserve anything good to happen to me
SRQ16	I harshly reject myself as worthless
SRQ18	I have physically hurt myself when I felt I deserved it

SRQ19	I have thought of hurting myself, although I haven't done it
SRQ20	I hurt myself by overburdening myself with work
SRQ30	I take my anger out on myself
SRQ31	I think of ways to punish myself

In addition to self-attack, earlier research by Capaldi and Elliott (2023) identified various manifestations of NTS, revealing numerous client process indicators that highlighted the hostile aspects of self-control, self-neglect, and self-affiliation. In light of their findings, these other treatments of self as measured by the SRQ, are presented below and incorporated into the subsequent studies of this thesis.

Self-Control. Clients presenting with social anxiety often exert significant effort to manage themselves and their emotions during social interactions to avoid negative judgements from others. Underpinned by experiences of early social degradation, and driven by a hypercritical '*shame-ridden defective self*', these individuals develop a controlling hypervigilance aimed at protecting against further debasement (Elliott & Shahar, 2017, p.145). These monitoring, restraining, and coercive self-aspects create and exacerbate emotional dysregulation, intending to protect and guard against exposure to others' appraisals and judgments. Examined within the SRQ self-control domain in statements such as '*I carefully monitor my behaviour*' and '*my goal is to be as perfect as possible*' (see Table 2), similarities can be drawn with the HEXACO-PI-R (Ashton & Lee, 2009) conscientiousness domain, which reflects organisation, diligence, perfectionism, and prudence. Conscientiousness, referring to a striving for perfection and discipline when undertaking tasks or achieving results, along with careful decision-making and organisation of personal time and space, is captured in statements such as '*I plan ahead and organise things, to avoid scrambling at the last minute*' and '*I often push myself very hard when trying to achieve a goal*'. While conscientiousness can often be adaptive, it also has the potential to become excessively rigid, distressing, or maladaptive—a form of self-control that might be more accurately termed hostile-control, which better reflects NTS yet remains measurable within this SRQ domain.

Table 2: SRQ Self-Control Items (n=10)

SRQ07	I carefully monitor my behaviour
SRQ10	I criticize myself harshly when I don't do something perfectly
SRQ21	I keep an eye on myself to be sure I am doing what I should
SRQ22	I keep tight control over myself
SRQ27	I put a great deal of energy into making sure I follow the rules properly
SRQ28	I put a lot of effort into everything that I do
SRQ33	I try very hard to become like an ideal image of myself
SRQ34	I try very hard to make sure my work is done on time
SRQ35	I watch myself closely to make sure I don't do the wrong thing
SRQ36	My goal is to be as perfect as possible

Self-Neglect. Although clients are unlikely to consciously seek therapy for self-neglect due to the nature of the construct, Lauder, Davidson et al. (2005) suggested that this issue is far more common than recognised and benefits from a multidisciplinary approach. Additionally, Lauder et al. (2005) emphasised the need for preventative measures and highlighted the prevalence and regularity of self-neglect in the elderly population, distinguishing it from instances of elder abuse or neglect. From a mental-health nursing perspective, often focused on concerns about physical impairment, Lauder et al. (2005) described self-neglect as involving an unhygienic and verminous living environment, with individuals exhibiting often bizarre and disorganised behaviours.

Whilst there is little psychotherapeutic research on self-neglect, attempting to measure this overlooked construct has the potential to bring awareness to these silenced self-aspects. The SRQ self-neglect domain addresses both obvious and subtle aspects of this phenomenon, and similarities can be drawn to Lauder et al.'s (2005) descriptions. This is reflected in statements such as '*I don't attend to the condition of my personal environment*' and '*I have no internal direction or goals*' (see Table 3).

Table 3: SRQ Self-Neglect Items (n=9)

SRQ05	I avoid paying attention to important things

SRQ06	I believe that whatever happens, happens, so it's better not to try
SRQ11	I don't attend to the condition of my personal environment
SRQ12	I don't check up on things to make sure they're done correctly
SRQ14	I don't spend much time planning for the future
SRQ15	I don't try to develop good habits or skills
SRQ17	I have no internal direction or goals
SRQ23	I let my needs go unattended
SRQ26	I only live for the moment

Self-Affiliation. Pointing to an inverse relationship with self-attack, the construct of self-affiliation is examined through SRQ statements such as '*even though I know I have some faults I am happy with myself as I am*' and '*I comfort myself when I am sad or hurt*' (see Table 4). This construct involves holding a compassionate and accepting attitude towards oneself, whilst actively caring for parts that may be experiencing vulnerability and pain, particularly those aspects that are more difficult to endorse (Neff, 2003). According to Neff (2016), self-compassion can be defined as the balance between uncompassionate (judgemental) and compassionate (kind) responses to oneself in the face of difficulty, how one makes sense of the experience (negatively isolating or positively recognising it as part of the human experience), and how one attends to their suffering (in an over-identified or mindful way). Reflecting similarities between the constructs of self-compassion and self-affiliation, statements such as '*I'm kind to myself when I'm experiencing suffering*' and '*when I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people*', highlight the importance of maintaining a healthy, adaptive relationship with oneself. Key themes include self-kindness, self-care, and self-acceptance. In their 2007 study, Neff et al. found negative correlations between self-compassion and anxiety, depression, and self-criticism, and positive associations with functioning and subjective well-being.

Although positive self-relating might seem synonymous with high self-esteem, Neff (2003) distinguished self-compassion from self-esteem by noting that self-esteem

often relies on a comparative appraisal of oneself relative to others. Neff (2011) acknowledged potential issues with high levels of self-esteem, such as the creation of elevated and unrealistic views of oneself, leading to tendencies towards superiority and aloofness. In contrast, the constructs of self-affiliation and self-compassion can exist independently, away from the judgemental comparisons inherent in self-esteem, thus providing better insight into a person's self-experience. This comparative process is reflected in Rosenberg's (1965) Self-Esteem Scale with statements such as '*I feel that I'm a person of worth, at least on an equal plane with others*' and '*I am able to do things as well as most other people*'. Whilst differences exist between these affiliative *self-to-self* and esteemed *self-in-relation-to-others* constructs, it was anticipated that this investigation would demonstrate some overlap between these somewhat similar and often confused concepts.

Table 4: SRQ Self-Affiliation Items (n=10)

SRQ01	Even though I know I have some faults I am happy with myself as I am
SRQ02	I am comfortable with listening to my innermost feelings
SRQ03	I am content with myself
SRQ04	I appreciate myself for just being me
SRQ08	I comfort myself when I am sad or hurt
SRQ09	I confidently allow myself to do what feels right
SRQ24	I like myself very much
SRQ25	I look after my own best interests
SRQ29	I respect myself deeply
SRQ32	I treat myself with love

Aims and Questions Guiding this Study

The aim of this study was to test the validity and reliability of the SRQ. This involved assessing the instrument's convergent and discriminant construct validity, as well as evaluating its internal consistency, test-retest reliability, and dimensionality. The following general questions guided this investigation:

a. Is the Self-Relationship Questionnaire (SRQ; Faur & Elliott, 2007) a reliable and valid measure of an individual's self-relationship, especially regarding self-attack?
b. Does the four-factor model accurately describe the different aspects of the self-relationship in the SRQ, or can the number of factors be reduced?
c. What is the test-retest reliability coefficient of the SRQ?
d. What are the Reliable Change Index (RCI) and clinical cut-off values for the SRQ?

Method

Philosophical Summary of Study 1

Following the analytical approach delineated in Chapter 1 (Philosophical Position of Study 1), this research embraced a critical realist standpoint while amalgamating diverse epistemological perspectives, thus positioning itself within a methodologically pluralistic framework. It acknowledged the dynamic nature of self-relating, emphasising the continual evolution of individuals' relationships with themselves. Utilising a phenomenological approach, the study collected quantitative data through self-report methods. Its principal aim was to validate the self-relationship questionnaire by leveraging correspondence, coherence, and pragmatist theories to evaluate its reliability, validity, and practical applicability in both research and clinical contexts. The incorporation of multiple truth criteria was deemed imperative to bolster the solidity of the research outcomes.

Ethical Considerations

The Counselling Unit's Social Anxiety research project, previously approved by the NHS Ethics and University of Strathclyde's Research Ethics Committee, was a comparative effectiveness study of PCT and EFT for clients with social anxiety. As a subsidiary to this program, the present study received additional approval from the School of Psychological Sciences and Health's Research Ethics Committee (see

Appendix A). The research was conducted in accordance with the Ethical Framework of the British Association for Counselling and Psychotherapy (BACP, 2018) and the Data Protection Act (2018). A comprehensive Risk Assessment was completed, and all participants received a Privacy Notice/GDPR Policy, Participant Information Sheet, and relevant Consent Form (see Appendix B).

This study incorporated a newly collected nonclinical digital sample of the SRQ along with archival SRQ clinical data from the EFT arm of the original effectiveness study. This inclusion was particularly relevant as the clinical protocol utilised the SRQ to measure changes in self-relating among individuals undergoing EFT-SA. For the online nonclinical dataset, potential participants were required to read the Participant Information Sheet, which outlined the study details, and to provide demographic information and informed consent before accessing the survey. Although participant consent was obtained digitally, a downloadable copy of the consent form was available for their records. Participants were informed that their responses to the questionnaires were non-diagnostic and that all data collected, processed, and stored in this study would be anonymised to ensure confidentiality.

Participants were informed of their option to withdraw from the study at any point and were supplied with contact details in case of questions or distress during the completion of the self-report measures. Given the potential for discomfort while answering the questionnaires, all participants were provided with signposting information in the unlikely event they needed access to psychological support. Consistent with the General Data Protection Regulations (GDPR), assurance was provided that any surplus data would be securely disposed of after the completion of analyses, thesis write-up, related articles, and the PhD evaluation process.

For the archival EFT clinical dataset, a two-stage screening process was employed to evaluate client-presenting difficulties, assess inclusion/exclusion criteria, and provide research details. After an initial telephone assessment, a trained researcher conducted further screening using a modified version of the Structured

Clinical Interview for DSM-IV-TR Axis I Disorders (SCID-I; First et al., 2007). Individuals meeting the clinical threshold for SA were invited to participate in the EFT-SA study and were assigned an EFT therapist. Those not meeting the SA criteria were offered an alternative PCT research protocol not focused on SA. Stringent procedures for informed consent were adhered to in order to ensure the use of anonymised client data in accordance with specified limitations. Prospective participants were provided with the Participant Information Sheet, Consent, and Release of Recordings forms (see Appendices B and C) during screening, which were reviewed and discussed. Upon agreeing to participate, they were requested to complete and return these forms to their counsellor at the initial session.

Participants

Nonclinical Researchers. The nonclinical research protocol was conducted by a team comprising one tutor and five postgraduate MSc Counselling & Psychotherapy students. The tutor contributed over 16 years of experience across diverse clinical settings and possessed advanced professional training in EFT. The students involved were novice to EFT, having just commenced their counselling training and placement, with no prior exposure or experience in this modality.

Clinical Researchers. The EFT-SA protocol involved several practitioner-researchers, predominantly qualified psychotherapists who had completed at least EFT Level 2 post-graduate training (one researcher held training as a Gestalt psychotherapist). The research team comprised students, staff, and volunteers affiliated with the Strathclyde Counselling & Psychotherapy Research Clinic.

Nonclinical Participants. Researchers recruited respondents through personal and professional contacts and various social media networks. Participants were invited to participate in an online survey, with eligibility criteria stipulating that they were not currently in therapy or considering themselves in need of therapy.

Out of the 371 respondents initially engaged, 127 did not meet the eligibility criteria, resulting in 244 potential participants. Additionally, 94 respondents who opted

out mid-questionnaire were excluded from the analysis, leaving a complete dataset of 150 participants. This final sample consisted of 103 people identifying as female (68.7%) and 47 as male (31.3%), and the age range was 18 to 70, with a mean age of 43.5 (sd: 14). Most participants were from the UK (N= 126), with 10 from Greece, 3 from the USA, 2 from France, and 9 from other countries including Cyprus, Switzerland, New Zealand, Germany, Ukraine, Latvia, and Lithuania. The default setting on the digital questionnaire was 'resident of UK', so it is possible that some participants did not amend this auto-filled response if it was inaccurate.

From this initial sample, 42 participants proceeded to the second test/retest phase. Following a two-week delay, of an initial 63 respondents who moved onto the retest stage, 21 were deemed ineligible due to therapy involvement, incomplete questionnaire responses, or failure to provide a unique reference code that could be matched to their first survey. This left 42 participants for the second phase, comprising 33 people who identified as female (78.6%) and 9 as male (21.4%), with a mean age of 47.1 (sd: 15). The majority of this sample were residents of the UK (N= 36), with the remainder residing in other EU countries.

While test-retest analysis is valuable for assessing stable psychological constructs (Furr, 2018), challenges can arise when examining the self-relationship with a smaller retest sample size. Despite these challenges, proceeding with the retest analysis was justified. Even with diminished statistical power, smaller samples can still yield valuable insights by providing meaningful and informative effect sizes (Cohen, 1988). In longitudinal studies, participant attrition often leads to smaller sample sizes over time. However, retaining participants for retest analysis enables the examination of within-subject stability and change, which is crucial for understanding developmental trajectories and individual differences (Biesanz et al., 2004).

Clinical Participants. Researchers recruited participants via personal and professional networks and university notices. They were offered between 4 and 20 sessions of EFT or PCT without charge, with the option to continue beyond 20 sessions

on a sliding fee basis. Participants were required to be 18 years or older, and interested in receiving counselling. They also needed to agree to participate in research procedures, including interviews, questionnaires, and video/audio recordings. Applicants were excluded if they were currently receiving counselling or psychotherapy elsewhere, experiencing severe substance abuse, active and severe psychosis, acute and serious suicidality (active plans or intent), or were in an acute domestic abuse situation.

Out of 115 EFT-SA participants and 488 potential SRQ data collection points (including pre-therapy, mid-therapy, post-therapy, 6-month follow-up, and 18-month follow-up), a total of 281-290 complete SRQ clinical administrations were included in this study. This range reflects the exclusion of 198-207 data points due to missing variables. This final sample consisted of 57 people who identified as female (49%), 49 as male (43%), and 9 as unspecified (8%), with an age range of 18 to 59 and a mean age of 34.4 (sd: 11). All respondents were residents of the UK.

Measures

Inclusion of Comparative Self-Report Instruments. Below is an overview of the assortment of self-report measurement tools selected for comparison with the SRQ. This includes their overall descriptions, an outline of the factors they aim to measure, their scoring systems, and the justification and hypotheses for their inclusion in this study:

1) Self-Relationship Questionnaire (Faur & Elliott, 2007)
2) CORE-OM (Evans et al., 2000)
3) Self-Compassion Scale (Neff, 2003)
4) Social Desirability Scale (Crowne & Marlowe, 1960)
5) Rosenberg Self-Esteem Scale (Rosenberg, 1965)
6) HEXACO-PI-R (Ashton & Lee, 2009)
7) Depressive Experiences Questionnaire (Blatt et al., 1976)

Self-Relationship Questionnaire (SRQ). The SRQ (Faur & Elliott, 2007) is a 36-item measure designed to assess key aspects of the self-relationship across four domains: self-affiliation, self-attack, self-control, and self-neglect. It employs a 4-point Likert scale ranging from 'not at all true' to 'always true', with no reverse-scored items. Previous exploratory analyses in a clinical population indicated acceptable to excellent reliability within the domains (α = .94, .84, .83, & .75, respectively), however overall reliability as a complete measure was questionable (α = .67). Further psychometric testing in a nonclinical population was necessary to enhance its validity for scientific publication and broaden its clinical applicability.

Previous exploratory analyses of the SRQ were based on the hypothesis that the four different treatments of self are relatively independent, functioning as separate factors. Conversely, the opposing poles of self-affiliation and self-attack exhibited a negative correlation with one another but were orthogonal to and relatively independent from self-control and self-neglect, demonstrating minimal correlation. This indicates that the SRQ has inbuilt discriminant validity, supporting the existence of these four distinct styles of self-relating, with at least two occurring independently of the others.

Following its initial development and preliminary analyses, Faur and Elliott (2007) recommended further study to:

- Explore and strengthen the psychometrics of the instrument;
- Conduct exploratory factor analysis to better understand the dimensionality and functions of each scale;
- Improve the subscales, particularly self-attack items, to ensure differentiation from self-neglect;
- Calculate the Reliable Change Index value and clinical cut-off point for enhanced measurement of change in clinical populations.

SRQ Hypotheses. Considering item and conceptual overlap within the instrument, it was hypothesised that the overall reliability of the SRQ could be

improved to beyond the minimally acceptable standard (α ≥.70). The SRQ was expected to show strong positive and negative correlations with specific items and subscales of the other measures of self-relating and psychological distress used in this study. Additionally, zero correlation, indicating discriminant validity, was anticipated with certain items and subscales, particularly those of the Social Desirability Scale (see elaborated hypotheses in sections below).

Clinical Outcomes in Routine Evaluation Outcome Measure (CORE-OM). The CORE-OM (Evans et al., 2000) is a 34-item generic measure of psychological distress across four domains: well-being (W), problems/symptoms (P), life functioning (F), and risk (R). This measure is pan-theoretical (not associated with any specific school of therapy) and pan-diagnostic (not focused on a single presenting problem). It draws upon practitioner views on the most important generic aspects of psychological well-being to measure. Widely used within counselling and psychotherapy, the CORE-OM is recognised as a reliable and valid instrument with good sensitivity to change (Evans et al., 2002). It provides clear cut-off points to distinguish between clinical and nonclinical cases, ranging from healthy to severe. Like most self-report measures, it is non-diagnostic and cannot be used to diagnose specific difficulties.

The CORE-OM uses a 5-point Likert scale ranging from 'not at all' to 'most or all of the time', with some items being reverse scored. The mean of all 34 items provides a global index of distress, while the subscale means for each dimension can be used separately if desired. The risk items are not regarded as a scale but rather as clinical flags to trigger more in-depth discussions around risk assessment. The CORE-OM was deemed appropriate for inclusion in this study as it clearly measures constructs related to the self-relationship, many of which overlap with the domains of the SRQ. Additionally, individuals in distress tend to exhibit poorer self-attachment, a more externalised locus of evaluation, and less ability to be self-caring.

CORE-OM Hypotheses. It was hypothesised that there would be correlations between certain items and subscales of the SRQ and the CORE-OM, as follows:

- SRQ Self-Affiliation was expected to negatively correlate with Risk to Self (R) and Problems (P), and positively correlate with Well-being (W).
- SRQ Self-Attack was expected to positively correlate with Risk to Self (R) and Problems (P), and negatively correlate with Well-being (W).
- SRQ Self-Control and Self-Neglect were expected to have minimal to zero correlation with the CORE-OM subscales.

Self-Compassion Scale (SCS). The Self-Compassion Scale (SCS; Neff, 2003) is a 26-item measure assessing self-compassion across key components: self-kindness versus self-judgment, common humanity versus isolation, and mindfulness versus over-identification. Neff (2016) further validated the scale, confirming it as a theoretically coherent measure of self-compassion. The SCS uses a 5-point Likert scale ranging from 'almost never' to 'almost always'. Negative subscale items are reverse-scored before calculating each subscale mean, which can then be used to compute a total self-compassion score. Researchers can analyse data using individual subscale sores or an overall score. The SCS is appropriate for inclusion in this study as it measures constructs related to the self-relationship, revealing how individuals emotionally respond to their difficulties—with judgment or kindness, seeing challenges as isolating or part of the human experience, and dealing with suffering mindfully or through over-identification.

SCS Hypotheses. It was hypothesised that there would be correlations between certain items and subscales of the SRQ and the SCS (before reverse scoring), anticipated as follows:

- SRQ Self-Affiliation was expected to positively correlate with Self-Kindness and negatively correlate with Self-Judgment.

- SRQ Self-Attack was expected to positively correlate with Self-Judgment and negatively correlate with Self-Kindness.
- SRQ Self-Neglect was expected to likely positively correlate with Isolation.
- SRQ Self-Control was expected to likely positively correlate with Over-Identified and negatively correlate with Mindfulness.
- SRQ was expected to have zero correlation with Common Humanity.

Social Desirability Scale (SDS). The Marlowe-Crowne Social Desirability Scale (MCSDS; Crowne & Marlowe, 1960) is a 33-item measure assessing the tendency of respondents to modify their behaviour to appear more socially acceptable or to gain approval. It uses a simple 2-point True (highly desirable behaviours with low probability of occurrence) or False (socially disapproved behaviours with high probability of occurrence) scale, with negative items reverse scored. Originally designed for nonclinical populations, this measure has since been widely used and tested across diverse studies. However, some researchers (Barger, 2002; Collazo, 2005; Fischer & Fick, 1993; Leite & Beretvas, 2005; Loo & Thorpe, 2000) have questioned its unidimensional structure, finding that it did not conform to a one-factor model (Seol, 2007). These findings suggest that the instrument may be more accurately characterised as having a multidimensional structure. Emphasising external presentation over internal attitudes, the SDS was deemed suitable for assessing discriminant validity in this study, given its focus on an externally oriented locus of evaluation aimed at seeking approval rather than self-focus.

SDS Hypotheses. It was hypothesised that there would be minimal to negligible correlations between the items and subscales of the SRQ and the SDS. Although statistically significant correlations might arise from potential associations between a fragile self-concept and an externalised locus of evaluation, they were anticipated to be substantially lower compared to other measures in this study. Any significant effects were expected to be of much lower magnitude than the convergent validity

coefficients of, for example, the CORE-OM or Self-Compassion Scale. For context, a 0.2 correlation with social desirability would be considered far less significant compared to, say, a 0.5 or 0.6 correlation with self-compassion, which was expected. This expected discrepancy between the convergent and discriminant validity coefficients of the SRQ and SDS was a critical factor for this study.

Rosenberg Self-Esteem Scale (RSE). The Rosenberg Self-Esteem Scale (RSE; Rosenberg, 1965) is a 10-item scale that measures global self-worth by assessing both positive and negative feelings about the self. It utilises a 4-point Likert scale ranging from 'strongly agree' to 'strongly disagree', with some items reverse-scored. This widely used instrument for evaluating self-esteem is understood to be unidimensional and has demonstrated good reliability and construct validity in previous studies (Crandall, 1973). Although some prior studies have extracted and separated the factors of self-confidence and self-depreciation, suggesting a multidimensional structure, further analyses identified a single common factor (Gray-Little et al., 1997). Due to its brevity and simplicity, this concise questionnaire is easy to follow and requires little time to complete. Considered appropriate for inclusion, the RSE specifically measures constructs related to the self-relationship, particularly global self-worth or self-esteem.

RSE Hypotheses. It was hypothesised that there would be both positive and negative correlations between the self-attack and self-affiliation subscales of the SRQ and the RSE. The SRQ factors of Self-Neglect and Self-Control were considered unlikely to correlate with the RSE.

HEXACO-PI-R (Honesty-humility, Emotionality, eXtraversion, Agreeableness, Conscientiousness, Openness to experience - Personality Inventory - Revised). Recommended for use in personality assessment contexts where administration time is limited and widely used in psychological research, the HEXACO-PI-R (Ashton & Lee, 2009) is a concise 60-item personality inventory that evaluates six dimensions: honesty-

humility, emotionality, extraversion, agreeableness, conscientiousness, and openness to experience. Developed as a subset of the longer HEXACO-PI–R-200 and 100 versions (Ashton & Lee, 2008; Lee & Ashton, 2004; 2006), the HEXACO–PI-R-60 demonstrates reasonably high levels of internal consistency and low inter-scale correlations. It utilises a 5-point Likert scale ranging from 'strongly disagree' to 'strongly agree'. Items indicated with R are reverse-scored, and facet scale scores are computed as means across all items with each subset. Considered appropriate for inclusion, the Conscientiousness domain appeared closely aligned with Self-Control, and the Social Self-Esteem facet of the Extraversion domain appeared both positively and negatively aligned with Self-Attack and Self-Affiliation. Although many items clearly measure constructs related to the self-relationship, some items, particularly within the Openness to Experience domain, were expected to have zero correlation. The incorporation of this measure was therefore deemed useful for testing both the convergent and divergent validity of the SRQ.

HEXACO-PI-R Hypotheses. It was hypothesised that there would be correlations between certain items and subscales of the SRQ and the HEXACO, anticipated as follows:

- SRQ Self-Control was expected to positively correlate with the Conscientiousness domain.
- SRQ Self-Affiliation was expected to positively correlate with the Social Self-Esteem and Liveliness facets of the Extraversion domain, and possibly correlate with the Modesty facet of the Honesty-Humility domain.
- SRQ Self-Attack was expected to negatively correlate with the Social Self-Esteem facet of the Extraversion domain.
- SRQ Self-Neglect was expected to weakly correlate with the Agreeableness facet.

- SRQ was expected to have zero correlation with the Openness to Experience domain, and weak correlation with Emotionality.

Depressive Experiences Questionnaire (DEQ). The Depressive Experiences Questionnaire (DEQ; Blatt et al., 1976) is a 66-item scale that assesses a broad range of feelings about the self and interpersonal relations. It utilises a 7-point Likert scale, anchored by 'strongly disagree' and 'strongly agree' at the extremes, with some items reverse-scored. The DEQ distinguishes between two types of depressive experiences: those involving strong dependency needs and those involving self-criticism/guilt. It has demonstrated satisfactory validity and is considered an appropriate tool for assessing vulnerability to depression (Yao et al., 2009). Multiple studies using exploratory factor analytic methods support the DEQ's psychometric properties in both clinical and nonclinical samples (Blatt, 2004; Desmet et al., 2007; Desmet et al., 2009).

Subsequent research by Santor et al. (1997) explored two later revisions of the DEQ and found psychometric differences between them and the original instrument. They developed and validated the DEQ McGill revision, which aimed to maintain the original between-scale orthogonality and provided a more valid estimate of the relationship between dependency, self-criticism, and other relevant constructs. In accordance with these findings, it was deemed appropriate to adopt the unit-weighted McGill scoring system for this study, utilising 48 of the original 66 items (18 dependency, 18 self-criticism, plus 12 items that measure both dependency and self-criticism depending on scoring direction, disregarding 18 surplus items).

Further research by Falgares et al. (2018) found low inter-correlations between dependency and self-criticism in both the original and McGill scoring methods, questioning the measures orthogonality. They suggested that the initial orthogonality might have resulted from the rotation procedure used by Blatt et al. (1976). Given that depressive experiences strongly relate to the self-relationship, particularly in low mood and distress, it appeared reasonable to include the DEQ. Individuals experiencing low

mood tend to have poorer self-attachment, a more externalised locus of evaluation, and reduced self-care abilities.

DEQ Hypotheses. It was hypothesised that there would be correlations between subscales of the SRQ and the DEQ, as follows:

- SRQ Self-Affiliation was expected to strongly negatively correlate with Self-Criticism, and weakly negatively correlate with Dependency, on the basis that individuals may have poor self-affiliation if they seek external approval and recognition.
- SRQ Self-Attack was expected to strongly positively correlate with Self-Criticism, as individuals may be more likely to attack themselves when their high achievement standards are unmet.
- SRQ Self-Control was expected to show a weak positive correlation with Self-Criticism, related to the achievement of external goals.
- SRQ Self-Neglect was expected to demonstrate zero correlation with any DEQ subscales.

Data Collection Procedure: Nonclinical Sample

Prior Survey Development Phase. Before recruiting participants via the Qualtrics survey, the research team conducted internal testing. All six research team members, along with some departmental staff, completed the test and retest surveys multiple times over a three-week period. During this time, the functionality and user experience of the tests were reviewed, and several adjustments were made to ensure the smooth operation of both survey phases. Preliminary test data collected were transferred to SPSS (Statistical Package for the Social Sciences) for a trial run of various statistical analyses.

Data Collection. The survey included a battery of validated self-report measures on aspects of self-relating, along with the SRQ, all compiled into one continuous survey to collect anonymous data from a nonclinical population. Hosted by Qualtrics, a cloud-based platform for creating and distributing web-based surveys, participants were

invited to complete the questionnaires online (see Appendix F). The survey was widely distributed through social media, email, and anonymous links, and remained open for four weeks. Participants who agreed to take part in the second phase received an email invitation to complete a second SRQ questionnaire (see Appendix G) two weeks after completing the first survey. The interval between the first and second surveys ranged from 14 to 21 days, with a mean interval of 14.8 days.

Due to the anticipated time required to complete the initial survey (up to 1 hour), respondents who did not complete the relevant consents or did not meet the eligibility criteria were automatically skipped to the end of the survey. Eligible participants were asked to enter demographic information (gender, date of birth, and country of residence). After completing the first survey, participants were invited to take part in the second phase and, if interested, to provide their email address and create a unique identification code (see Appendix H). This code was used to match their responses between the initial and subsequent survey. The retest survey included only the SRQ to evaluate its stability and reliability over time.

Recruitment Phase. To ensure sufficient respondents and corresponding data, the recruitment phase was closely monitored to track responses and adjust social media notices and solicitation emails if necessary. Each team member actively approached their networks to gather data. A task was set up on the Qualtrics survey to prevent ballot stuffing, with a target of at least 100 respondents for the first survey and 25 for the second, which was exceeded for both phases.

Data Collection Procedure: Clinical Sample

SRQ data were collected along with other measures at multiple points: pre-therapy during the structured intake interview, mid-therapy after session 8, after session 20, at the end of therapy if it continued beyond 20 sessions, and at optional 6 and 18-month follow-up interviews. Data were gathered in paper form and stored confidentially within the client's anonymised file, identified by code numbers. Codebooks, consent forms, and release of recording forms were stored separately in a

locked cabinet. Although not utilised in this first study, all audio/video recordings were stored on a dedicated, secure, password-protected computer and backed up to an encrypted external hard drive, both stored securely. Data were stored for a minimum of 5 years or as long as there was scientific use. Of the potential 488 SRQ data collection points, 198-207 were missing due to human error.

Data Preparation: Nonclinical Sample

Data Cleaning. Initial data cleaning involved scoping for patterns of missing data and sorting by eligibility, consent, and clinical vs nonclinical status. Ineligible, non-consenting, and clinical participant data were removed. Cases with incomplete or missing data were excluded to ensure accurate multivariate statistics, such as Cronbach's Alpha. This approach was deemed appropriate because many multivariate statistical methods employ a reliability procedure that excludes entire cases if any variable is missing. This 'listwise deletion' removes any case with missing data for any of the variables in the analysis.

Item acceptability was assessed to identify any systematically rejected items. Means and standard deviations were observed to check for any questionable or out-of-range values. However, it was anticipated that this would not be an issue as the online digital survey used radio buttons, preventing participants from endorsing more than one choice or entering their own value. Basic descriptors for all variables were checked on both the Qualtrics output files and the transferred SPSS files to ensure clear identification and readability. Finally, potential Qualtrics survey software programming errors were also examined.

Statistical Outliers. Diverging abnormally from the general pattern of data, statistical outliers are extreme scores in a data set that may impact the overall analyses. Such scores may reflect qualitatively distinct processes, often caused by participants not adhering to the intended task (Osborne & Overbay, 2004). A review of the dataset for abnormalities by checking the SRQ domain means revealed that two respondents demonstrated high scores in the self-attack and self-neglect domains,

three respondents scored high and one low in self-control, and one scored low in self-affiliation (see Appendix I for domain outlier graphs). Although these samples might be ineligible clinical cases rather than eligible nonclinical cases, their data were retained in the overall analyses because the respondents had indicated that they were nonclinical and did not consider themselves in need of therapy. It was concluded that there was insufficient information to exclude these cases and that their impact on the overall data output would likely be minimal.

Examining the data's nature and shape, the distributions of mean responses for self-affiliation and self-control appeared well balanced (skewness = -.271 and .141, and kurtosis = .167 and .073 respectively). Conversely, the distributions for self-attack and self-neglect showed positive skewness (skewness = 1.952 and .978 respectively), indicating a right-tail extension and sharper peaks than a normal distribution (kurtosis = 6.943 and 1.587 respectively), suggesting a propensity for higher scores in the lower range. Despite these characteristics, all distributions remained within an acceptable range for analysis (see Appendix J for distribution graphs).

Reverse Scoring. To accurately calculate Cronbach's alpha, it is crucial to ensure that all negatively scored items are reverse scored prior to the analysis (Pallant, 2013). As previously mentioned, negative questions were reverse scored appropriately for each questionnaire during the data preparation phase. While the range of measurement tools set up in Qualtrics included various subscales and scoring systems, these did not always transfer accurately to SPSS. Consequently, it was necessary to thoroughly check all automated scoring systems in Qualtrics and write transformations for those that did not carry over correctly. SPSS syntax was developed to correct any inaccuracies, ensuring precise scoring of all subscales within each instrument, especially those employing a reverse scoring system.

Matching Test and Retest Data. Care was taken to ensure accurate pairing of the initial test and subsequent retest surveys, achieved by matching them based on the unique participant identification codes. During data sorting, it was observed that

certain respondents inconsistently entered their codes in a mix of uppercase and lowercase, posing a challenge due to SPSS's case sensitivity. Consequently, manual transformation of all 'key' data into a uniform format was necessary, while meticulously checking for errors to ensure precise survey matching. Integration of both surveys utilised the unique key through an SPSS data merge process, revealing that 'SMIJOH76' had been duplicated across six cases. Although this code was provided as an example during participant guidance, it was unforeseen that some would replicate it directly. Consequently, these cases were omitted from the analysis, as they couldn't be accurately matched.

Data Preparation: Clinical Sample

Following an initial data-cleaning phase, the clinical SRQ sample and various other measures were provided to the research clinic team for input and analysis in SPSS, all under the direct supervision of the Chief Investigator of the EFT/PCT-SA protocol. This archival dataset, previously used in studies within the research clinic, was made available by the Chief Investigator. As with the nonclinical sample, cases with incomplete or missing data were excluded in accordance with multivariate statistical procedures like Cronbach's Alpha, which require the removal of entire cases when any variable is missing. This 'listwise deletion' approach ensured that any case with missing data for any SRQ variable was excluded from the analysis.

Data Analysis: Nonclinical and Clinical Samples

The nonclinical datasets from both study phases were consolidated and prepared for analysis using SPSS. In contemporary psychometric research, calculating sample-specific reliability statistics such as Cronbach's alpha is imperative to ensure internal consistency across all items, rather than relying solely on published values. Cronbach's alpha, a reliability coefficient, measures the degree of interrelatedness among items within a specific group (refer to Table 5). By calculating Cronbach's alpha, the covariance of each item with the others was assessed. Consequently, the data

collected from both study phases underwent testing for internal consistency within each instrument's domains or subscales. A similar procedure was also applied to the archival clinical SRQ dataset.

Table 5: Standards for Interpreting Cronbach's Alpha Internal Consistency Coefficients (Barker et al., 2016)

$0.9 \leq \alpha$	Excellent
$0.8 \leq \alpha < 0.9$	Good
$0.7 \leq \alpha < 0.8$	Acceptable
$0.6 \leq \alpha < 0.7$	Questionable
$0.5 \leq \alpha < 0.6$	Poor
$\alpha < 0.5$	Unacceptable

The Pearson correlation coefficient, which ranges between -1 and +1 and indicates the degree of linear relationship between two variables or sets of data, was employed. It was used to assess correlation among various constructs: the SRQ inter-domain correlations for both nonclinical and clinical samples, correlations between SRQ domains and constructs measured in the other questionnaires for the nonclinical sample, and to gauge the test-retest stability and reliability of the SRQ across the two data points for the nonclinical sample. Whilst this process of content validation can reveal whether different instruments are measuring similar constructs, it does not ascertain the accuracy of measurement for these constructs (Strauss & Smith, 2009). Nonetheless, it has been deemed appropriate for psychometric validation, as demonstrated, for instance, by Zech et al. (2018) in their validation of the Strathclyde Inventory. They compared its structure with that of similar and dissimilar measures such as the NEO-FFI (Costa & McCrae, 1989), the Beck Depression Inventory (BDI-II; Beck et al., 1996), and the Barrett-Lennard Relationship Inventory (BLRI; Barrett-Lennard, 1962; 1978; 1986). The Pearson correlation coefficient is also referred to as the '*product moment correlation coefficient*' (PMCC) or simply '*correlation*'.

Calculating Reliable Change and Clinical Change. The Jacobson and Truax (1991) Jacobson Criterion C formula was applied to the SRQ nonclinical test scores and compared to the existing clinical sample in order to calculate the reliable change and clinical cut-off indices of the instrument. Psychometric standards were met, and clinical cut-off points were established for each domain, indicating the threshold where a score transitions from the nonclinical to the clinical range.

Internal Structure Analyses. Finally, exploratory factor analyses (EFA) was performed on the nonclinical, clinical, and combined datasets to investigate the SRQ's dimensionality and internal structure. This analysis aimed to clarify the factors of the SRQ, assess whether it accurately measures its intended constructs, and uncover the underlying theoretical structure and relationships among its variables. The goal was to condense the variables into a smaller, more robust set of summary variables.

Overview of the SPSS Data Analysis Plan

- Transformations (SPSS syntax for scoring on the subscales) were written to correct score all of the subscales in all of the instruments.
- Basic housekeeping involved running Cronbach's alpha across all measurement tools to derive sample-specific psychometric values of internal consistency for the instruments and their respective subscales.
- Reliability and validity statistics, including Cronbach's alpha and Pearson correlation, were computed for the SRQ within each subscale and across the entire instrument.
- To assess convergent and discriminant construct validity, Pearson correlations were conducted within each SRQ subscale and across the subscales of the various instruments.
- The SRQ test-retest datasets were merged to examine the stability of scores over time. The test-retest reliability coefficients were calculated using Pearson correlations within each SRQ subscale between the two data points, informing the calculation of reliable change values (Jacobson & Truax, 1991).

- Clinical cut-off indices of the instrument were determined using the Jacobson and Truax (1991) Criterion C formula.
- Exploratory factor analyses were performed on the SRQ.

All analyses were conducted using SPSS, and detailed syntax for each calculation is provided in Appendix K, which informed the corresponding output files.

Results

Nonclinical Sample: Reliability and Item Analyses for the SRQ

Internal Consistency of the SRQ. The internal consistency of the SRQ nonclinical sample was assessed using Cronbach's alpha across the entire instrument and within each of its domains (see Table 7). Each SRQ subscale demonstrated acceptable to good internal consistency individually (self-affiliation: $\alpha = .86$, self-attack: $\alpha = .77$, self-control: $\alpha = .80$, and self-neglect: $\alpha = .72$). However, the overall measure of self-relationship exhibited questionable internal consistency ($\alpha = .65$). This finding was expected and indicates evidence of discriminant validity, as the SRQ subscales are not designed to measure the same construct.

Item Analyses of SRQ Items: Corrected Item-Total Correlations. The corrected item-total correlation, which indicates how well each item aligns with the other items in its subscale, was evaluated for each question within each SRQ domain. Items scoring below 0.3, as shown in Table 6, were flagged as potentially problematic, suggesting they may not align well with the rest of the scale items. Additionally, items scoring slightly above 0.3 were included since their removal could potentially increase the Cronbach's alpha. An example of such an issue is observed within the CORE-OM, where the risk items did not correlate well with the rest of the scale or contribute to the instrument's reliability. However, these risk items were retained in the measure due to their clinical utility.

Table 6: Item Analyses for the SRQ Subscales (Nonclinical Sample, time 1)

SRQ Domain	Item No.	Question	Corrected Item-Total	Cronbach α	Cronbach α Item Deleted
Self-Affiliation	8	I comfort myself when I am sad or hurt	.22	.86	.87
	9	I confidently allow myself to do what feels right	.37	.86	.86
Self-Attack	20	I hurt myself by overburdening myself with work	.35	.77	.77
Self-Control	10	I criticize myself harshly when I don't do something perfectly	.30	.80	.80
Self-Neglect	6	I believe that whatever happens, happens, so it's better not to try	.23	.72	.72
	23	I let my needs go unattended	.27	.72	.72
	26	I only live for the moment	.28	.72	.72

Note: N=150 (nonclinical)

While the overall alpha scores for each domain indicate that the items measure distinct psychological constructs within each subscale, some items may detract from the scale's coherence by being too dissimilar and misaligned with the rest of the scale. The lowest corrected item-total correlation was found in item 8. '*I comfort myself when I am sad or hurt*' (.22) within the self-affiliation domain. Removing this item would slightly increase the Cronbach's alpha from .86 to .87. Although this item clearly pertains to a self-affiliative/self-soothing construct, its association with sadness and pain might be confounding its alignment. In the self-neglect domain, three items had corrected item-total correlations below 0.3: item 6. '*I believe that whatever happens, happens, so it's better not to try*' (.23), item 23. '*I let my needs go unattended*' (.27), and item 26. '*I only live for the moment*' (.28). While removing these items does not

improve the Cronbach's alpha, their poor fit with the rest of the subscale suggests they may benefit from modification or removal.

The remaining items (9, 10, & 20) had corrected item-total correlations slightly above 0.3, yet their removal did not improve the Cronbach's alpha. The self-attack item 20. '*I hurt myself by overburdening myself with work*' (.35), indicates self-harm, but also overlaps with the self-control domain by reflecting a 'pressurising self' behaviour, similar to other self-control items. Similarly, the self-control item 10. '*I criticize myself harshly when I don't do something perfectly*' (.30), suggests 'pressurising self' to achieve perfection and also intersects with self-attack by involving self-criticism. Lastly, item 9. '*I confidently allow myself to do what feels right*' (.37), though indicative of self-affiliation, appears more about external action and offers little insight into self-liking or self-care.

Item Analyses: Squared Multiple Correlations. The squared multiple correlation, also known as the coefficient of determination, measures the redundancy of any item within a subscale. For example, a score of r= > 0.7 suggests that an item is redundant, meaning it measures something identical to all other items in the subscale and could be removed to avoid repetition. Items that measure the same construct rather than reflecting differing constructs can negatively impact an instrument's reliability. For instance, a score of .75 indicates that the other items in the scale account for 75% of the variance of that item (if you used all the other items to predict that score), demonstrating high shared variance and suggesting redundancy. Within each domain, the squared multiple correlations ranged from .12 to .65 for self-affiliation, .14 to .52 for self-attack, .19 to .55 for self-control, and .09 to .33 for self-neglect, indicating no redundant items across these subscales. However, the self-affiliation subscale showed squared multiple correlations greater than 0.6 for two items: item 1. '*even though I know I have some faults I am happy with myself as I am*' (r=.62), and item 3. '*I am content with myself*' (r=.65), suggesting these items may conceptually overlap with the rest of the scale.

SRQ Test-Retest Reliability. Using Pearson's correlation to measure the strength and direction of the relationship between the SRQ at time 1 (n=150) and time 2 (n=42) for the nonclinical dataset, test-retest reliability was calculated for each domain of the SRQ and for the instrument as a whole (see Table 7). Strong correlations were observed between responses from the initial survey and the retest survey, which was completed after a 14 to 21 day delay. The highest correlation between the two time points was observed for the overall SRQ measure of self-relating, with a correlation of r=.84 ($p < .01$). Among the individual subscales, the strongest correlation was within the self-neglect domain (r=.83, $p < .01$), while the weakest, albeit still strong, was within the self-attack domain (r=.80, $p < .01$). These findings indicate that both the SRQ as a whole and its individual subscales remain stable over time, showing minimal variation in the self-relating of this nonclinical sample during the intervening period. Thus, the SRQ demonstrates stability and consistency over time in a nonclinical adult population.

Table 7: Descriptive Statistics for the SRQ and its Subscales (at time 1 and 2)

	M(SD)	Cronbach α	Retest M(SD)	Retest Cronbach α	Test-Retest Correlation
SRQ	1.12(.21)	.65	1.12(.22)	.67	.84**
Self-Affiliation	1.79(.49)	.86	1.71(.56)	.90	.82**
Self-Attack	.45(.44)	.77	.48(.54)	.85	.80**
Self-Control	1.44(.51)	.80	1.52(.55)	.82	.80**
Self-Neglect	.55(.38)	.72	.51(.39)	.73	.83**

Note: Original Test N=150, Retest N=42 (nonclinical)
** Correlation is significant at the <0.01 level (2-tailed)

SRQ Subscale Inter-Item Correlations. The internal consistency of the SRQ was assessed using Pearson's correlation to measure the interrelationship between its

subscales (n=4, see Table 8), between its subscales and other measures and their domains (n=24, see Table 10), and within all individual SRQ items (n=36, see Appendix L). The inter-item correlation matrix of the SRQ, detailed in Appendix L, distinguishes items within the same domain (highlighted in green) from those in different domains (highlighted in red). Additionally, the mean inter-item correlations within each SRQ domain were measured as follows: self-affiliation (n=10, mean r=.38), self-attack (n=7, mean r=.35), self-control (n=10, mean r=.28), and self-neglect (n=9, mean r=.22). These correlations reflect weak to moderate positive correlations among the questions within each domain, indicating that while the items are cohesive within their constructs, they represent different aspects of the concept.

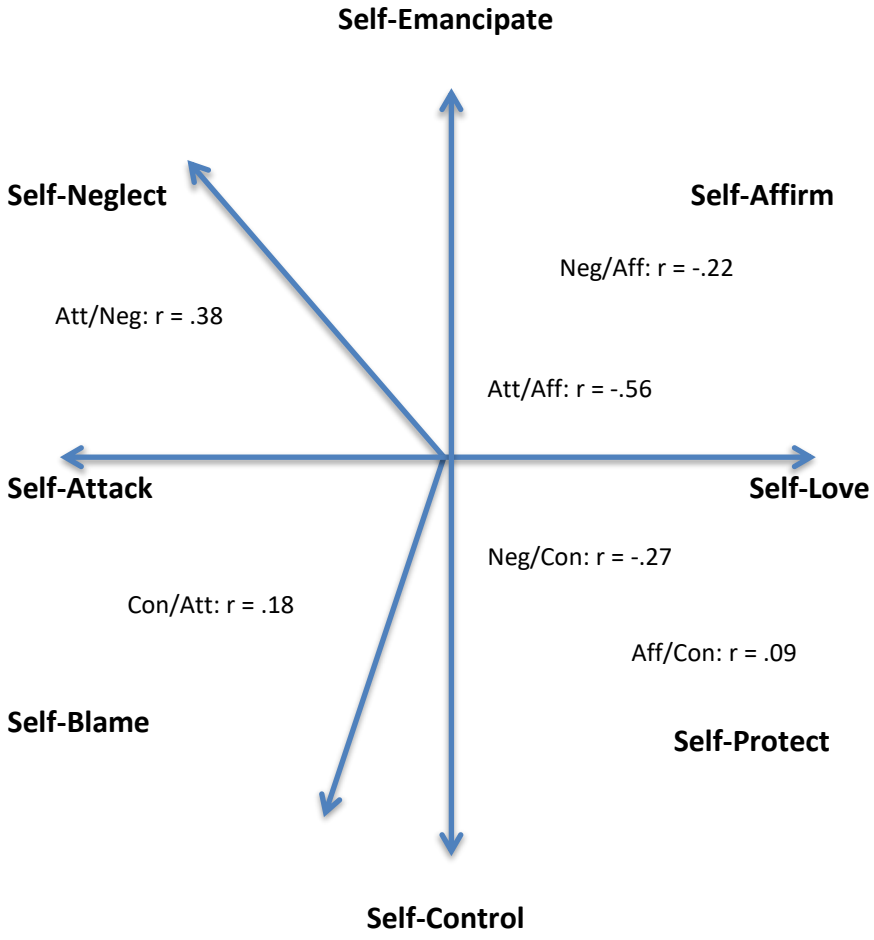
Inter-Correlations Among SRQ Domains. Similar to the SASB model (Benjamin, 1974; 1996) with its opposing poles of self-attack and self-love, a statistically significant negative correlation was found between the SRQ domains of self-attack and self-affiliation ($r = -.56$, $p < .01$), indicating that these domains operate as inverse measures of each other. Conversely, the self-control and self-neglect domains showed a weak negative correlation ($r = -.27$, $p < .01$), suggesting a dissimilar relationship to the SASB poles of self-control and self-emancipation. Interestingly, a stronger positive correlation was found between self-attack and self-neglect ($r = .38$, $p = < .01$), suggesting some overlap between these constructs rather than orthogonality. This is also reflected in the SASB model, which positions self-neglect as a quadrant lying between the poles of self-attack and self-emancipation (rather than as the opposing pole of self-control). Additionally, a weak positive correlation was noted between self-attack and self-control ($r = .18$, $p = < .05$), slightly challenging the idea that they are completely orthogonal, as suggested by the SASB model. Considering Benjamin's quadrant of self-blame, which lies between these poles, may provide some insight to this potential overlap between these constructs. The inter-correlation of the SRQ domains are listed in Table 8, and depicted in Figure 2 as a circumplex model.

Table 8: Pearson Correlation of the SRQ Domains (at time 1)

	Self-Attack	Self-Control	Self-Neglect	Self-Affiliation
Self-Attack	1			
Self-Control	.18*	1		
Self-Neglect	.38**	-.27**	1	
Self-Affiliation	-.56**	.09	-.22**	1

Note: N=150 (nonclinical)
* Correlation is significant at the <0.05 level (2-tailed)
** Correlation is significant at the <0.01 level (2-tailed)

Figure 2: Circumplex Model of the SRQ Domain Correlations (at time 1)



Nonclinical Sample: Internal Consistency of the Comparative Measures

The CORE-OM (α=.95), SCS (α=.94) and RSE (α=.91) all demonstrated excellent internal consistency, while the HEXACO-PI-R (α=.81) and DEQ (α=.81) showed good internal consistency. The SDS (α=.78) was slightly lower but still reflected acceptable internal consistency within this sample. All of the questionnaires selected for the analyses to investigate the reliability and validity of the SRQ have demonstrated at least acceptable reliability, making them suitable for this study (see Table 9). The high internal consistency scores of the CORE-OM, SCS, and RSE could indicate item redundancy within these measures, particularly as each showed a number of inter-item correlations greater than .50. However, any issues with item redundancy in other measures are irrelevant to this study, as the aim is to correlate items of the SRQ with other validated constructs to evaluate its construct validity.

Table 9: Descriptive Statistics of each Measure's Internal Consistency (at time 1)

	Number of Items	Mean	Standard Deviation	Cronbach α
SRQ				
Self-Affiliation	10	17.86	4.92	.86
Self-Attack	7	3.11	3.11	.77
Self-Control	10	14.43	5.09	.80
Self-Neglect	9	4.97	3.44	.72
SRQ Total	36	40.37	7.49	.65
CORE-OM				
Problems/Symptoms	12	13.51	9.59	.91
Risk	6	1.34	2.54	.78
Subjective Well-being	4	4.19	3.22	.79
Functioning	12	11.77	8.38	.88
CORE-OM Total	34	30.81	21.75	.95
SCS				
Self-Kindness	5	15.68	4.94	.88
Self-Judgement	5	15.82	4.99	.85
Common Humanity	4	13.83	4.07	.83
Isolation	4	13.36	4.11	.79
Mindfulness	4	14.48	3.43	.78

Over-Identification	4	12.85	4.14	.82
SCS Total	26	86.03	20.65	.94
Social Desirability Scale	33	16.41	5.24	.78
Rosenberg Self-Esteem	10	20.68	5.82	.91
HEXACO-PI-R				
Honesty-Humility	10	36.55	6.37	.77
Emotionality	10	31.56	6.40	.74
Extraversion	10	34.53	6.70	.82
Agreeableness	10	31.68	6.50	.80
Conscientiousness	10	36.28	5.49	.74
Openness to Exp.	10	37.04	6.08	.78
HEXACO-PI-R Total	60	207.65	18.79	.81
DEQ				
Dependency	18	130.03	18.52	.78
Self-Criticism	18	110.84	21.23	.83
DEQ Total	48	197.91	30.13	.86

Note: N=150 (nonclinical)

Nonclinical Sample: Construct Validity Analyses for SRQ

The internal consistency of the SRQ was evaluated using Pearson's correlation to measure the interrelationships between its subscales and other validated measures of self-relating and their domains (n=24; see Table 10).

Inter-Correlation of the SRQ with CORE-OM. The self-attack and self-affiliation domains demonstrated significantly strong positive and negative correlations with the overall CORE-OM measure (r=.67, p<.01 and r=.-61, p<.01 respectively), and with most of its individual subscales (ranging r=.63 to r=-.65, p<.01). A notable exception was the correlation between the self-affiliation and risk scales, which, although significant, was moderate (r =-.36, p<.01). Interestingly and somewhat unexpectedly, the self-neglect domain also showed moderate yet significant correlations with all CORE-OM subscales, ranging from r=.35 to r=.44 (p<.01), indicating some overlap with self-attack and self-affiliation. The self-control domain, indicating it measures a different aspect of the self-relationship, exhibited almost zero correlation with any of the CORE-OM domains.

Inter-Correlation of the SRQ with SCS. As hypothesised, the self-compassion scale as an overall measure showed strong positive and negative correlations with self-affiliation (r=.67, p<.01) and self-attack (r=-.61, p<.01), respectively. Additionally, both self-affiliation and self-attack demonstrated moderate to strong positive and negative correlations with the individual SCS high and low self-compassion subscales (ranging r=.63 to r=-.62, p<.01). These findings strongly suggest that both the self-affiliation and self-attack subscales of the SRQ are measuring similar psychological constructs as the SCS. Furthermore, the similar strength in the positive and negative directions of the affiliation/attack correlations supports the assertion that these constructs act as inverse measures of each other. Surprisingly, there was particularly weak correlation between self-compassion and the SRQ self-control (ranging r=.05 to r=-.25) and self-neglect (ranging r=.-14 to r=-.27) subscales, with the only notable moderate negative correlation being found between self-kindness and self-neglect (r=-.36, p<.01). This minimal relationship between the self-compassion subscales and self-control indicates that this SRQ construct measures a different type of self-relationship.

Inter-Correlation of the SRQ with SDS. As hypothesised, the construct of social desirability, intended as a measure of discriminant validity, demonstrated particularly weak correlations with the SRQ subscales. The most significant correlation was observed in the self-affiliation domain (r=.28, p<.01), with similarly negative correlations in both the self-attack (r=-.26, p<.01) and self-neglect domains (r=-.23, p<.01). Although these correlations are low, they were unexpected, as no relationship was anticipated. Further indicating that the self-control domain may measure a different type of self-relationship, there was practically zero correlation with the SDS (r=.08). These findings suggest that the SRQ and SDS measure different aspects of relating, with one focusing on self-to-self relationships and the other on self-to-other relationships. Incidentally, a significantly high correlation was noted between social desirability and the HEXACO agreeableness scale (r=.45, p<.01).

Inter-Correlation of the SRQ with RSE. The construct of self-esteem was found to significantly overlap with the SRQ, particularly due to its very strong positive correlation with self-affiliation ($r=.80$, $p<.01$), and strong negative correlation with self-attack ($r=-.63$, $p<.01$). This suggests that the self-affiliation and self-attack domains act as inverse measures of a similar concept, on a continuum of self-relating. The strong correlations with self-esteem indicate that both instruments may be measuring a similar construct. Additionally, the self-neglect subscale demonstrated a moderate negative correlation with self-esteem ($r=-.38$, $p<.01$), supporting the assertion of meaningful overlap between these aspects of self-relating. Conversely, indicating that the self-control domain measures a different type of self-relationship, there was practically zero correlation with Rosenberg's self-esteem scale ($r=.03$).

Inter-Correlation of the SRQ with HEXACO-PI-R. Overall, primarily weak to moderate correlations were observed between the HEXACO subscales and the domains of the SRQ, with a few notable exceptions. The strongest correlations were found between the Extraversion domain and the SRQ subscales self-attack and self-affiliation ($r=-.59$, $p<.01$ and $r=.64$, $p<.01$ respectively), highlighting the inverse nature of these SRQ subscales. This suggests a strong relationship between extroverted personality types, who tend to exhibit confidence and feel positively about themselves, and self-affiliation, making the strong negative correlation with self-attack unsurprising.

The only other significant, though moderate, correlations were between the Conscientiousness domain and the self-control and self-neglect SRQ subscales ($r=.47$, $p<.01$ and $r=-.45$, $p<.01$ respectively). This indicates a positive connection between conscientious personality types, who tend to be disciplined, organised, and strive for accuracy and perfection, and self-control, and a negative correlation with self-neglect. It is noteworthy that these SRQ subdomains presented antithetically when compared to this HEXACO domain.

When comparing the measure as a whole, moderate correlations were noted for the SRQ subscales self-attack, self-neglect, and self-affiliation ($r=-.40$, $r=-.39$ and

r=.45 respectively, all with a significance level of p<.01). Overall, the HEXACO demonstrated practically zero correlation with self-control, again indicative of a distinct type of self-relating.

Inter-Correlation of the SRQ with DEQ. As expected, significantly strong positive and negative correlations were found between the SRQ domains of self-attack (r=.59, p<.01) and self-affiliation (r=-.57, p<.01) with the self-criticism domain of the DEQ, respectively. Notably, the dependency scale showed little correlation with self-attack (r=.19, p<.05), self-affiliation (r=-.16), or self-neglect (r=-.06), but demonstrated a slightly higher correlation with self-control (r=.24, p<.01), highlighting the inherent differences between the DEQ's constructs of dependency and self-criticism.

Furthermore, comparing the DEQ as a whole with the SRQ domains indicated moderate to strong correlations with the self-attack (r=.50, p<.01) and self-affiliation (r=-.46, p<.01) subscales. These findings suggest overlapping similarities between the DEQ's expression of depressive experiences and aspects of the SRQ's self-relationship.

Table 10: Pearson Correlation of the SRQ Subscales with Other Measures and their Domains

	Self-Attack	Self-Control	Self-Neglect	Self-Affiliation
CORE-OM				
Problems/Symptoms	.63**	.07	.37**	-.55**
Risk	.58**	.11	.38**	-.36**
Subjective Well-being	.61**	-.03	.35**	-.65**
Functioning	.61**	.01	.44**	-.58**
CORE-OM Total	.67**	.04	.43**	-.61**
SCS				
Self-Kindness	-.51**	-.01	-.36**	.63**
Self-Judgement	-.62**	-.25**	-.20*	.62**
Common Humanity	-.33**	.04	-.14	.44**
Isolation	-.58**	-.09	-.27**	.53**
Mindfulness	-.35**	.05	-.25**	.55**
Over-Identification	-.48**	-.21*	-.16	.42**
SCS Total	-.61**	-.11	-.29**	.67**
Social Desirability Scale	-.26**	.08	-.23**	.28**

Rosenberg Self-Esteem	-.63**	.03	-.38**	.80**
HEXACO-PI-R				
Honesty-Humility	-.17*	-.23**	-.11	-.04
Emotionality	.14	.13	-.15	-.19*
Extraversion	-.59**	.04	-.29**	.64**
Agreeableness	-.29**	-.07	-.11	.27**
Conscientiousness	-.19*	.47**	-.45**	.27**
Openness to Exp.	-.06	.13	-.08	.38**
HEXACO-PI-R Total	-.40**	.14	-.39**	.45**
DEQ				
Dependency	.19*	.24**	-.06	-.16
Self-Criticism	.59**	.17*	.29**	-.57**
DEQ Total	.50**	.29**	.13	-.46**

Note: N=150 (nonclinical)
* Correlation is significant at the 0.05 level (2-tailed)
** Correlation is significant at the 0.01 level (2-tailed)

SRQ Item Analyses (Nonclinical Sample)

The internal consistency and coherence of measurement tools are indispensable for ensuring their reliability and validity in psychometric assessment. Internal consistency gauges the degree to which items within an instrument are interrelated and measure the same underlying construct, with higher correlations indicating stronger alignment with the construct. Coherence refers to the logical consistency or clarity in the items comprising the tool (Barker et al., 2016). To effectively assess and refine the internal consistency and coherence of the SRQ, conducting inter-item correlations within each subscale using Pearson's correlation coefficient was essential. These correlations ensure that the scale produces consistent and dependable results, with item-total correlations closer to +1 or -1 suggesting significant contribution to the overall construct, while correlations close to 0 indicate weak relationships between the item and the construct (Furr, 2018).

Through an iterative process of content analysis, item coherence was investigated and enhanced to ensure that SRQ domain items accurately capture the

intended construct and are consistently understood by respondents. Additionally, factor analysis was employed to assess item coherence by examining how the items load onto the underlying dimensions of the construct. Insights gleaned from content and factor analyses informed suggested revisions of the SRQ.

Overall, achieving high internal consistency and coherence among SRQ items and domains is paramount for enhancing the reliability and validity of the instrument, thereby enabling precise and meaningful assessment outcomes (Barker et al., 2016).

Inter-Correlations of the SRQ Individual Items with Domains. Providing unities down the diagonal, which correlates a variable with itself (r=1), the inter-item correlation matrix (see Appendix L) was used to analyse the SRQ's internal consistency reliability within the nonclinical sample. This matrix offers a detailed overview of item statistics for all individual questions within the instrument. Serving as a diagnostic tool, the matrix facilitated the identification of negative values within a particular domain (often indicative of mis-scoring errors), very high values (certainly above 0.6, but often above 0.5), and unexpectedly weak within-domain correlations (<0.2).

Negative values were noted both within the self-control domain (item 10. '*I criticize myself harshly when I don't do something perfectly*', and item 34. '*I try very hard to make sure my work is done on time*', r=-.03) and the self-neglect domain (item 23. '*I let my needs go unattended*', and item 26. '*I only live for the moment*', r=-.13). Interestingly, items 10, 23 and 26 were also flagged in the corrected item-total correlations for the SRQ subscales (see Table 6), indicating a poor fit with the rest of their respective domains, thus posing a potential problem for the reliability of the instrument.

Strong Positive Intercorrelations. Indicative of overlapping or similar items and suggesting redundancy within the scale, strong positive correlations, some particularly high (ranging >.50 to >.60), were noted. The primary goal was to shorten the instrument by removing redundant items while retaining enough internally consistent items to achieve an overall SRQ reliability of at least $\alpha = .70$, the minimal acceptable

standard. Additionally, it was crucial to ensure that the conceptual territory of the self-relationship was adequately covered without overemphasising any particular aspect of the concept. Upon reviewing the matrix, a clear pattern emerged: higher correlations were found between items within the same domain, and lower correlations between items from different domains. Strong correlations >.50 were found in 14 same-domain question pairs, with 2 pairs reflecting very high correlation at ≥.60. Interestingly, the majority of these strong correlations appeared within the self-affiliation domain (n=11), with n=2 in the self-control domain, and n=1 in the self-attack domain (see Table 11).

Table 11: Strong Inter-Item Correlations within SRQ Domains (Nonclinical sample, time 1)

SRQ Domain	Item No's.	Question Pairs	Inter-Item Correlation
Self-Attack	13	I don't feel that I deserve anything good to happen to me	.56
	31	I think of ways to punish myself	
Self-Control	21	I keep an eye on myself to be sure I am doing what I should	.55
	22	I keep tight control over myself	
	22	I keep tight control over myself	.56
	35	I watch myself closely to make sure I don't do the wrong thing	
Self-Affiliation	1	Even though I know I have some faults I am happy with myself as I am	.76
	3	I am content with myself	
	1	Even though I know I have some faults I am happy with myself as I am	.51
	4	I appreciate myself for just being me	
	3	I am content with myself	.58
	4	I appreciate myself for just being me	
	1	Even though I know I have some faults I am happy with myself as I am	.53
	24	I like myself very much	
	3	I am content with myself	.57
	24	I like myself very much	
	4	I appreciate myself for just being me	.53
	24	I like myself very much	

2	I am comfortable with listening to my innermost feelings	.53
29	I respect myself deeply	
4	I appreciate myself for just being me	.54
29	I respect myself deeply	
24	I like myself very much	.56
29	I respect myself deeply	
25	I look after my own best interests	.51
32	I treat myself with love	
29	I respect myself deeply	.60
32	I treat myself with love	

Note: N=150 (nonclinical)

Two particularly high correlations (r ≥.60) were observed within the self-affiliation domain, indicating that these question pairs are too similar, measuring the same aspect of the concept, and could be amalgamated into a single coherent item. Item 29. '*I respect myself deeply*' and item 32. '*I treat myself with love*' (r=.60), could be combined into a single item such as '*I treat myself with love and respect'*. Similarly, item 1. '*even though I know I have some faults I am happy with myself as I am*' and item 3. '*I am content with myself*' (r=.76), could be merged into '*even though I know I have some faults I am happy and content with myself*'. Additionally, item 3. '*I am content with myself*', demonstrated strong correlations (r=>.50) with both item 4. '*I appreciate myself for just being me*' (r=.58), and item 24. '*I like myself very much*' (r=.57). However, item 3. would be more suitable for amalgamation with item 1. due to its higher inter-item correlation.

The numerous strong correlations within the self-affiliation domain indicated multiple layers of conceptual overlap, particularly for items 24. '*I like myself very much*' and 29. '*I respect myself deeply*', which correlate at r=.56. Item 24. also demonstrated significant correlations with item 1. '*even though I know I have some faults I am happy with myself as I am*' (r=.53), and item 4. '*I appreciate myself for just being me*' (r=.53). Similarly, item 29. showed strong correlations with item 2. '*I am comfortable with listening to my innermost feelings*' (r=.53), and item 4. '*I appreciate myself for just*

being me' (r=.54). These findings suggest that the 10-item self-affiliation domain would benefit from a reduction in items to avoid overemphasising any particular aspect of the phenomenon.

Item 13. '*I don't feel that I deserve anything good to happen to me*' and item 31. '*I think of ways to punish myself*' appeared to be similar measures of an aspect of self-attack, correlating at r=.56. Reflecting a strong correlation, it may be pertinent to combine these items into a single question, such as '*I think of ways to punish myself and don't feel that I deserve anything good*'. Within the self-control domain, item 22. '*I keep tight control over myself*' showed significant correlations with item 21. '*I keep an eye on myself to be sure I am doing what I should*' (r=.55), and item 35. '*I watch myself closely to make sure I don't do the wrong thing*' (r=.56). Again suggesting conceptual overlap, items 22. and 35. (with a slightly higher correlation at r=.56) might be merged into single item, such as '*I keep tight control over myself to make sure I don't do the wrong thing*'.

Weak Inter-Item Correlations. The overall pattern also revealed numerous exceptions to the expected within-domain inter-item relationships, with a total of 29 same-domain question pairs weakly correlating at <0.2. Interestingly, while several item pairs appeared across the self-control (n=9), self-neglect (n=14), and self-affiliation domains (n=6), there were none within the self-attack domain (see Table 12).

Table 12: Weak Inter-Item Correlations for the SRQ (Nonclinical sample, time 1)

SRQ Domain	Item No's.	Question Pairs	Inter-Item Correlation
Self-Control (n=9)	7	I carefully monitor my behaviour	.15
	10	I criticize myself harshly when I don't do something perfectly	
	7	I carefully monitor my behaviour	.17
	34	I try very hard to make sure my work is done on time	
	10	I criticize myself harshly when I don't do something perfectly	.18
	21	I keep an eye on myself to be sure I am doing	

		what I should	
	10	I criticize myself harshly when I don't do something perfectly	.18
	28	I put a lot of effort into everything that I do	
	10	I criticize myself harshly when I don't do something perfectly	.10
	33	I try very hard to become like an ideal image of myself	
	21	I keep an eye on myself to be sure I am doing what I should	.17
	27	I put a great deal of energy into making sure I follow the rules properly	
	21	I keep an eye on myself to be sure I am doing what I should	.15
	34	I try very hard to make sure my work is done on time	
	27	I put a great deal of energy into making sure I follow the rules properly	.16
	28	I put a lot of effort into everything that I do	
	27	I put a great deal of energy into making sure I follow the rules properly	.10
	33	I try very hard to become like an ideal image of myself	
Self-Neglect (n=14)	5	I avoid paying attention to important things	.18
	17	I have no internal direction or goals	
	5	I avoid paying attention to important things	.12
	26	I only live for the moment	
	6	I believe that whatever happens, happens, so it's better not to try	.12
	11	I don't attend to the condition of my personal environment	
	6	I believe that whatever happens, happens, so it's better not to try	.15
	12	I don't check up on things to make sure they're done correctly	
	6	I believe that whatever happens, happens, so it's better not to try	.08
	14	I don't spend much time planning for the future	
	6	I believe that whatever happens, happens, so it's better not to try	.16
	15	I don't try to develop good habits or skills	

	6	I believe that whatever happens, happens, so it's better not to try	.13
	17	I have no internal direction or goals	
	6	I believe that whatever happens, happens, so it's better not to try	.10
	23	I let my needs go unattended	
	6	I believe that whatever happens, happens, so it's better not to try	.11
	26	I only live for the moment	
	12	I don't check up on things to make sure they're done correctly	.14
	17	I have no internal direction or goals	
	12	I don't check up on things to make sure they're done correctly	.16
	23	I let my needs go unattended	
	15	I don't try to develop good habits or skills	.07
	23	I let my needs go unattended	
	15	I don't try to develop good habits or skills	.19
	26	I only live for the moment	
	17	I have no internal direction or goals	.14
	26	I only live for the moment	
Self-Affiliation (n=6)	1	Even though I know I have some faults I am happy with myself as I am	.13
	8	I comfort myself when I am sad or hurt	
	2	I am comfortable with listening to my innermost feelings	.11
	8	I comfort myself when I am sad or hurt	
	3	I am content with myself	.10
	8	I comfort myself when I am sad or hurt	
	4	I appreciate myself for just being me	.01
	8	I comfort myself when I am sad or hurt	
	8	I comfort myself when I am sad or hurt	.19
	9	I confidently allow myself to do what feels right	
	8	I comfort myself when I am sad or hurt	.11
	29	I respect myself deeply	

Note: N=150 (nonclinical)

It was noted that 4 out of the 9 weak correlation pairs in the self-control domain involved item 10. '*I criticize myself harshly when I don't do something*

perfectly', which had previously been flagged for having a corrected item-total correlation of .30. Although removing this item would not affect Cronbach's alpha, it highlights an overlap between self-control and self-attack (criticising oneself harshly), which may cause some redundancy with self-attack items. Additionally, 3 weak correlation pairs involved item 21. '*I keep an eye on myself to be sure I am doing what I should*', and another 3 involved item 27. '*I put a great deal of energy into making sure I follow the rules properly*'. Thus all but one of the weak correlation pairs involved items 10, 21, and 27.

The self-neglect domain exhibited the highest number of weak correlations between questions, notably involving all items within the subscale. This raises concerns about whether these items are effectively measuring the same psychological construct of the self-relationship. It was noted that 12 out of the 14 weak correlation pairs involved items 6. '*I believe that whatever happens, happens, so it's better not to try*', 23. '*I let my needs go unattended*', and 26. '*I only live for the moment*'. As mentioned previously, these items also demonstrated corrected item-total correlations below 0.3 (.23, .27, and .28 respectively), indicating a lack of coherence with the rest of the subscale and potentially harming the instrument's reliability.

Several weak correlations were present within the self-affiliation domain, all involving item 8. '*I comfort myself when I am sad or hurt*'. Interestingly, this item also showed the most significant corrected item-total correlation (.22), indicating that removing it would increase Cronbach's alpha from α=.86 to α=.87. As previously suggested, while this item reflects a self-affiliative/self-soothing construct, the aspects of sadness and pain may be confounding it, particularly since it correlates weakly with other questions within the domain.

Attack/Affiliation Inter-Item Correlations. Providing further evidence that the self-attack and self-affiliation domains may represent opposing poles, functioning as inverse measures of each other, 41 out of the 48 possible attack/affiliation correlation pairs demonstrated negative correlations. Seven of these

pairs showed notable negative correlations ranging between r=-.41 and r=-.49 (see Table 13). The two most significant negatively correlated pairs were item 16. '*I harshly reject myself as worthless*' and item 1. '*even though I know that I have some faults I am happy with myself as I am*' (r=-.49), and item 16. '*I harshly reject myself as worthless*' and item 3. '*I am content with myself*' (r=-.46). This suggests a self-attack/self-affiliation continuum of the same underlying factor. These inter-item correlations support the previously documented inter-domain correlation (r=-.56, p< .001) as detailed in Table 8.

Table 13: Significant Attack/Affiliation Inter-Item Correlations for the SRQ (Nonclinical sample, time 1)

SRQ Domain	Item No's.	Question Pairs	Inter-Item Correlation
Self-Attack/ Self-Affiliation (n=7)	13	I don't feel that I deserve anything good to happen to me	-.41
	1	Even though I know I have some faults I am happy with myself as I am	
	16	I harshly reject myself as worthless	-.49
	1	Even though I know I have some faults I am happy with myself as I am	
	31	I think of ways to punish myself	-.44
	1	Even though I know I have some faults I am happy with myself as I am	
	16	I harshly reject myself as worthless	-.46
	3	I am content with myself	
	31	I think of ways to punish myself	-.45
	3	I am content with myself	
	16	I harshly reject myself as worthless	-.43
	4	I appreciate myself for just being me	
	31	I think of ways to punish myself	-.45
	4	I appreciate myself for just being me	

Note: N=150 (nonclinical)

Neglect/Affiliation Inter-Item Correlations. Offering insight into the potential overlap between low levels of self-neglect and high levels of self-affiliation, 10

neglect/affiliation correlation pairs demonstrated moderate negative correlations ranging from r=-.32 to r=-.40 (see Table 14). The two most significant negatively correlated pairs were item 23. '*I let my needs go unattended*', with item 4. '*I appreciate myself for just being me*' (r=-.40), and item 23. with item 32. '*I treat myself with love*' (r=-.40). This suggests some conceptual overlap between the underlying factors of self-neglect and self-affiliation. Notably, all 10 correlation pairs involved self-neglect items 17. '*I have no internal direction or goals*', and 23. '*I let my needs go unattended*', which, reflecting a lack of self-care, may well be the antithesis of self-affiliation. These problematic items are further evidenced by the previously documented inter-domain correlation as detailed in Table 8, which reflected a relatively weak score of r= -.22, $p < .001$.

Table 14: Significant Neglect/Affiliation Inter-Item Correlations for the SRQ (Nonclinical sample, time 1)

SRQ Domain	Item No's.	Question Pairs	Inter-Item Correlation
Self-Neglect/ Self-Affiliation (n=10)	17 25	I have no internal direction or goals I look after my own best interests	-.32
	17 29	I have no internal direction or goals I respect myself deeply	-.34
	17 32	I have no internal direction or goals I treat myself with love	-.35
	23 1	I let my needs go unattended Even though I know I have some faults I am happy with myself as I am	-.32
	23 3	I let my needs go unattended I am content with myself	-.34
	23 4	I let my needs go unattended I appreciate myself for just being me	-.40
	23 24	I let my needs go unattended I like myself very much	-.33
	23 25	I let my needs go unattended I look after my own best interests	-.35
	23 29	I let my needs go unattended I respect myself deeply	-.39
	23	I let my needs go unattended	-.40

	32	I treat myself with love

Note: N=150 (nonclinical)

More notable was the previously documented inter-domain correlation between the self-neglect and self-attack domains (see Table 8), which reflected a moderate yet relatively significant positive correlation of r=.38, p<.001. Reviewing the inter-item correlation matrix, 9 neglect/attack correlation pairs demonstrated medium correlations ranging from r=-.30 to r=-.49 (see Table 15).

Table 15: Significant Neglect/Attack Inter-Item Correlations for the SRQ (Nonclinical sample, time 1)

SRQ Domain	Item No's.	Question Pairs	Inter-Item Correlation
Self-Neglect/ Self-Attack (n=9)	11	I don't attend to the condition of my personal environment	.33
	13	I don't feel that I deserve anything good to happen to me	
	17	I have no internal direction or goals	.36
	13	I don't feel that I deserve anything good to happen to me	
	17	I have no internal direction or goals	.31
	18	I have physically hurt myself when I felt I deserved it	
	17	I have no internal direction or goals	.31
	19	I have thought of hurting myself, although I haven't done it	
	17	I have no internal direction or goals	.36
	31	I think of ways to punish myself	
	23	I let my needs go unattended	.49
	13	I don't feel that I deserve anything good to happen to me	
	23	I let my needs go unattended	.40
	16	I harshly reject myself as worthless	
	23	I let my needs go unattended	.30
	30	I take my anger out on myself	
	23	I let my needs go unattended	.48
	31	I think of ways to punish myself	

Note: N=150 (nonclinical)

Notably, all but one of the 9 neglect/attack correlation pairs involved self-neglect items 17. '*I have no internal direction or goals*', and 23. '*I let my needs go unattended*'. Similar to the neglect/affiliation correlations previously presented (see Table 14), if these items reflect a lack of self-care, representing the antithesis of self-affiliation, it makes sense that they would also positively correlate with self-attack items. These findings support the hypothesis that self-attack and self-affiliation constructs exist on a continuum, acting as inverse measures of each other. The two most significant correlated neglect/attack pairs were item 23. '*I let my needs go unattended*', with item 13. '*I don't feel that I deserve anything good to happen to me*' (r=.49), and item 23. with item 31. '*I think of ways to punish myself*' (r=-.48). This suggests some overlap in the underlying factors of self-neglect and self-attack.

Table 16 below provides an overview of all significant attack/neglect/ affiliation inter-item pairs, collated and presented side-by-side to highlight commonly recurring item numbers (highlighted in bold). These commonalities clearly indicate potential overlap between specific questions within each domain, suggesting that these item numbers merit further investigation to better understand the constructs they are measuring. Consequently, these findings support the appropriateness of conducting exploratory factor analyses on the existing data to further elucidate the various constructs of the self-relationship. This analysis will help clarify whether, in relation to this nonclinical sample, the four-factor model of self-attack, self-control, self-neglect, and self-affiliation offers a valid representation of the measure's dimensionality.

Table 16: Overview of Significant Attack/Neglect/Affiliation Inter-Item Pairs

Attack/Affiliation Item Pairs		Neglect/Affiliation Item Pairs		Neglect/Attack Item Pairs	
13	1	17	25	11	13
16	1	17	29	17	13
31	1	17	32	17	18

16 31 16 31	3 3 4 4	23 23 23 23 23 23 23	1 3 4 24 25 29 32	17 17 23 23 23 23	19 31 13 16 30 31
13, **16**, **31**	**1**, **3**, **4**	**17**, **23**	**1**, **3**, **4**, 24, 25, 29, 32	11, **17**, **23**	**13**, **16**, 18, 19, 30, **31**

Notes: N=150 (nonclinical)

Significant Self-Control Inter-Item Correlations. A few significant inter-item correlations were found within the self-control domain, as detailed in Table 17 below. Demonstrating little overlap with the other subscales, there were four control/affiliation paired items, which interestingly, included both positive and negative correlations ranging from r=-.35 to r=.47. Notably, a significant positive correlation was found between self-control item 21. '*I keep an eye on myself to be sure I am doing what I should*', and self-affiliation item. 8. '*I comfort myself when I am sad or hurt*' (r=.47), indicating they may be measuring similar aspects. There was one moderate control/neglect correlation pair between self-control item 21. '*I keep an eye on myself to be sure I am doing what I should*', and self-neglect item 14. '*I don't spend much time planning for the future*' (r=-.33), again suggesting conceptual similarity.

Overall, the minimal overlap found between the self-control subscale and the other domains suggests that it represents a conceptually different construct of self-relating. While it is clear that we can measure the positive and negative valence of the self-relationship, the self-control dimension appears to be somewhat orthogonal to the constructs of self-affiliation, self-attack, and self-neglect.

Table 17: Significant Self-Control Inter-Item Correlations for the SRQ (Nonclinical sample, time 1)

SRQ Domain	Item No's.	Question Pairs	Inter-Item Correlation
Self-Control/	10	I criticize myself harshly when I don't do	-.35

Self-Affiliation (n=4)		something perfectly	
	1	Even though I know I have some faults I am happy with myself as I am	
	10	I criticize myself harshly when I don't do something perfectly	-.31
	3	I am content with myself	
	21	I keep an eye on myself to be sure I am doing what I should	.47
	8	I comfort myself when I am sad or hurt	
	33	I try very hard to become like an ideal image of myself	.31
	25	I look after my own best interests	
Self-Control/ Self-Neglect (n=1)	21	I keep an eye on myself to be sure I am doing what I should	-.33
	14	I don't spend much time planning for the future	

Notes: N=150 (nonclinical)

Reliable Change Index Value and Clinical Cut-Off of the SRQ Using Nonclinical and Clinical Samples

Clinically significant change, as defined by Jacobson et al. (1984, p.340), occurs '*when the client moves from the dysfunctional to the functional range during the course of therapy on whatever variable is being used to measure the clinical problem*'. To maximise the clinical utility of the SRQ, it is essential to establish its clinical cut-off point and reliable change index (RCI). These metrics provide insight into whether individuals in therapy are experiencing significant changes that exceed what could be attributed to chance alone. By determining the clinical cut-off and RCI, the SRQ can reliably assess client change processes in therapy, supporting its use in clinical settings. This '*twofold criterion for clinically significant change*' not only measures the extent of a client's improvement but also ensures that the change is statistically reliable (Jacobson & Truax, 1991, p. 12).

Jacobson and Truax (1991) highlighted the distinction between treatment effect (the statistical comparison of mean changes in therapy) and the clinical significance of the effect (meeting client, practitioner, and researcher standards of efficacy). They noted that while the size of an effect and its clinical significance are relatively

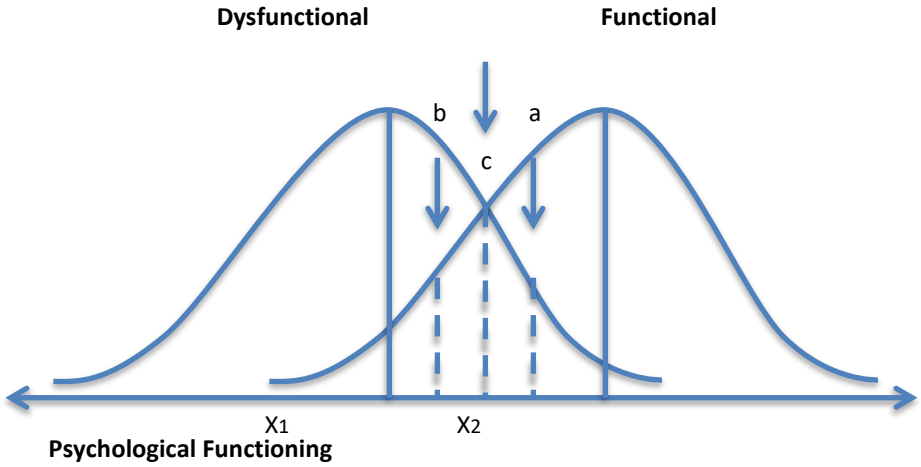
independent, a larger effect size is more likely to be perceived as clinically significant. Clinical significance measures any treatment effect in terms of its noticeable and practical importance in a person's day-to-day life. In contrast, statistical significance, based on probability, indicates that a treatment effect is unlikely to have occurred by chance but does not necessarily reflect the meaningfulness of the change for an individual.

Statistical significance, governed by the p-value, helps establish the significance of test results concerning the null hypothesis, which assumes no relationship between two variables. A p-value of less than .05 (indicating less than a 5% probability that the null hypothesis is correct) suggests that an alternative hypothesis is statistically significant and unlikely to have occurred by random chance. Confidence intervals, which refer to the probability that a population parameter will fall within a specific range, further aid in understanding statistical significance. Establishing the clinical cut-off and Reliable Change Index (RCI) for the SRQ is essential to differentiate and measure results that are: (a) both statistically and clinically significant, (b) not statistically significant but clinically relevant, or (c) statistically significant but not clinically relevant. This differentiation clarifies whether a change is significant rather than a result of random fluctuations or measurement imprecision (Jacobson & Truax, 1991).

Contributing to the development of evidence-based practice, the concept of reliable change in the context of psychological treatment was introduced by Jacobson and colleagues in 1984 (Jacobson et al., 1984; 1986; Jacobson & Revenstorf, 1988; Jacobson & Truax, 1991). The Reliable Change Index (RCI) proposed by Jacobson and Truax (1991) is a classical approach commonly applied in psychological research. Therefore, it was used to ascertain the clinical cut-off and RCI values of the SRQ. To calculate these values, the Jacobson Criterion C formula was applied to a pre-treatment clinical and nonclinical sample. In this formula, '*c*' represents the cut-off point (*caseness*) for clinically significant change, indicating a post-treatment assessment

crossover point that classifies a person as having changed significantly or moved from a clinical to nonclinical range (see Figure 3). The calculated clinical cut off and RCI values are detailed in Figures 4 and 5 below, with definitions provided in Tables 18 and 19.

Figure 3: Jacobson and Truax (1991) – A Reliable Change Index



Notes: Pre (X_1) and post (X_2) test scores for hypothetical subject with reference to three suggested cut-off points for clinically significant change (a, b, c), with c representing the mid-point of the means between the dysfunctional and functional groups.

In their discussion of the above index, Jacobson and Truax (1991) acknowledged that although post-test scores may surpass a cut-off point, the overlap in distributions between dysfunctional and functional samples could compromise the statistical reliability of the scores. To address this concern, Jacobson et al. (1984), later revised by Christensen and Mendoza (1986), had previously introduced a reliable change index, detailed in Figure 5, aimed at mitigating such uncertainties.

Figure 4: Jacobson Criterion C Formula

$$(C - M_1)/S_1 = (M_0 - C)/S_0$$

or

$$C = \frac{S_0 M_1 + S_1 M_0}{S_0 + S_1}$$

Table 18: Jacobson Criterion C Definitions

Symbol	Definition
C	Caseness or clinical cut-off
M_1	Mean of pre-treatment clinical group
M_0	Mean of nonclinical group
S_1	Standard deviation of pre-treatment clinical group
S_0	Standard deviation of nonclinical group

The Jacobson Criterion C formula was deemed appropriate for the calculation as it utilises data from both dysfunctional and functional populations, using the normative sample as a baseline to establish the standardised difference score. Comparison was made between the current nonclinical sample (n=150) and a pre-treatment clinical sample (n=74) from the EFT-SA archival database, specifically the EFT arm of a larger effectiveness study comparing EFT to PCT (Elliott et al., 2013), alongside an EFT Training study (Elliott & Michael, 2018). Clinical cut-off points and minimum RCI values at the p <.05 and p <.20 alpha levels were established (see Table 20). For change to be considered statistically significant, it must also be reliable. Therefore while the RCI value of 1.29 (80% probability of reliable change) demonstrated an acceptable level of reliable change for case study research (e.g., Elliott et al., 2009), the RCI value of 1.96 (95% probability of reliable change) sets a more robust psychometric standard. Providing insight into the significance level and meaning of individual test scores, a z-score indicates '*the degree to which an individual's test score is above or below the mean test score*'. Converting a raw test score to a z-score involves calculating the difference between the score and the mean of its distribution, and then dividing that

difference by the standard deviation of the distribution (Furr, 2018, p.60). It is generally understood that while the initial baseline RCI value reflects one z-unit of change within an instrument, it lacks statistical reliability, whereas approaching two z-units (RCI=1.96) between two successive scores demonstrates 95% probability of reliable change (beyond reasonable doubt). The RCI values were thus calculated by multiplying the baseline RCI score by the desired significance levels, obtaining the minimum RCI difference or z-score for that level of statistical significance.

To measure the variability at pre-treatment between dysfunctional and functional populations, the Jacobson C formula (see Figure 4 and Table 18) was used to calculate the clinical cut-off point, which is where the curves of the nonclinical and pre-treatment clinical samples intersect. These scores were determined using the pre-therapy mean and standard deviation from the EFT-SA archival SRQ outcome data and the current nonclinical sample's mean and standard deviation. These clinical cut-off points, or *caseness* scores, were defined for each domain as follows: self-affiliation <1.31, self-attack >.62, self-control >1.57 and self-neglect >.74. Utilising the test-retest reliability statistics for each domain from the normative nonclinical sample, the Jacobson reliable change index formula was applied as shown in Figure 5 and Table 19 below. Although the literature is somewhat ambiguous about the definitions of reliable change and the reliable change index, Jacobson and Truax (1991) describe reliable change as an *index*—a standardised difference score that measures the absolute difference needed for a change score to be considered reliable, rather than a result of measurement error. Consistent with the hypothesised standard deviation range of .40 to .70, the SRQ's RCI psychometric standards were met. At the p<.20, RCI=1.29 level, the results were: self-affiliation .38, self-attack .48, self-control .47, and self-neglect .40. In contrast, at the more stringent p<.05, RCI= 1.96 level, the results showed higher standard deviations: self-affiliation .58, self-attack .74, self-control .72 and self-neglect .61.

Figure 5: Jacobson Reliable Change Index

$$RC = \frac{X_2 - X_1}{S_{diff}}$$

Table 19: Jacobson Reliable Change Index Definitions

Symbol	Definition
RC	Reliable change index value
X_1	Pre-test score of hypothetical subject
X_2	Post-test score of hypothetical subject
S_{diff}	Standard error of difference between the two test scores (describing the spread of the distribution of change scores that would be expected if no actual change had occurred)

Whilst affirming the psychometric soundness of their approach to reliable change, Jacobson and Truax (1991) acknowledged issues related to the assumption that both functional and dysfunctional distributions are normal. They also noted the variability in expectations for '*return to normal functioning*' (p.18) across different client populations and types of difficulties. Maassen (2004) explored various approaches to calculating the standard error of measurement at pre and post-test, clarifying Christensen and Mendoza's (1986) statement that it '*represents the amount of difference which one could expect between two scores obtained on the same test by the same individual as a function of measurement error alone*' (p.889). Although Jacobson and Truax (1991) acknowledged that normative nonclinical data is often lacking for psychotherapeutic instruments used in research, this study was able to compare a substantial SRQ nonclinical sample with a clinical sample.

Table 20: Jacobson Criterion C Clinical Cut-Off and RCI Values

SRQ Domain	Nonclinical M	Nonclinical SD	Pre-Treatment Clinical M	Pre-Treatment Clinical SD	Nonclinical Test/Retest r	(Caseness) Jacobson C	RCI=1.96 *p*<.05	RCI=1.29 *p*<.20
Self-Affiliation	1.786	0.492	0.832	0.498	0.824	1.312	0.579	0.381
Self-Attack	0.445	0.444	0.842	0.587	0.796	0.616	0.735	0.484
Self-Control	1.443	0.509	1.713	0.587	0.804	1.568	0.720	0.474
Self-Neglect	0.552	0.382	1.003	0.542	0.833	0.738	0.614	0.404

Note: Nonclinical N = 150, Pre-Treatment Clinical N = 74.

p<.05 and *p*<.20 = 95% and 80% probability of reliable change.

Factor Structure of the SRQ Using Nonclinical and Clinical Samples

Building upon the preliminary statistical analyses of the SRQ, exploratory factor analysis (EFA) was conducted as a theory-building exercise to investigate the interrelationships of the observed variables and dimensions of the instrument in both the nonclinical and clinical samples. EFA is useful for summarising a large number of observations into a smaller number of factors and provides further evidence of the measures' construct validity, including factorial, convergent, and discriminant validity. This exploration aimed to further examine the SRQ's underlying structure. To this end, the inter-correlation matrix of the 36 SRQ items from the nonclinical sample (n=150), and the clinical sample (n=281-290) were subjected to principal axis factoring (PAF). PAF is considered a more accurate form of factor analysis and is often preferred over principal components analysis (PCA) due to PCA's tendency to apply a descriptive set of assumptions that can lead to over-factoring. As stated by Furr (2018), although the results from both methods can often be similar, PAF is generally recommended. Citing Fabrigar et al. (1999), they advise against using PCA in psychometric testing '*when the goal of the analysis is to identify latent constructs underlying measured variables*' (p.276).

Two measures of psychometric adequacy were applied to ensure the suitability of the correlation matrices for factor analysis (see Table 21 for the nonclinical sample and Table 24 for the clinical sample). Evaluating all available data, the Kaiser-Meyer-Olkin (KMO) Measure of Sampling Adequacy (1970; 1974) and Bartlett's Test of Sphericity (1951) assessed the sample factorability. The KMO test, which indicates the degree to which items are psychometrically linked in a construct, measures the proportion of variance within each item that might be attributed to underlying factors. Values between .80 and 1 suggest that the sample is adequate for factor analysis. Bartlett's test compares the observed correlation matrix to an identity matrix, determining if there is any redundancy among the variables that could be summarised with fewer factors. This test assesses whether the correlation matrix contains

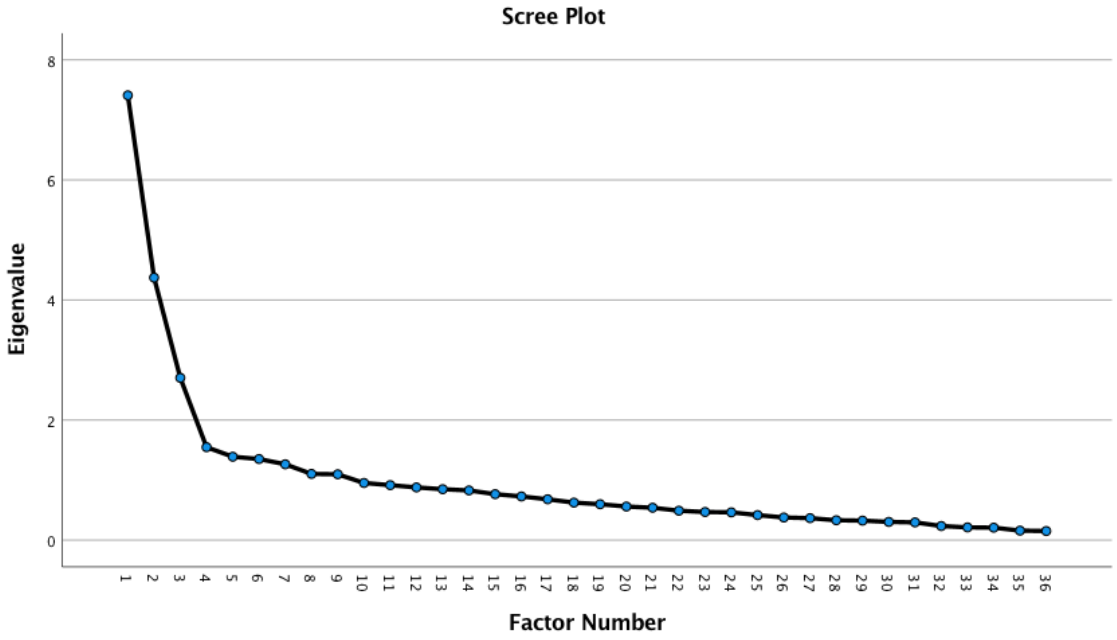
significant correlations among at least some variables, which is essential for the success of factor analysis. Therefore, it was crucial to ensure that Bartlett's test showed statistically significant shared variance (indicating interdependence among item scores) before proceeding with the analysis. KMO values above .50 and a significance level below .05 for Bartlett's test indicate substantial correlation within the data. A null hypothesis for this test suggests no correlation between the variables, implying they are orthogonal and unsuitable for factor analysis.

Table 21: Measures of Psychometric Adequacy – Nonclinical Sample

KMO and Bartlett's Test	
Kaiser-Meyer-Olkin Measure of Sampling Adequacy	.80
Bartlett's Test of Sphericity:	
Approx. Chi-Square	2144.89
df	630
Sig.	<.001

Factor Structure of the SRQ: Nonclinical Sample. Indicating that the items are psychometrically linked in a construct for the nonclinical sample, the Kaiser-Meyer-Olkin measure of sampling adequacy was above the .50 acceptable minimal level (MSA = .80). Bartlett's test of sphericity confirmed the interdependence of item scores, $\chi^2(630) = 2144.89$, $p<.001$. The scree plot (see Figure 6) suggested a three-factor solution was suitable for rotation, reflecting a break between the third and fourth factors. The first component accounted for a significant proportion of the variance (eigenvalue = 7.41, 20.58%), with smaller proportions attributed to the second (eigenvalue = 4.37, 12.15%) and third (eigenvalue = 2.70, 7.51%) components. Collectively, the three-factor solution explained 40.24% of the total variance.

Figure 6: Scree Plot – Nonclinical Sample



Note: N=150 (nonclinical sample)

The current version of the SRQ was previously reported to have a four-factor structure. Thus, the nonclinical matrix was initially subjected to 'varimax' rotation with four fixed factors. Factors are typically rotated in multidimensional scales to confirm their underlying psychological meaning. Generating uncorrelated factors, '*varimax is the standard orthogonal rotation*' (Furr, 2018). This rotation revealed that only one item loaded on the fourth factor at .40, the minimum acceptable positive or negative coefficient loading for interpretation. Since it is generally accepted that at least three items are needed to create a reliable scale, this finding suggested a three-factor solution was more appropriate. When the matrix was subjected to varimax rotation with three fixed factors, further evidence supported the hypothesised combination of self-affiliation and self-attack into a single bipolar dimension, indicating their inverse relationship. In this three-factor solution, the rotated factor matrix identified three

robust factors: self-affiliation and self-attack merged into one factor, along with self-control and self-neglect, consistent with the previously observed correlations of the various scales.

Factor 1 accounted for 20.58% of the total variance and included eight positively keyed self-affiliation items, four negatively keyed self-attack items, one negatively keyed self-control item (10. I criticize myself harshly when I don't do something perfectly), and one negatively keyed self-neglect item (23. I let my needs go unattended) item. Factor 2, comprising eight positively keyed self-control items, accounted for 12.15% of the total variance. Factor 3 included seven positively keyed self-neglect items, accounting for 7.51% of the total variance (see Table 22). The internal consistency was α=.90 for Factor 1, α=.79 for Factor 2, and α=.72 for Factor 3.

While the results demonstrate higher loadings on the self-affiliation items, indicating a more definitive factor, the self-attack items are negatively weighted (ranging from -.62 and below). Consequently, the two parts of the factor are not conceptually separable. This confirms a bipolar construct where the presence of one indicates the absence of the other; therefore, self-affiliation can also be measured by the absence of self-attack, and vice versa. For example, item 10, '*I criticize myself harshly when I don't do something perfectly*' (-.49), suggests that a lack of harsh self-criticism when not achieving perfection represents a lower level of self-affiliation. Defined on one end by self-affiliation and the other by self-attack, the factor reflects self-attack as the slightly less distinct end of the dichotomy. It is evident that retaining the two subscales may be superfluous, as they are likely to continue demonstrating a high negative correlation with each other.

Based on the extracted factors, the extraction communalities in Table 22 provide estimates of the shared variance for each item. These communalities indicate the extent to which the variance in each item is accounted for by the factors in the factor solution. High communalities suggest that the extracted components represent the variables well, while lower communalities, particularly those close to zero, indicate

variables that do not fit well with the factor solution and may need to be dropped from the instrument.

Table 22: Factor Analysis with Three Fixed Factors and Varimax Rotation – Nonclinical Sample

Item No.	Question	1	2	3	Extraction Commun-alities
1	Even though I know I have some faults I am happy with myself as I am	.75	.050	-.06	.57
3	I am content with myself	.74	.04	-.08	.56
29	I respect myself deeply	.72	.19	-.03	.56
32	I treat myself with love	.71	.07	-.06	.52
24	I like myself very much	.71	.03	.11	.52
4	I appreciate myself for just being me	.65	.03	-.03	.42
31	I think of ways to punish myself	-.62	.23	.36	.56
13	I don't feel that I deserve anything good to happen to me	-.61	.09	.27	.45
2	I am comfortable with listening to my innermost feelings	.58	.22	.10	.40
16	I harshly reject myself as worthless	-.57	.20	.22	.41
25	I look after my own best interests	.57	.19	-.13	.37
23	I let my needs go unattended	-.52	.09	.31	.38
30	I take my anger out on myself	-.50	.09	.18	.29
10	I criticize myself harshly when I don't do something perfectly	-.49	.32	-.06	.34
19	I have thought of hurting myself, although I haven't done it	-.36	.20	.34	.29
9	I confidently allow myself to do what feels right	.36	.16	.13	.17
18	I have physically hurt myself when I felt I deserved it	-.36	.18	.33	.27
8	I comfort myself when I am sad or hurt	.23	.14	.23	.12
35	I watch myself closely to make sure I don't do the wrong thing	-.08	.75	-.03	.57
36	My goal is to be as perfect as possible	-.10	.65	-.04	.44
22	I keep tight control over myself	-.04	.63	-.17	.42
7	I carefully monitor my behaviour	.06	.54	-.06	.29
33	I try very hard to become like an ideal image of myself	.20	.52	.07	.32

21	I keep an eye on myself to be sure I am doing what I should	.10	.50	-.22	.31
34	I try very hard to make sure my work is done on time	.03	.45	-.18	.23
28	I put a lot of effort into everything that I do	.17	.44	-.16	.25
27	I put a great deal of energy into making sure I follow the rules properly	-.07	.38	-.06	.15
12	I don't check up on things to make sure they're done correctly	.05	-.29	.58	.42
11	I don't attend to the condition of my personal environment	-.26	-.10	.53	.36
5	I avoid paying attention to important things	-.03	-.14	.50	.27
14	I don't spend much time planning for the future	-.09	-.25	.47	.29
15	I don't try to develop good habits or skills	-.05	-.17	.44	.22
17	I have no internal direction or goals	-.34	-.01	.43	.30
26	I only live for the moment	.24	-.20	.40	.26
20	I hurt myself by overburdening myself with work	-.19	.30	.33	.23
6	I believe that whatever happens, happens, so it's better not to try	-.02	-.05	.26	.07

Note: Extraction Method: Principal Axis Factoring (N=150, nonclinical)
Rotation Method: Varimax with Kaiser Normalization (rotation converged in 8 iterations)

The principal axis analysis matrix revealed seven variables (items 6, 8, 9, 18, 19, 20, and 27) with factor loadings below the absolute value of .40, indicating vague interpretability and potential redundancy within the measure (see Table 23). However, there is a case for retaining items 18. '*I have physically hurt myself when I felt I deserved it*', and 19. '*I have thought of hurting myself, although I haven't done it*', as risk items. Self-attack items involving self-harm tend to be endorsed less frequently, especially within a nonclinical population. A similar issue was noted during the development of the CORE Outcome Measure, where risk items did not factor well with the rest of the instrument partly due to their low base rate. In consultation with clinicians testing the measure, the risk items were retained due to their clinical usefulness. The extraction communalities for items 18 and 19 are .27 and .29,

respectively. These relatively low values suggest that these items may not effectively measure the intended construct or that respondents are hesitant to endorse such items. Rather than simply dropping these items, it is important to consider how the factor analysis might differ in a clinical population. If a comparison with a clinical sample shows similar results or only slightly higher loadings, it would be justifiable to drop these items. The means and standard deviations for these items would help identify any restriction of range issues. Therefore, before removing the items or arguing for their clinical relevance, it is essential to investigate how the factor analysis presents in a clinical sample.

Table 23: Factor Loadings Below Absolute Value – Nonclinical Sample

Item No.	Question	1	2	3	Extraction Commun-alities
6	I believe that whatever happens, happens, so it's better not to try	-.02	-.05	.26	.07
8	I comfort myself when I am sad or hurt	.23	.14	.23	.12
9	I confidently allow myself to do what feels right	.36	.16	.13	.17
18	I have physically hurt myself when I felt I deserved it	-.36	.18	.33	.27
19	I have thought of hurting myself, although I haven't done it	-.36	.20	.34	.29
20	I hurt myself by overburdening myself with work	-.19	.30	.33	.23
27	I put a great deal of energy into making sure I follow the rules properly	-.07	.38	-.06	.15

Note: Extraction Method: Principal Axis Factoring (N=150, nonclinical)
Rotation Method: Varimax with Kaiser Normalization (rotation converged in 8 iterations)

Comparing the Factor Structure of the SRQ Nonclinical Sample to a Clinical Sample. As previously mentioned, the SRQ was initially developed as an experimental measure and was used in the EFT arm of a larger effectiveness study comparing EFT to PCT (Elliott et al., 2013). It was administered to clients as part of a broader set of

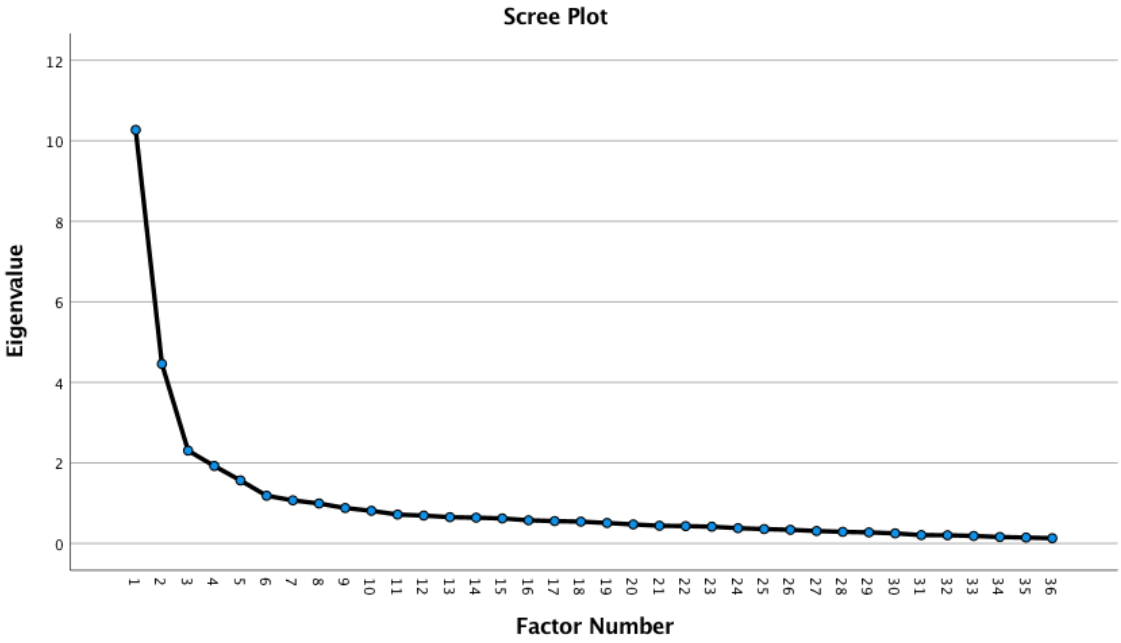
outcome measures after the intake process, prior to session 1, after session 8, at the end of therapy (usually after session 20), and optionally at 6 and 18-month follow-up interviews. The aim was to measure change in the client's relationship with their self, and to assist therapists in evaluating client progress. A further clinical sample of the SRQ was later compiled as part of an EFT Training study (Elliott & Michael, 2018), adding to the existing EFT archival database. To challenge the results from the nonclinical sample and to offer a robust comparison, the inter-correlation matrix of the 36 SRQ items from these combined clinical samples (n=281-290 per SRQ item) was also subjected to principal axis factoring (PAF). Two measures of psychometric adequacy, the KMO and Bartlett's test (see Table 24), indicated that the clinical correlation matrix was suitable for factor analysis. The KMO measure of sampling adequacy was above the acceptable minimum level of 0.50 (MSA = 0.90), suggesting that the items are psychometrically linked. Bartlett's test of sphericity indicated item score interdependence, $\chi^2(630) = 5482.29$, $p<.001$. The scree plot (see Figure 7) indicated a break between the third and fourth factors, suggesting that a three-factor solution was suitable for rotation. The first component accounted for a large proportion of the variance (eigenvalue 10.27, 28.54%), with smaller proportions of variance in the second (eigenvalue 4.46, 12.39%) and third (eigenvalue 2.31, 6.41%) components. Overall, the three-factor solution accounted for 47.34% of the total variance.

Factorial Structure of the SRQ: Clinical Sample

Table 24: Measures of Psychometric Adequacy – Clinical Sample

KMO and Bartlett's Test	
Kaiser-Meyer-Olkin Measure of Sampling Adequacy	.90
Bartlett's Test of Sphericity:	
Approx. Chi-Square	5482.29
df	630
Sig.	.000

Figure 7: Scree Plot – Clinical Sample



Note: N=281-290 (clinical)

As with the nonclinical sample, the clinical matrix was initially subjected to varimax rotation with four fixed factors. This rotation revealed five items loading on the fourth factor at 0.4 or greater, the minimum acceptable positive or negative coefficient loading for interpretation. Whilst it is generally accepted that at least three items are required to generate an adequately reliable scale, closer inspection showed that the analysis had discriminated the more punishing aspects of self-attack as the fourth factor. These items included SRQ item 31. '*I think of ways to punish myself*', item 19. '*I have thought of hurting myself, although I haven't done it*', item 20. '*I hurt myself by overburdening myself with work*', item 18. '*I have physically hurt myself when I felt I deserved it*', and item 30. '*I take my anger out on myself*'. As with the nonclinical sample, the remaining self-attack items, item 16. '*I harshly reject myself as worthless*', and item 13. '*I don't feel that I deserve anything good to happen to me*', were

incorporated into factor 1 as an inverse measure of self-affiliation. Due to this apparent differentiation of moderate to severe aspects of self-attack, the matrix was then subjected to varimax rotation with three fixed factors.

Similar to the nonclinical sample, this analysis provided further evidence of the hypothesised combination of self-affiliation and self-attack into a single bipolar dimension, indicative of their inverse relationship. When forced into a three-factor solution, the rotated factor matrix revealed three solid factors, merging self-affiliation and self-attack into one factor, along with self-control and self-neglect. Factor 1, accounting for 28.54% of the total variance, comprised ten positively keyed self-affiliation items and five negatively keyed self-attack items. Factor 2, accounting for 12.39% of the total variance, included ten positively keyed self-control items and one positively keyed self-attack item ('I hurt myself by overburdening myself with work'). Factor 3, accounting for 6.41% of the total variance, consisted of seven positively keyed self-neglect items (see Table 25). Overall, the three-factor solution accounted for 47.34% of the total variance. The internal consistency of Factor 1 was α=.94, Factor 2 was α=.83, and Factor 3 was α=.78. As with the nonclinical results, the clinical results demonstrated higher loadings on the self-affiliation items, indicating a more definitive factor. The self-attack items were negatively weighted from -.71 and below, providing further evidence that the two parts of the factor are not conceptually separable.

Table 25: Factor Analysis with Three Fixed Factors and Varimax Rotation – Clinical Sample

Item No.	Question	1	2	3	Extraction Commun-alities
4	I appreciate myself for just being me	.84	-.10	-.14	.74
1	Even though I know I have some faults I am happy with myself as I am	.82	-.13	-.13	.70
3	I am content with myself	.82	-.17	-.18	.73
24	I like myself very much	.81	-.04	-.12	.68
32	I treat myself with love	.81	.03	-.29	.73
29	I respect myself deeply	.80	.05	-.26	.72

16	I harshly reject myself as worthless	-.71	.27	.29	.66
2	I am comfortable with listening to my innermost feelings	.68	-.05	-.03	.47
25	I look after my own best interests	.63	.13	-.19	.45
9	I confidently allow myself to do what feels right	.62	.02	-.24	.44
8	I comfort myself when I am sad or hurt	.60	.01	-.10	.37
13	I don't feel that I deserve anything good to happen to me	-.59	.18	.35	.51
30	I take my anger out on myself	-.50	.30	.19	.38
19	I have thought of hurting myself, although I haven't done it	-.47	.31	.16	.34
31	I think of ways to punish myself	-.42	.39	.13	.35
18	I have physically hurt myself when I felt I deserved it	-.25	.21	.06	.11
35	I watch myself closely to make sure I don't do the wrong thing	-.13	.75	.05	.57
36	My goal is to be as perfect as possible	-.11	.63	-.01	.41
28	I put a lot of effort into everything that I do	.16	.62	-.32	.50
27	I put a great deal of energy into making sure I follow the rules properly	.00	.61	.06	.38
22	I keep tight control over myself	-.12	.59	.10	.37
33	I try very hard to become like an ideal image of myself	-.04	.57	-.06	.33
21	I keep an eye on myself to be sure I am doing what I should	.04	.52	.03	.27
10	I criticize myself harshly when I don't do something perfectly	-.40	.49	.13	.42
7	I carefully monitor my behaviour	.02	.48	.12	.25
34	I try very hard to make sure my work is done on time	.02	.48	-.44	.42
20	I hurt myself by overburdening myself with work	-.28	.41	-.01	.24
14	I don't spend much time planning for the future	-.31	-.08	.63	.49
15	I don't try to develop good habits or skills	-.17	.01	.60	.39
5	I avoid paying attention to important things	-.19	.17	.58	.40
17	I have no internal direction or goals	-.42	-.06	.51	.44
23	I let my needs go unattended	-.35	.21	.46	.38
6	I believe that whatever happens, happens,	-.08	.03	.45	.21

	so it's better not to try				
11	I don't attend to the condition of my personal environment	-.21	.16	.44	.26
12	I don't check up on things to make sure they're done correctly	-.14	-.16	.29	.13
26	I only live for the moment	.25	.04	.28	.14

Note: Extraction Method: Principal Axis Factoring (N=281-290 clinical)
Rotation Method: Varimax with Kaiser Normalization (rotation converged in 5 iterations)

The principal axis analysis matrix for the clinical sample revealed three variables (items 12, 18, and 26) with factor loadings below the absolute value of .40, indicating vague interpretability and their potential redundancy within the instrument (see Table 26). As with the nonclinical sample, there is a case for retaining item 18. '*I have physically hurt myself when I felt I deserved it*', as a risk item within the measure. Similar to the nonclinical sample, this item has a particularly low extraction communality, indicating lower variability. While this item may not be effectively measuring the intended construct, respondents might be hesitant to endorse it, or they might be less likely to experience the phenomenon. One might hypothesise that a clinical population may be reluctant to admit to physically hurting themselves, while a nonclinical population might be less likely to experience the type of distress leading to inflicting such physical self-harm.

Table 26: Factor Loadings Below Absolute Value – Clinical Sample

Item No.	Question	1	2	3	Extraction Commun-alities
12	I don't check up on things to make sure they're done correctly	-.14	-.16	.29	.13
18	I have physically hurt myself when I felt I deserved it	-.25	.21	.06	.11
26	I only live for the moment	.25	.04	.28	.14

Note: Extraction Method: Principal Axis Factoring (N=281-290 clinical)

Rotation Method: Varimax with Kaiser Normalization (rotation converged in 5 iterations)

Combined Factorial Structure of the SRQ Nonclinical and Clinical Samples

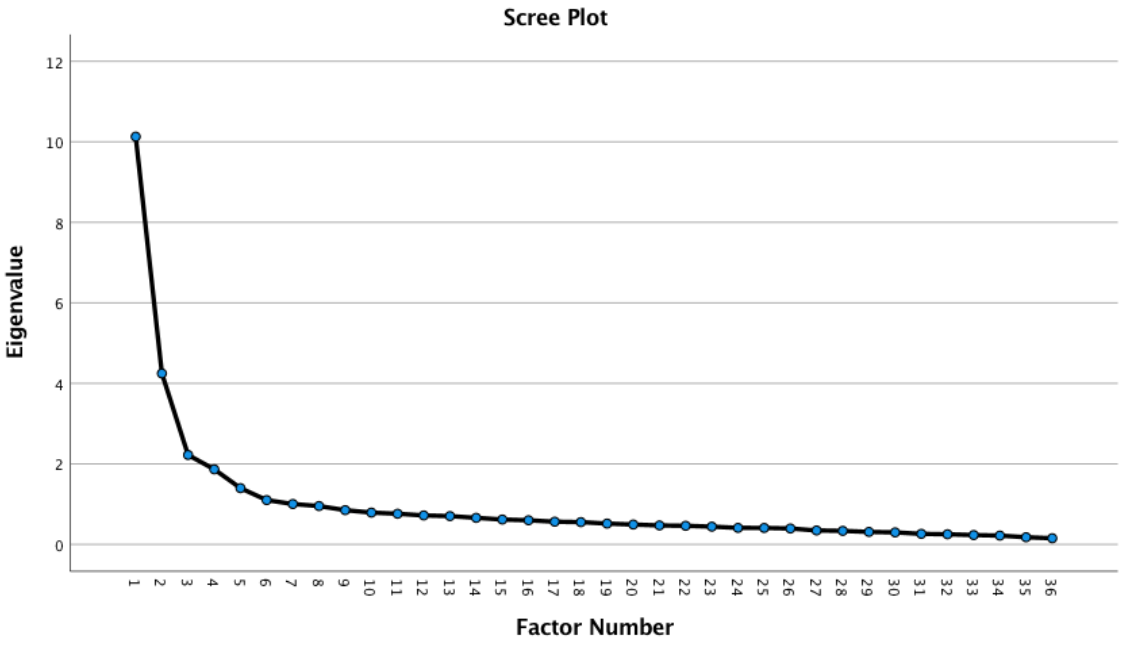
After conducting exploratory factor analyses for both the nonclinical (n=150) and clinical groups (n=281-290), the decision was taken to combine both populations to enhance the exploration of the instrument's dimensionality (n=431-440 combined sample). Subjecting the complete dataset to principal axis factoring (PAF), two measures of psychometric adequacy (KMO and Bartlett's test, see Table 27) were applied, indicating that the correlation matrix was suitable for factor analysis. The KMO measure of sampling adequacy was well above the acceptable minimum level of .50 (MSA = .92), suggesting that the items are psychometrically linked. Bartlett's test of sphericity indicated item score interdependence, χ ^2(630) = 7617.00, p<.001. The scree plot (see Figure 8) indicated a break between the third and fourth factors, suggesting a three-factor solution was suitable for rotation. The first component accounted for a large proportion of the variance (eigenvalue 10.13, 28.14%), with smaller proportions in the second (eigenvalue 4.25, 11.80%) and third (eigenvalue 2.22, 6.18%) components. The three-factor solution accounted for 46.12% of the total variance. The internal consistency of Factor 1 was α=.94, Factor 2 α=.82, and Factor 3 α=.77. The combined results demonstrated higher loadings on the self-affiliation items, indicating a more definitive factor, while the self-attack items were negatively weighted from -.70 and below. This provides further evidence that the two parts of the factor are not conceptually separable (see Table 28).

Table 27: Measures of Psychometric Adequacy - Combined Nonclinical and Clinical Samples

KMO and Bartlett's Test

Kaiser-Meyer-Olkin Measure of Sampling Adequacy	.92
Bartlett's Test of Sphericity:	
Approx. Chi-Square	7617.00
df	630
Sig.	.000

Figure 8: Scree Plot – Combined Nonclinical and Clinical Samples



Note: N=431-440 (combined sample).

As with the nonclinical and clinical samples, the combined matrix was initially subjected to varimax rotation with four fixed factors. This rotation indicated that four items loaded on the fourth factor at .40 or greater, the minimum acceptable positive or negative coefficient loading for interpretation. While it is generally accepted that at

least three items are required to generate a reliable scale, closer inspection revealed that the analysis had once again distinguished the more punishing aspects of self-attack as the fourth factor. These items included SRQ 31. '*I think of ways to punish myself*', 19. '*I have thought of hurting myself, although I haven't done it*', 20. '*I hurt myself by overburdening myself with work*', and 18. '*I have physically hurt myself when I felt I deserved it*'. As with the nonclinical sample, the remaining self-attack items 16. '*I harshly reject myself as worthless*', 13. '*I don't feel that I deserve anything good to happen to me*', and 30. '*I take my anger out on myself*' were incorporated into factor 1 as an inverse measure of self-affiliation. Due to this apparent differentiation between the moderate and more severe aspects of self-attack, the matrix was then subjected to varimax rotation with three fixed factors.

Similar to both nonclinical and clinical samples, the combined analysis yielded additional support for the hypothesised integration of self-affiliation and self-attack into a unified bipolar dimension, demonstrating their inverse relationship. Under a forced three-factor solution, the rotated factor matrix consistently revealed three robust factors, consolidating self-affiliation and self-attack into one factor alongside self-control and self-neglect. Factor 1, which explained 28.14% of the total variance, comprised ten positively rated self-affiliation items, five negatively rated self-attack items, and one negatively rated self-neglect item (e.g., 'I let my needs go unattended,' item 23). Factor 2 consisted of ten positively rated self-control items, explaining 11.80% of the total variance, while Factor 3 included seven positively rated self-neglect items, explaining 6.18% of the total variance (refer to Table 28). Together, the three-factor solution accounted for 46.12% of the total variance.

Table 28: Factor Analysis with Three Fixed Factors and Varimax Rotation – Combined Nonclinical and Clinical Samples

Item No.	Question	1	2	3	Extraction Commun-alities
1	Even though I know I have some faults I	.82	-.12	-.15	.71

	am happy with myself as I am				
4	I appreciate myself for just being me	.82	-.11	-.15	.70
3	I am content with myself	.81	-.15	-.19	.72
24	I like myself very much	.81	-.05	-.07	.66
29	I respect myself deeply	.81	.04	-.23	.71
32	I treat myself with love	.80	.01	-.22	.69
16	I harshly reject myself as worthless	-.70	.27	.30	.64
2	I am comfortable with listening to my innermost feelings	.69	-.01	-.05	.48
9	I confidently allow myself to do what feels right	.63	-.00	-.20	.43
25	I look after my own best interests	.62	.13	-.16	.42
13	I don't feel that I deserve anything good to happen to me	-.60	.18	.36	.52
8	I comfort myself when I am sad or hurt	.54	.03	-.03	.29
30	I take my anger out on myself	-.48	.25	.20	.34
31	I think of ways to punish myself	-.43	.35	.20	.35
23	I let my needs go unattended	-.42	.19	.41	.38
19	I have thought of hurting myself, although I haven't done it	-.41	.28	.20	.28
18	I have physically hurt myself when I felt I deserved it	-.19	.16	.08	.07
35	I watch myself closely to make sure I don't do the wrong thing	-.15	.75	.01	.59
36	My goal is to be as perfect as possible	-.14	.64	-.01	.43
22	I keep tight control over myself	-.13	.60	-.01	.38
27	I put a great deal of energy into making sure I follow the rules properly	-.03	.56	.05	.32
33	I try very hard to become like an ideal image of myself	.00	.56	-.02	.31
28	I put a lot of effort into everything that I do	.20	.55	-.26	.41
21	I keep an eye on myself to be sure I am doing what I should	.03	.52	-.03	.27
7	I carefully monitor my behaviour	.00	.50	.04	.25
10	I criticize myself harshly when I don't do something perfectly	-.44	.46	.09	.41
34	I try very hard to make sure my work is done on time	.08	.45	-.38	.35
20	I hurt myself by overburdening myself with work	-.22	.37	.08	.19
5	I avoid paying attention to important	-.19	.11	.63	.44

	things				
14	I don't spend much time planning for the future	-.30	-.09	.61	.47
15	I don't try to develop good habits or skills	-.19	-.02	.56	.35
11	I don't attend to the condition of my personal environment	-.27	.13	.50	.33
17	I have no internal direction or goals	-.45	-.01	.49	.44
12	I don't check up on things to make sure they're done correctly	-.12	-.17	.42	.22
6	I believe that whatever happens, happens, so it's better not to try	-.10	.03	.40	.18
26	I only live for the moment	.24	-.03	.33	.16

Note: Extraction Method: Principal Axis Factoring (N=431-440 combined sample) Rotation Method: Varimax with Kaiser Normalization (rotation converged in 5 iterations)

The principal axis analysis matrix for the combined nonclinical and clinical samples revealed three variables (items 18, 20, and 26) with factor loadings below the absolute value of .40, suggesting unclear interpretability and potential redundancy within the measure (see Table 29). Similar to findings from the individual nonclinical and clinical analyses, there is a rationale for retaining item 18. '*I have physically hurt myself when I felt I deserved it*', as a risk item in the measure. Consistent with earlier samples, this item exhibited notably low extraction communality when considered independently, indicating limited variability. As previously discussed, it is plausible that this item does not effectively measure its intended construct; respondents may be hesitant to endorse it or may infrequently experience the phenomenon it describes. Consistently across all factor analyses, it is clear that respondents from different populations are reluctant to endorse this item.

Table 29: Factor Loadings Below Absolute Value – Combined Nonclinical and Clinical Samples

Item No.	Question	1	2	3	Extraction Commun-alities
18	I have physically hurt myself when I felt I	-.19	.16	.08	.07

	deserved it				
20	I hurt myself by overburdening myself with work	-.22	.37	.08	.19
26	I only live for the moment	.24	-.03	.33	.16

Note: Extraction Method: Principal Axis Factoring (N=431-440 combined sample) Rotation Method: Varimax with Kaiser Normalization (rotation converged in 5 iterations)

Summary of Exploratory Factor Analyses: Nonclinical, Clinical and Combined Samples. Comparing the structures across nonclinical, clinical, and combined populations provided compelling evidence that the SRQ conforms to a three-factor solution, assessing distinct aspects of the self-relationship within the dimensions of self-affiliation versus self-attack, self-control, and self-neglect. Analysis of item loadings within each dimension across all three populations consistently revealed similarities, detailed in Table 30 below. This overview highlights uniformity in item weights (with variability ≤.20), irrespective of whether the sample was nonclinical, clinical, or combined, underscoring the broad relevance of these items within the instrument.

Table 30: Factors Loading Across the Nonclinical, Clinical and Combined Populations

Item No.	Question	Non-Clinical	Clinical	Combined
Self-Affiliation vs Self-Attack (12 items):				
1	Even though I know I have some faults I am happy with myself as I am	.75	.82	.82
2	I am comfortable with listening to my innermost feelings	.58	.68	.69
3	I am content with myself	.74	.82	.81
4	I appreciate myself for just being me	.65	.84	.82
13	I don't feel that I deserve anything good to happen to me	-.61	-.59	-.60
16	I harshly reject myself as worthless	-.57	-.71	-.70
24	I like myself very much	.71	.81	.81
25	I look after my own best interests	.57	.63	.62
29	I respect myself deeply	.72	.80	.81
30	I take my anger out on myself	-.50	-.50	-.48
31	I think of ways to punish myself	-.62	-.42	-.43

32	I treat myself with love	.71	.81	.80
Self-Control (8 items):				
7	I carefully monitor my behaviour	.54	.48	.50
21	I keep an eye on myself to be sure I am doing what I should	.50	.52	.52
22	I keep tight control over myself	.63	.59	.60
28	I put a lot of effort into everything that I do	.44	.62	.55
33	I try very hard to become like an ideal image of myself	.52	.57	.56
34	I try very hard to make sure my work is done on time	.45	.48	.45
35	I watch myself closely to make sure I don't do the wrong thing	.75	.75	.75
36	My goal is to be as perfect as possible	.65	.63	.64
Self-Neglect (5 items):				
5	I avoid paying attention to important things	.50	.58	.63
11	I don't attend to the condition of my personal environment	.53	.44	.50
14	I don't spend much time planning for the future	.47	.63	.61
15	I don't try to develop good habits or skills	.44	.60	.56
17	I have no internal direction or goals	.43	.51	.49

Note: Extraction Method: Principal Axis Factoring (N=150 nonclinical, plus N=281-290 clinical). Rotation Method: Varimax with Kaiser Normalization (rotation converged in 5-8 iterations)

Moreover, additional consistencies were observed by examining items that loaded across two of the three samples (see Table 31). This analysis highlights similarities in item weightings, showing variability of ≤.20 across two datasets, thereby underscoring the relevance of these items within their relevant domains. Similar to the approach used by Rhodes et al. (1994) for frequency ratings, this method aims to identify the occurrence of general, typical, and unique items within various factor structures. In this context, General (G) indicates items that loaded across all three data samples, Typical (T) refers to items that loaded on at least two samples, and Unique (U) denotes items that loaded on only one sample.

Table 31: Typical Factors Loading Across Two of the Three Datasets

Item No.	Question	Non-Clinical	Clinical	Combined
Self-Affiliation vs Self-Attack (4 items):				
8	I comfort myself when I am sad or hurt		.60	.54
9	I confidently allow myself to do what feels right		.62	.63
19	I have thought of hurting myself, although I haven't done it		-.47	-.41
23	I let my needs go unattended *(*self-neglect item loading as such in clinical sample)*	-.52	*(*.46)*	-.42
Self-Control (2 items):				
10	I criticize myself harshly when I don't do something perfectly *(*self-control item loading in nonclinical sample as self-attack)*	*(*-.49)*	.49	.46
27	I put a great deal of energy into making sure I follow the rules properly		.61	.56
Self-Neglect (2 items):				
6	I believe that whatever happens, happens, so it's better not to try		.45	.40
12	I don't check up on things to make sure they're done correctly	.58		.42

Note: Extraction Method: Principal Axis Factoring (N=150 nonclinical, plus N=281-290 clinical). Rotation Method: Varimax with Kaiser Normalization (rotation converged in 5-8 iterations)

Notably, item 23. '*I let my needs go unattended*', originally intended to measure SRQ self-neglect, loaded as such in the clinical sample (.46). However, in the nonclinical (-.52) and combined (-.42) datasets, this item was negatively weighted as a form of self-affiliation. This suggests that the absence of neglecting one's personal needs may be experienced as self-affiliative, reflecting self-care. Conversely, overlooking personal needs could imply a type of self-harm. Similarly, item 10. '*I criticize myself harshly when I don't do something perfectly*', intended as a self-control measure, loaded as such in the clinical (.49) and combined (.46) datasets, but also appeared as a self-attack (-.49) item in the nonclinical sample. This indicates that harsh self-criticism can represent

both self-harm (due to the severity of the criticism) and self-control (due to the expectation of perfection).

Continuing with the frequency ratings theory, items that appeared inconsistent by loading uniquely on only one data sample were considered (see Table 32). Items 20. '*I hurt myself by overburdening myself with work*' and 26. '*I only live for the moment*' barely met the minimum acceptable positive or negative coefficient loading of ≥.40 for interpretation. Additionally, item 20., originally intended as a self-attack variable in the instrument, was weighted as a self-control item in the clinical population.

Table 32: Unique Factors Loading on One Dataset

Item No.	Question	Non-Clinical	Clinical	Combined
Self-Control (1 item):				
20	I hurt myself by overburdening myself with work *(*self-attack item)*		.41	
Self-Neglect (1 item):				
26	I only live for the moment	.40		

Note: Extraction Method: Principal Axis Factoring (N=150 nonclinical, plus N=281-290 clinical). Rotation Method: Varimax with Kaiser Normalization (rotation converged in 5-8 iterations)

While there were nine items in total that loaded below the absolute value of .40 within the nonclinical, clinical, and combined populations, only three of them appeared across two or more of the samples (see Table 33). As previously discussed, item 18. '*I have physically hurt myself when I felt I deserved it*', was the only flagged item appearing across all three observations reflecting particularly low extraction communality values. It seems that participants, whether from nonclinical, clinical, or combined populations, were reluctant to endorse this item, possibly due to reluctance to admit to such behaviour or the rarity of experiencing it. Nonetheless, as a practicing psychotherapist with almost twenty years of clinical experience, I believe it is important to retain this item for its clinical usefulness.

Interestingly, item 20. '*I hurt myself by overburdening myself with work*', intended as a self-attack item within the original SRQ, appeared more weighted towards the self-neglect domain in the nonclinical population (.33) and the self-control domain within the combined population (.37), both of which reflect slightly higher loadings than self-attack. Additionally, the item loaded as a self-control variable (.41) in the clinical sample. Thus, it appears that this items lacks consistency and may be detrimental to the instrument. Finally, item 26. '*I only live for the moment*', intended as a self-neglect item, just met the minimum absolute value in the nonclinical sample (.40), but did not meet the necessary criteria within the clinical and combined populations. Considering their particularly low extraction communalities (.14 and .16 respectively), it seems prudent to consider removing this item from the instrument. These findings are consistent with those presented previously regarding unique factors loading on one dataset in Table 32.

Table 33: Common Factors Loading Below Absolute Value Across the Nonclinical, Clinical and Combined Populations (≥ 2 Occurrences)

Item No.	Question	Non-Clinical	Clinical	Combined
Self-Affiliation vs Self-Attack (2 items):				
18	I have physically hurt myself when I felt I deserved it	-.36	-.25	-.19
20	I hurt myself by overburdening myself with work	-.19		-.22
Self-Neglect (1 item):				
26	I only live for the moment		.28	.33

Note: Extraction Method: Principal Axis Factoring (N=150 nonclinical, plus N=281-290 clinical). Rotation Method: Varimax with Kaiser Normalization (rotation converged in 5-8 iterations)

Before outlining recommendations for a revised version of the SRQ based upon this set of exploratory factor analyses, I will first review the reliability and validity analyses for the clinical dataset to compare their consistency with the nonclinical sample.

Review of Clinical Reliability and Validity Analyses: Are the Clinical Results Consistent with the Nonclinical Sample?

Having utilised the clinical sample to calculate the SRQ reliable change and clinical cut-off indices, and to provide more robust exploratory factor analyses, it follows that the reliability and validity statistics for this dataset are reviewed. Similar to the nonclinical sample, the clinical data demonstrated acceptable to excellent internal consistency (self-affiliation: α=.94, self-attack: α=.84, self-control: α=.83 and self-neglect: α=.75). Once more, all constructs met the minimum acceptable standard of internal consistency (α ≥.70), with self-affiliation emerging as the most reliable and self-neglect as marginally less so, yet still within acceptable limits. On reviewing the corrected item-total correlations for the clinical sample, only two items scored <.30, both within the self-neglect domain. Items 12. '*I don't check up on things to make sure they're done correctly*' (.27), and 26. '*I only live for the moment*' (.11), appeared to have little in common with the rest of the domain, indicating problematic items for this subscale in the clinical population. The squared multiple correlations for the clinical sample were as follows: self-affiliation (r=.38 >.78), self-attack (r=.26 >.58), self-control (r=.28 >.57), and self-neglect (r=.05 >.44). For this clinical population, a few items within the self-affiliation domain appeared to be conceptually overlapping, specifically items 1. '*even though I know I have some faults I am happy with myself as I am*' (.76), 3. '*I am content with myself*' (.75), 4. '*I appreciate myself for just being me*' (.78), and 32. '*I treat myself with love*' (.71). Notably, items 1. and 3. were also flagged within the nonclinical sample.

When examining the clinical inter-item correlation matrix for each dimension of the SRQ, negative values were noted within the self-neglect domain for items 11. '*I don't attend to the condition of my personal environment*' and 26. '*I only live for the moment*' (r=-.02), and items 12. '*I don't check up on things to make sure they're done correctly*' and 26. '*I only live for the moment*' (r=-.03). As previously noted, items 12. and 26. were flagged in the corrected item-total correlations, indicating poor domain fit and thus potentially harming the reliability of the instrument. Indicative of significant

conceptual overlap and the need for item reduction, twenty pairs of high correlations were observed within the self-affiliation domain (ranging from r=.60 to r=.82), involving items 1., 2., 3., 4., 9., 24., 29., and 32 (see Table 34). The self-attack domain reflected two significant correlation pairs, items 13. '*I don't feel that I deserve anything good to happen to me*' and 16. '*I harshly reject myself as worthless*' (r=.69), and items 19. '*I have thought of hurting myself, although I haven't done it*' and 31. '*I think of ways to punish myself*' (r=.61). There was one significant correlation pair observed within the self-control domain, items 33. '*I try very hard to become like an ideal image of myself*' and 36. '*My goal is to be as perfect as possible*' (r=.64).

Table 34: Strong Self-Affiliation Inter-Item Correlations for the SRQ - Clinical Sample

SRQ Domain	Item No's.	Question Pairs	Inter-Item Correlation
Self-Affiliation (n=20)	1	Even though I know I have some faults I am happy with myself as I am	.63
	2	I am comfortable with listening to my innermost feelings	
	1	Even though I know I have some faults I am happy with myself as I am	.81
	3	I am content with myself	
	1	Even though I know I have some faults I am happy with myself as I am	.82
	4	I appreciate myself for just being me	
	1	Even though I know I have some faults I am happy with myself as I am	.69
	24	I like myself very much	
	1	Even though I know I have some faults I am happy with myself as I am	.64
	29	I respect myself deeply	
	1	Even though I know I have some faults I am happy with myself as I am	.65
	32	I treat myself with love	
	2	I am comfortable with listening to my innermost feelings	.63
	3	I am content with myself	
	2	I am comfortable with listening to my innermost feelings	.60

4	I appreciate myself for just being me	
3	I am content with myself	.82
4	I appreciate myself for just being me	
3	I am content with myself	.65
24	I like myself very much	
3	I am content with myself	.66
29	I respect myself deeply	
3	I am content with myself	.69
32	I treat myself with love	
4	I appreciate myself for just being me	.70
24	I like myself very much	
4	I appreciate myself for just being me	.72
29	I respect myself deeply	
4	I appreciate myself for just being me	.71
32	I treat myself with love	
9	I confidently allow myself to do what feels right	.61
29	I respect myself deeply	
9	I confidently allow myself to do what feels right	.61
32	I treat myself with love	
24	I like myself very much	.73
29	I respect myself deeply	
24	I like myself very much	.74
32	I treat myself with love	
29	I respect myself deeply	.74
32	I treat myself with love	

Note: N=279 (clinical).

Three weak correlation pairs were noted in the self-control subscale, and eight within self-neglect (see Table 35). Most of the weak correlation pairs found in the self-neglect domain involved items 12. '*I don't check up on things to make sure they're done correctly*' and 26. '*I only live for the moment*'. These items were previously flagged in the inter-item correlation matrix where negative values were observed, and within the corrected item-total correlations, thus indicating poor domain fit within the instrument.

Table 35: Weak Inter-Item Correlations for the SRQ - Clinical Sample

SRQ Domain	Item No's.	Question Pairs	Inter-Item Correlation
Self-Control (n=3)	7 28	I carefully monitor my behaviour I put a lot of effort into everything that I do	.14
	7 34	I carefully monitor my behaviour I try very hard to make sure my work is done on time	.01
	10 34	I criticize myself harshly when I don't do something perfectly I try very hard to make sure my work is done on time	.11
Self-Neglect (n=8)	5 26	I avoid paying attention to important things I only live for the moment	.12
	6 12	I believe that whatever happens, happens, so it's better not to try I don't check up on things to make sure they're done correctly	.14
	6 26	I believe that whatever happens, happens, so it's better not to try I only live for the moment	.14
	12 15	I don't check up on things to make sure they're done correctly I don't try to develop good habits or skills	.08
	12 17	I don't check up on things to make sure they're done correctly I have no internal direction or goals	.08
	14 26	I don't spend much time planning for the future I only live for the moment	.13
	17 26	I have no internal direction or goals I only live for the moment	.06
	23 26	I let my needs go unattended I only live for the moment	.02

Note: N=277-280 (clinical).

Recommendations for Revising the SRQ

Central to the evaluation and revision of quantitative measures are the core considerations of reliability and validity. By '*dropping misfitting items*' (Barker et al., 2016, p.69), the goal is to enhance the internal reliability of the SRQ. This strategy

involves removing redundant items that are highly correlated with other similar items within the instrument, as well as those that fail to load on any of the factors within the three-factor solution (using the .40 or minimum threshold .30 criterion). Another key consideration is the instrument's content validity, ensuring that the range of items adequately covers the construct intended to be measured. This requires scrutinising both the general descriptors of different types of the construct and its intensity range, and examining whether dropping any particular item leaves certain aspects of the concept inadequately covered. According to Barker et al. (2016), this process is a '*qualitative judgment*', as they assert '*there is no such thing as a content validity coefficient*' (p.65). Considering all of the relevant analytical outputs, recommendations for revising the 36-item SRQ, the process of revising the instrument, an updated 26-item version, and its new domain structures are presented in Appendix M: Supplemental Tables, Tables 1, 2, 3, and 4.

Developing a Scoring System for the SRQ

Although some domain and item overlap has been observed within the SRQ, it was originally developed on the theoretical basis that its subscales are orthogonal, and therefore unrelated to each other. Based on this conceptual framework describing four different types of self-relationship that were not expected to significantly correlate with each other, the practical approach to scoring focuses on individual domain scores rather than offering an overall value. Although evidence suggests that the subscales of the instrument are not empirically distinct, they are theoretically distinct. Thus, it is less meaningful to discuss the degree of self-relationship across the entire scale.

The incongruity between theoretical distinctions and empirical data suggests a discrepancy between the framework proposed by the theory and real-world observations. This disparity may stem from factors such as measurement error, methodological limitations, sample characteristics, complexity of constructs, and contextual influences. However, it does not necessarily invalidate the theory. Instead, it emphasises the importance of critically evaluating measurement instruments, study

designs, and contextual factors to align theoretical frameworks with empirical evidence. This process can also uncover opportunities for further refinement or exploration within the theory (Furr, 2018).

While not always the case when measuring positive and negative phenomena, the self-affiliation and self-attack domains have demonstrated significantly strong negative correlation. However, they were conceptually intended to be scored separately. For example, when measuring emotionality, Mauss and Robinson (2009) found that participants could experience both high distressing emotions and pleasant emotions simultaneously, particularly among emotionally intense individuals. This means that pleasant and negative emotions don't necessarily correlate with each other. Instead of being structured around emotionally discrete states, Mauss and Robinson (2009) suggested that emotionality is dimensionally arranged, highlighting the relevance of factors such as arousal and valence. They stated that '*emotions are constituted by multiple, situationally and individually variable processes*' (p.229).

To provide greater insight into the continuum of self-affiliation and self-attack when combined into a single bipolar index, it remains evident that this spectrum, while requiring reverse scoring of some items, retains both self-attacking and self-affiliative variables. While the exploratory factor analyses forced a three-factor solution, the clinical cut-off and reliable change indices have been calculated based on the original four-factor model. Rather than taking a dimensional approach, it seems appropriate to proceed with scoring these four individual and conceptually distinct categories, particularly as the revised SRQ retains six individual variables in both the self-affiliation and self-attack domains.

Considering Benjamin's (1995) Intrex Introject scale of the SASB model, the self-relationship can be conceptualised dimensionally as opposing poles or as varying categories along the circumplex, each representing a segment of the self-relating spectrum. Benjamin described constructs such as self-love, self-attack, self-control, and self-emancipation as both dimensions and distinct entities. According to this

dimensionality concept, self-affiliation and self-attack are predicted to be negatively correlated. However, it was incorrectly anticipated that self-neglect and self-control would negatively correlate on the vertical axis.

Benjamin's scoring system allows for both dimensional and categorical scoring, with the latter described as quadrants or octants depending on whether they occupy a quarter or an eighth of the circumplex. This quadrant scoring approach suggests correlated inverse concepts. A notable distinction between the SRQ and SASB models lies in the conceptual difference between Faur and Elliott's (2007) self-neglect subscale and Benjamin's self-emancipation pole. Opposing self-control or strict self-regulation, self-emancipation describes a sense of freedom, which can be either beneficial or harmful depending on the quadrant: the upper right quadrant represents freedom and affiliation (constructive self-compassion), while the upper left quadrant represents hostile freedom (neglecting one's needs). In developing the SRQ, Faur and Elliott emphasised self-neglect as a clinically relevant phenomenon. Aligning with the harmful aspect of self-emancipation, self-neglect does not seem completely orthogonal to other dimensions and does not inversely measure self-control. Self-neglect demonstrates weak correlations with self-attack, self-control, and self-affiliation. This conceptual difference adds complexity to the instrument and the overall concept of the self-relationship and its measurement.

Utilising an adaptation of Lambert et al.'s (2002) rationally-derived signal alarm approach, developed and applied by Elliott (2014) for in-house clinical and research purposes, the clinical cut-off and reliable change indices were used to calculate clinical distress bands. Lambert et al.'s original method, designed for their Outcome Questionnaire 45, aimed to monitor progress and provide feedback on a person's response to psychotherapy. They referred to patients not responding in therapy as '*signal-alarm cases*'. These '*rationally-derived identification procedures*' (p.149) have been found to improve patient outcomes. Comparing two methods—the rational approach based on clinical observation and an empirical approach based on statistical

recovery expectations—Lambert and colleagues found that while the empirical approach more accurately identified deterioration, the rational method was more clinically useful due to its faster identification of severity and decline. Elliott reverse-engineered Lambert's criteria to create generic signal alarm criteria expressed in RCI units. This adaptation has been applied to create the SRQ clinical distress bands, though it faces several challenges. First, the lack of validation and publication of Elliott's approach is notable, as it has been used primarily as an in-house method. Second, the deduction process to convert Lambert et al.'s procedure, which correlated both rational and empirical results, presents many hurdles to arrive at the remodelled version. Lastly, the output of this procedure is dependent on the normative data that was used in the formulae to generate the RCI and cut-off indices. Despite these challenges, this method remains relevant and useful for generating SRQ levels of clinical severity, particularly for more distressed client populations.

To define the mild to moderate level of clinical distress, Elliott (2014) adopted the psychometrically accepted value of 1.25, although some researchers, such as the CORE-OM development team, now use a value of 1. Similarly, a value ≥2.5 indicates very severe distress, akin to the CORE outcome measure. Using the previously calculated RCI units and caseness scores, the clinical distress bands were created as follows:

- Nonclinical: 0.5 of an RCI unit below the clinical threshold (indicating that a person is clearly in the nonclinical range).
- Mild clinical distress: 0.5 of an RCI unit above the clinical threshold (indicating that a person is clearly in the clinical range).
- Moderate clinical distress: 0.5 to 1.5 RCI units above the clinical threshold (indicating that a person is clearly in the moderate clinical range).
- Severe clinical distress: 1.5 to 2.5 RCI units above the clinical threshold (indicating that a person is clearly in the severe clinical range).

- Very severe clinical distress: ≥2.5 RCI units above the clinical threshold (indicating that a person is clearly in the very severe clinical range).

Using RCI 1 units (rather than RCI 1.96 or 1.29 values), these generic signal alarm criteria can be adapted to any outcome measure where the clinical cut-off and RCI indices have been established. By simply multiplying the RCI by 0.5, 1.5, or 2.5, and then adding or subtracting this value to the caseness value, one can generate the clinical distress bands. It is important to consider the direction of the concept being measured, automatically adding or subtracting the value to the cut-off threshold. For example, in the SRQ, a decrease in clinical distress is represented by an increase in self-affiliation and a corresponding decrease in self-attack, self-control, and self-neglect. In adopting this signal alarm approach for the Personal Questionnaire (Elliott, 2014) used in the Strathclyde Counselling & Psychotherapy Research Clinic, only four levels of severity could be distinguished due to insufficient variability at the top of the scale to discriminate between severe and very severe bands. Therefore, it is crucial to review the sample distribution.

The SRQ uses an agreement unipolar scale, indicating degrees of truth ranging from 0 (not at all true), to 3 (always true). On this 0-3 scale, the caseness values are as follows:

- Self-affiliation: 1.3 (RCI 1 = .30).
- Self-attack: .60 (RCI 1 = .38).
- Self-control: 1.6 (RCI 1 = .37).
- Self-neglect: .70 (RCI 1 = .31).

The SRQ signal alarm criteria are outlined in Table 36 below.

Table 36: SRQ Signal Alarm Criteria

Level of Clinical Distress	Self-Affiliation Cut-off = 1.3 RCI 1 = .30	Self-Attack Cut-off = .60 RCI 1 = .38	Self-Control Cut-off = 1.6 RCI 1 = .37	Self-Neglect Cut-off = .70 RCI 1 = .31

Nonclinical: At least .5 RCI below clinical level	**Clinical Range**	≥ 1.45	≤ .41	≤ 1.41	≤ .54
Mild: .5 RCI above clinical level		1.15	.79	1.79	.86
Moderate: .5 to 1.5 RCI above clinical level		1.15 to .85	.79 to 1.17	1.79 to 2.16	.86 to 1.17
Severe: 1.5 to 2.5 RCI above clinical level		.85 to .55	1.17 to 1.55	2.16 to 2.53	1.17 to 1.48
Very severe: >2.5 RCI above clinical level		≤ .55	≥ 1.55	≥ 2.53	≥ 1.48

Notes: Adapted from Lambert et al., 2002. "Up to" = up to but not including.

Chapter Summary and Discussion

Findings indicated that SRQ scores demonstrate excellent temporal consistency in a nonclinical population, as well as generally good reliability, validity, and inter-item consistency in both nonclinical and clinical samples. Numerous significant correlations were observed between SRQ domain items and various similar constructs from selected psychometric instruments. Notably, SRQ variables showed substantial correlations with self-criticism as measured by the DEQ (Depressive Experiences Questionnaire, Blatt et al., 1976), self-esteem (Self-Esteem Scale, Rosenberg, 1965), self-compassion (Self-Compassion Scale, Neff, 2003), and psychological distress as measured by the CORE-OM (Clinical Outcomes Routine Evaluation Outcome Measure, Evans et al., 2000), while demonstrating less apparent overlap with the distinct construct of social desirability (Social Desirability Scale, Crowne & Marlowe, 1960).

Multiple statistically significant positive and negative correlations were observed between self-affiliation and self-attack, with subsequent exploratory factor analyses merging them into a bipolar construct. Consistent across the nonclinical,

clinical, and combined datasets, the exploratory factor analysis results provided compelling evidence for a three-factor solution that measures the multidimensional components of self-relating within the domains of self-affiliation vs self-attack, self-control, and self-neglect. The first factor clearly unified the self-affiliation and self-attack dimensions into a single variable. The second and third factors differentiated the controlling and neglectful aspects of the self-relationship. Highlighting the multi-dimensionality of the SRQ, while weak to moderate correlations were found for the self-neglect domain, results indicated that self-control represents a distinct type of self-relationship. Notably, weak correlations were observed between the self-control domain, the other SRQ subscales, and the domains of other measures, suggesting a unique type of self-relating.

While the HEXACO (Ashton & Lee, 2009) demonstrated virtually zero correlation with self-control overall, moderate correlations were found between its conscientiousness domain and the self-control and self-neglect subscales ($r=.47$, $p<.01$ and $r=-.45$, $p<.01$ respectively). This indicates a positive connection between conscientious personality types and traits such as self-control or self-management, while showing a negative correlation with self-neglectful behaviours. This is consistent with a study by Elliott et al. (2002), which used NEO-FFI (Neuroticism-Extraversion-Openness Five-Factor Inventory, Costa & McCrae, 1992) pre-therapy scores for a sample of clients whose mean score for conscientiousness was at the fourth percentile, indicative of very low scores. Observations of the client group revealed that many were neglecting important aspects of their lives, such as a hoarder who was unable to sleep in their bed due to clutter. This apparent self-neglect was reflected in the instrument as an absence of conscientiousness, demonstrating similar findings to those observed between the HEXACO conscientiousness, self-control, and self-neglect triad.

Overall, results indicated that the SRQ possesses good psychometric qualities and confirms its multidimensional structure. The SRQ consistently relates to other validated measures of various aspects of the self-relationship, suggesting it is well-

suited to measure the spectrum of personal experiences and attitudes an individual holds towards themselves. Convergent validity was observed for the SRQ and its subscales, reflecting similarities with other measures of self-compassion, self-esteem, self-criticism, and psychological distress, and the personality dimensions of extraversion and conscientiousness. As anticipated, discriminant validity was demonstrated through the SRQ's weak correlation with the construct of social desirability.

Each subscale of the instrument exhibited commendable internal consistency (self-affiliation: α=.86, self-attack: α=.77, self-control: α=.80, and self-neglect: α=.72), supported by robust longitudinal reliability (self-affiliation: α=.90, self-attack: α=.85, self-control: α=.82, and self-neglect: α=.73). Despite a few confounding items and some conceptual overlap, the SRQ is generally internally consistent and a reliable and valid measure for examining key forms of the self-relationship. Exploratory factor analyses were conducted to determine whether the four domains of the SRQ accurately reflected their underlying constructs. Interim analyses indicated evidence of a three-factor model in the underlying structure of the SRQ, warranting further confirmatory investigation. To further enhance the reliability and internal consistency of the SRQ, suggestions for refinement were proposed. These suggested revisions, such as consolidating or eliminating specific items, were deliberated upon to enhance the overall reliability of the measure, leading to a more refined version of the instrument.

Providing a robust measure of the quality and state of a person's self-relationship—improvement of which is central to the success of therapy—the SRQ has proven to be a useful and applicable clinical instrument. Considering Rogers' (1963) concept of the therapeutic movement toward becoming more integrated and fully functioning, the need for an effective tool to measure self-to-self processes becomes clear. To achieve this, clinical cut-off points were established for each SRQ subscale to mark the transition from clinical to nonclinical scores. Additionally, Reliable Change

Index (RCI) values were calculated to capture statistically reliable and significant therapeutic changes in an individual's self-relationship as measured by the SRQ.

Limitations and Suggestions for Future Research

While Barker et al. (2016) argued that larger sample sizes are likely to contribute more effectively to knowledge, they also acknowledged the potential for sample sizes to become excessively large, surpassing what is necessary for achieving adequate statistical power. Participant attrition, a common occurrence in longitudinal studies, often results in diminished sample sizes over time, potentially compromising the study's validity and statistical power. This attrition can be influenced by factors such as study duration, participant characteristics, and data collection methods (Little & Rubin, 2019). Despite a relatively high nonclinical participant response rate during the recruitment phase, many were excluded either for not fully meeting the eligibility criteria or for inadequately completing the Qualtrics combined 247-item survey. Response fatigue likely contributed to the drop out rate, which could have been minimised with a shorter questionnaire. Additionally, the low uptake of participants for the retest portion of the survey may have been due to low motivation following the initial test. Among those who completed the retest phase, some participants demonstrated uncertainty by using the example provided instead of creating a unique identifier code, resulting in data loss due to the inability to match phase one and phase two surveys.

Acknowledging the challenges associated with smaller retest sample sizes, Cohen (1988) suggested that such samples offer potential for yielding meaningful effect sizes. However, the disparity in sample sizes within this study—particularly between the nonclinical test and retest datasets, as well as between the nonclinical and clinical samples—was noted as a limitation. Nevertheless, the sample sizes were considered adequate for conducting a robust set of analyses, thereby enhancing the scale and broadening the scope of its clinical applicability. Although there is no

universally agreed-upon standard for determining sample size adequacy, the analyses adhered to established guidelines suggesting a minimum of 100 participants for exploratory factor analysis, ensuring reliable estimates and ample statistical power (Fabrigar et al., 1999).

Although some differences were observed between the nonclinical, clinical, and combined analyses, the structures of the SRQ appeared to be generally consistent and replicable across the various populations, aside from a few items. While exploratory factor and reliability analyses across the datasets facilitated the revision of the instrument, further confirmatory factor and reliability studies will be essential to test the amended version. These studies should encompass not only nonclinical and clinical data but also demographic variables such as gender and ethnicity. The importance of studying these disparities was underscored by Yao et al. (2009), who found significantly higher levels of self-criticism among Chinese undergraduate students compared to their American counterparts using the DEQ. Similarly, Neff (2003) observed gender differences in self-judgment and self-compassion, with females scoring higher on self-judgment and lower on self-compassion as measured by the SCS. Nolen-Hoeksema et al. (1999) also found that females were more likely to be self-critical than males. Given the strong correlation of the SRQ's bipolar construct of self-affiliation vs self-attack with SCS self-compassion and DEQ self-criticism, it is likely that differences in the quality of the self-relationship will emerge based on gender and ethnicity.

The clinical participants in this study all met the criteria for 'social phobia' according to the American Psychiatric Association's 2013 Diagnostic and Statistical Manual of Mental Disorders (DSM-5), and received emotion-focused therapy for social anxiety (EFT-SA). Therefore, the results from this specific sample may not be generalisable to other clinical presentations or issues. Further research to explore SRQ scores across different client groups will help establish cut-off values that can be applied more broadly across various settings. The SRQ has been utilised clinically as an experimental measure within the EFT-SA protocol. Participants underwent emotion-

focused therapy, a process guiding approach rooted in person-centred principles such as empathy, congruence, unconditional positive regard, non-directivity, and relational alliance. After conducting confirmatory analyses of the revised SRQ, it would be advisable to conduct comparative studies with other therapeutic modalities to assess its applicability across a range of therapies.

The reliability and validity analysis in this study is rooted in classical test theory (CTT), a widely accepted framework for enhancing the reliability of psychometric tests. CTT acknowledges individual variations in test performance, including difficulties with specific questions or the rating scale used. Reliability is assessed by comparing an individual's 'observed score' with the measurement error to estimate their 'true score' (Barker et al., 2016). While these analyses provided initial insights into correlation errors among variables of the SRQ and suggestions for improving overall reliability, a significant limitation persists until the revised instrument is tested in relevant populations. According to Zech et al. (2018), another drawback of CTT is its assumption regarding Likert scale data, where respondents may not perceive each scale point as equidistant from the next as intended. To further validate an instrument, Zech et al. recommend employing Rasch analysis on both nonclinical and clinical data to assess item fit, scale structure, and rating function more rigorously.

Implications for Practice and Research

The results of this study suggest that the reliability and validity of the SRQ could be enhanced through item revision or removal, while still proving effective in measuring changes in the self-relationship across normative and distressed groups. Particularly useful in assessing the effectiveness of humanistic-experiential therapy, the SRQ meets rigorous psychometric standards, including clinical cut-off and reliable change indices, demonstrating sensitivity to fluctuations in psychological distress. These findings underscore its potential utility in both clinical practice and research. By providing a snapshot of a person's current thoughts, feelings, and behaviour towards

themselves, the SRQ serves as a valuable tool that fosters self-reflection. This process can deepen self-awareness and help clarify therapeutic goals, especially when addressing negative self-treatment. However, Neff (2003) notes the challenges some individuals face in accurately assessing themselves and their negative emotions, which may be unconsciously repressed, denied, or distorted. Similarly, Elliott et al. (2004) suggest that silenced aspects of the self can be difficult to identify and measure due to their implicit or inadequately symbolised nature. Given these limitations in self-reporting, adopting a mixed-methods approach that includes clinical observation or discourse analysis could help mitigate biases. Nevertheless, drawing on Rogers' (1961) seven stages of psychological development, the SRQ can serve as a valuable tool for tracking an individual's movement from emotional rigidity and external fixation toward internal fluency and a deeper self-affiliation. This progression aligns with Rogers' notion of transitioning to a fully functioning way of being, characterised by reduced self-controlling, neglectful, and attacking behaviours.

Elliott and Shahar (2019) described socially anxious clients as possessing a harsh internal critic, which correlates with elevated levels of self-attack. Previous findings by Elliott et al. (2014) indicated that socially anxious clients undergoing emotion-focused therapy showed increases in self-affiliation scores and concurrent decreases in self-attack from pre to post-therapy assessments. Similarly, Elliott et al. (2004) observed in clients with depression a notable tendency towards punitive self-responses, often resulting in a collapse under the weight of self-criticism. While the symptomatology of anxiety and depression exhibit differing clinical presentations, they are often comorbid, representing differing manifestations of this unrelenting inner critic. Consequently, fluctuations in self-affiliation and self-attack scores measured by the SRQ provide valuable insight into the severity and improvement of these challenges. It can be further argued that anxiety and depression often co-occur with various other clinical presentations, thereby underscoring the SRQ's wide-ranging clinical applicability. Originally designed for its accessibility compared to Benjamin's SASB model (Benjamin,

1996), the SRQ has evolved through this study to refine its utility in understanding and measuring fundamental aspects of the self-relationship. This progression has transformed the SRQ from an experimental tool to a robust instrument suitable for publication and wider clinical application.

Chapter 4: Negative Treatment of Self in Socially Anxious Clients as it Presents at the Beginning Phase of Therapy

Introduction

Characterised by a fear of scrutiny from others and subsequent avoidance of social situations, underpinned by overwhelming self-consciousness and anxiety, social phobia or social anxiety (SA) has been found to correlate with high levels of self-criticism and dependency on others, as well as low levels of self-esteem and self-efficacy (Iancu et al., 2015). Depicting SA as '*implicit over-generalised emotion schemes*', MacLeod et al. (2012, p.68) linked these experiences to abuse, shame, or criticism received from significant others, resulting in a socially defective self-construct that views others as a source of threat. Self-criticism, characterised by the tendency to harshly and punitively scrutinise oneself, is a core feature of many forms of psychopathology and holds significant relevance in SA (Shahar et al., 2012; Cox et al., 2004; Cox et al., 2000). Shahar et al. (2015) conceptualised self-criticism as a protective strategy aimed at concealing defects and shortcomings to avoid further shame-based processes, while also highlighting how it perpetuates social awkwardness and derogatory self-attitudes. Evidence suggests that targeted treatment interventions focusing on self-criticism and underlying shame are crucial for successful outcomes, as these factors sustain the experience of SA (Shahar et al., 2015). MacLeod et al. (2012) demonstrated the effectiveness of emotion-focused therapy for the treatment of social anxiety (EFT-SA), particularly due to its emphasis on building a strong, empathic, and accepting therapeutic relationship, along with specific tasks that help clients access and process their inner self-critical conflicts.

While the investigation into harmful self-treatment is often reduced to the exploration of self-critical processes, this study posits that the inner critic is just one aspect of a broader spectrum of negative treatment of self (NTS; Capaldi & Elliott, 2023) that impacts a person's experiencing. Recognising the complexity of self-critical and inimical self-processes in therapy and their emotional effects, this qualitative study

aimed to further describe and classify these presentations. By analysing early-stage therapy sessions of clients receiving emotion-focused therapy for social phobia, the goal was to test and refine an existing taxonomy of the multitude of harmful-to-self discourse, behaviours, and effects of negative self-treatment. Building upon the preliminary research and early-stage rational-empirical model of NTS developed by Capaldi and Elliott (2023), this study aimed not only to challenge the existing model but also to develop a more detailed and refined empirical version through further investigation. Acknowledging the foundational framework established by the earlier model, this study emphasised the need for replication and further empirical analysis with a larger sample size to validate and elaborate upon it.

Participants selected for this study exhibited high pre-therapy scores in self-attack, as measured by the Self-Relationship Questionnaire (SRQ; Faur & Elliott, 2007). They demonstrated one of two distinct patterns of reliable change from the beginning to the end of therapy, indicating an overall decrease in patterns of detrimental self-relating. Utilising archival data from the Strathclyde Counselling & Psychotherapy Research Clinic's EFT-SA protocol, verbatim transcripts of the client-therapist dialogues were analysed to identify the main themes and create structures depicting the range of injurious intrapersonal treatments. Following the descriptive-interpretative approach to qualitative research (GDI-QR; Elliott & Timulak, 2005; 2021), processes of negative treatment of self were extracted and categorised, aiming for model *saturation* (Corbin & Strauss, 2015) for these early-stage expressions of NTS. The subsequent chapter, which is the final study of this thesis, further develops the framework by exploring the concluding phase of therapy for each participant. This exploration reveals a significant reduction in the occurrence and severity of NTS, aligning with the changes reported in SRQ scores throughout the therapeutic process.

Although previous research outlined both subtle and apparent process indicators of different types of negative self-treatment (Capaldi & Elliott, 2023), it did not obtain saturation, as new categories continued to emerge with each case analysed.

In line with *theoretical sampling* (Corbin & Strauss, 2015), which aims to formulate more robust descriptions by testing emerging theories, replication was recommended. This involves using a wider sample of clients and more varied therapy time points to explore the broad-ranging facets of negative treatment of self as it presents in therapy. Taking a theory-building rational-empirical approach to the analysis (Pascual-Leone, 1978), the preliminary outline of NTS was viewed as an early-stage rational-empirical model, constructed through prior observation of '*regularities perceived across people and across situations*'. Using this initial framework as a guide, an empirical investigation was conducted through '*rigorous observation and induction*' (Rice & Greenberg, 1984, p.20), to challenge, refine, and elaborate the model. Rather than simply testing the theory, Timulak and Elliott (2019) asserted that this type of theoretically-informed research facilitates greater dialogue between theoretical constructs and client's experiences, allowing for modification, greater specificity, and refined elaboration, all with the potential to '*break the organising theory*' (p.8). Acknowledging the presence of an unavoidable interpretative strategy, they emphasised the importance of clearly stating any expectations brought to the analysis and maintaining a permeable openness to being changed through the reflexive process.

In their expansion of the defintion of negative treatment of self to include self-critical processes, inimical self-actions, and their resulting emotional effects, Capaldi and Elliott (2023) provided evidence of the insidious and interdependent nature of these constructs. They defined self-attack broadly, considering it similar and interchangeable with negative treatment of self, encompassing anything a person does that is harmful to them, with self-attack being the most blatant and obvious form. Their description also included other types of negative self-treatment, such as hostile forms of self-neglect, freedom, and control. Building on these preliminary analyses, which focused on patterns of NTS at the onset of therapy, the current study not only advances this model but also provides insights and categorisations regarding the fluctuations in intensity as therapy progresses, as delineated in the subsequent

chapter. The six cases selected for this research were chosen due to their differing SRQ self-reported patterns of change in self-attack during therapy. While all participants exhibited high self-attack scores at the beginning of therapy, they demonstrated varying change processes: half showed a gradual decline from the beginning to the mid and end points of therapy, while the other half showed worsening at mid-therapy before gradually declining. Despite participants self-reporting these patterns of change in their experiences of self-attack, the relationship between their reports and what they actually did in the therapy was a point of interest for this study. Previous findings acknowledged that clients' appraisals of their self-relationship, as measured by the SRQ, did not always align with their in-therapy expressions of self-relating. Highlighting the subtleties of negative self-treatment, particulary in socially anxious clients, these often undisclosed and somewhat restricted self-to-self processes point to the usefulness of combining in-session observation with clients' self-report measures.

In their study of self-criticism, Shahar et al. (2012) emphasised the importance of examining these implicit processes alongside the clients' self-reports and patterns of emotional processing to better address such outcomes. These case examples outline various ways in which NTS discourse is expressed in therapy, including in the later study, the articulation of patterns of softening and change. Highlighting the complexity of negative self-treatment, which includes a myriad of behavioural and affective responses, findings indicated a diverse range of harmful-to-self process markers involving both direct and indirect strategies. Contributing to the current literature on self-criticism and negative treatment of self, the implications of these findings for theory, practice, and future research are discussed.

Literature Review and Rationale for Exploring Negative Treatment of Self in Socially Anxious Clients

Central to emotion-focused therapy (EFT) is the evolving self-relationship, encompassing emotion, cognition, and other experiential aspects (Elliott et al., 2004; Elliott & Greenberg, 1997; 2021). These elements are fundamental to EFT practice.

Negative self-treatment, characterised by self-attacking and critical self-to-self processes, is integral to the development of psychopathology (Greenberg, 1979) and is widely regarded as a key factor in emotional pain and distress (Greenberg et al., 2003). Psychotherapy research and practice has long recognised this tendency to belligerently denigrate and attack oneself as pivotal features in various psychological difficulties (Shahar et al., 2012). Exploring the phenomenology of negative self-treatment in its diverse forms and effects enhances the ability to address these inner conflicts, which is crucial for successful therapy outcomes. However, according to Kramer and Pascual-Leone (2015), the subtle and often implied nature of self-loathing and hostility poses challenges for observing and measuring these processes. Therefore, there is a need for more comprehensive understanding and awareness of these inimical self-actions. Developing the taxonomy of negative treatment of self and its various manifestations will further aid in recognising the impact, influence, and reach of NTS.

An unforgiving inner critic lies at the core of negative self-treatment, expressed through varying forms and intensities, from mild disappointment and self-reproach to severe self-hatred and rejection. Whelton et al. (2007) characterised self-criticism as an intense focus on creating a worthy self-image, depicting it as a driver of excessive expectations that undermine, devalue, and shame oneself. Shahar (2015) outlined how self-imposed demands for perfection are closely linked with harsh and inflexible expectations for high performance, accompanied by self-directed hostility when these expectations are not met. On reviewing the literature, it is evident that difficulties in the self-relationship as they present in therapy, are often reduced to the pursuit of describing and understanding the inner critic and its process characteristics. Stinckens et al. (2002a; 2002b; 2013a; 2013b) conducted multiple investigations that conceptualised the features of the inner critic around five main clusters: historical rejection and neglect, negative self-schemes, challenges in processing information, self-protection, and interpersonal difficulties (2002a). They described the valuing process related to the inner critic as a *destructive extreme*, elaborating on the critic's attributes

and therapeutic interventions (2002b). Later, they outlined the micro-processes of the inner critic, including its degrees of intensity and pathways to change, offering a task-orientated approach involving identification, distancing, tuning into the critic, attending to experiences, and integrating self-aspects (2013a). They described various strategies for working with the inner critic, highlighting the need for an adaptive and accepting approach attuned to the critic's concerns, noting that a uniform response may hinder client progress. Stinckens et al. presented a descriptive set of process markers (2013a), emphasising the need for more active engagement with the critic to enhance awareness of its function and ramifications, thus increasing the likelihood of successful therapeutic outcomes (2013b).

Whelton and Greenberg (2005) investigated the role of emotion in self-criticism among a group of students by first identifying those with either very high or low levels of self-criticism using Blatt et al.'s (1976) Depressive Experiences Questionnaire (DEQ). The self-critical processes of the two groups were then rated by observers as they recalled experiences of failure. The findings clearly identified that individuals with harsh inner critics exhibited higher levels of self-contempt, disgust, sadness, and shame, along with a corresponding decrease in assertiveness and resiliency. This connection between negative cognition, emotional pain, and depressive states highlighted the need for a vulnerability model that more effectively integrates emotional processes. In their review of self-criticism and the working alliance, Whelton et al. (2007) highlighted that higher levels of self-criticism negatively impacted the client's experience and ratings of the therapeutic relationship's effectiveness, indicating difficulties in developing and sustaining this crucial aspect of therapy.

In their formulation of *'the vulnerability effect'*, Iancu et al. (2015, p.170) linked high self-criticism and low self-esteem to social anxiety. These difficult processes often develop as a result of early attachment injuries, typically triggered by mistreatment from caregivers and significant others (Elliott et al., 2004; Elliott, 2013). Rooted in ongoing and traumatic experiences of shame or bullying during childhood or

adolescence (Elliott & Shahar, 2017), these humiliating and abusive events often lead to broadly applied and undifferentiated emotional responses, as seen in vague expressions like '*I feel bad*', and are often reflected in a restricted and oversimplified manner. Consequently, individuals may consistently experience pervasive anxiety across various situations, regardless of context. This difficulty in articulating nuanced emotions suggests an interruption in their ability to describe internal experiences, leading to more global descriptors (Elliott et al., 2004). Similarly, Stinckens et al. (2002a, p.41) asserted that '*the inner critic emerges from a relationship with parents who are intrusive, controlling, and punitive*', resulting in a self-esteem bashing introject of the critical parent (Blatt, 1995). These early experiences of social humiliation shape an individual's sense of self, fostering a deep and lasting feeling of guilt and shame. Clients with social anxiety, employing a severe inner critic to evade others' scrutiny or the risk of seeming flawed, develop avoidant and hypervigilant behaviours to shield themselves from additional humiliation and harm. Motivated by these fundamental maladaptive emotional patterns, their social anxiety centres on this protective and evasive approach to avoid the distress of further shame-filled social encounters (Elliott & Shahar, 2017; 2019). Introjected configurations of '*oughts*' and '*shoulds*' (Greenberg et al., 1993) fuel the self-critical process, generating hostility and contempt toward oneself. These annihilative, interruptive, and coercive styles of self-to-self relating are recognised as core factors contributing to the development and maintenance of social anxiety difficulties (Elliott & Shahar, 2017).

Conceptualising self-criticism as a protective strategy, Gilbert and Irons (2005) described its intent to avoid provocation or escalation of conflict and attack from more dominant others. Exploring the development of social anxiety and its connection with emotional neglect, abuse, and the resulting underlying shame, Shahar et al. (2015, p.572), asserted that '*because intensive shame states from childhood are remembered as highly aversive, individuals develop a self-monitoring and self-critical style as a safety strategy*'. Interestingly, their findings showed that emotional abuse, rather than

emotional neglect, was a predictor of shame, self-criticism, and ensuing social phobia. This contradicts previous research, which used self-report measures to evaluate childhood maltreatment among individuals with social anxiety and associated both emotional neglect and abuse with the development of SA symptoms (Bruce et al., 2012; Kuo et al., 2011). However, the clear link between the formation and perpetuation of social anxiety difficulties, disparaging self-criticism (Cox et al., 2004), and underlying shame is undisputed.

Lazarus and Shahar (2018) further explored the connection between self-criticism and shame, including its variability in relation to experiences of social anxiety. Collecting a baseline of social anxiety symptoms for a group of undergraduate students, they measured fluctuations in these constructs following significant social interactions. As expected, their findings indicated that social anxiety predicted greater levels of shame during interactions and self-criticism afterward. Furthermore, they found that experiences of shame evoked greater levels of self-criticism. Interestingly, the intensity of social anxiety symptoms acted as a moderator; those with lower levels of SA exhibited high self-criticism only after more intense shame-inducing interactions. Their findings supported the idea that self-criticism acts as a coping strategy in the face of shame-inducing situations, adding to the evidence of the connection between social anxiety and a harsh, rigid, inner critic.

Viewing the self-critical process as a continuum, the inner critic—often seen as hostile—paradoxically acts as a protective or coping mechanism rooted in a need for self-preservation (Cornell, 2005). Cornell identified two distinct facets of this process: at the milder end, the inner critic may function protectively, reflecting desires or needs for self-improvement; at the more extreme end, it becomes more intense and driven by deep-seated fears aimed at avoiding distressing feelings or experiences. In an attempt to circumvent the psychological pain evoked by the inner critic, individuals often develop elaborate depersonalisation and dissociative avoidance strategies (Firestone, 1997). Although the inner critic may aim to shield and protect against the

intolerable emotions linked to abusive or humiliating experiences (Cornell, 2005), its insidious nature can severely undermine emotional well-being (Kramer & Pascual-Leone, 2015), and is directly associated with both conscious and unconscious patterns of self-attack (Firestone, 2010). This critical self-relationship is linked to an increased risk of suicidal ideation and suicide attempts (Cox et al., 1994). Social phobia, which severely disrupts interpersonal relationships and leads to isolation (Alden & Taylor, 2004), has been demonstrated to have a profound and detrimental impact on those affected by this crippling condition. Elliott and Shahar (2017, p.144) highlighted the debilitating '*complexity and multiplicity of the different emotion processes*' linked to social anxiety, which frequently contributes to heightened substance abuse and depressive symptoms, resulting in an incapacitating condition that can be difficult to treat.

Stinckens et al. (2013a) connected the stubbornness of the inner critic and the difficulty in treating harsh self-criticism to its primary protective function. In their study of the EFT two-chair dialogue for addressing self-criticism, Shahar et al. (2012) noted that despite self-criticism being a key factor in psychological distress and a predictor of poor outcomes in therapy, much remains to be learned about self-critical processes and their effective treatment. Nevertheless, their findings indicated the effectiveness of the two-chair dialogue for conflict splits task in reducing self-critical depressive and anxiety states, thereby increasing self-compassion. Furthermore, for treating social anxiety disorder, Shahar et al. (2017) found that EFT is an effective therapeutic intervention. Using a 28-session model, they demonstrated the efficacy of EFT for treating SA in a group of adults, with the majority of participants no longer meeting the criteria for social phobia by the end of therapy. As an integral feature of EFT, the two-chair dialogue for conflict splits task is specifically designed to work with self-critical, self-coercive, or self-interruptive splits by '*enacting the self-critical attacks and evoking the resulting feelings'* (p.239). However, highlighting the challenging nature of treating self-criticism, Blatt (2004) emphasised the interpersonal difficulties it

poses, its impact on developing trust in the therapeutic relationship, and the need for more extensive, long-term therapy.

A common theme in the literature is the interest in understanding and effectively addressing the inner critic's presentations and processes. This focus is unsurprising, given the strong correlation between self-criticism and various psychological disorders, underscoring the importance of comprehending the functions of self-attacking and self-critical behaviours (Gilbert & Irons, 2005). Building on earlier investigations into measuring the self-relationship and conceptualising negative self-treatment, it is evident that while self-critical processes significantly contribute to the development and maintenance of psychological distress, focusing exclusively on the inner critic provides a narrow and overly simplistic view of negative self-relating. Furthermore, despite thorough analysis of the characteristics and processes of self-criticism, the identification and classification of its diverse patterns of expression and evolution remain largely unexplored. In considering successful therapy outcomes, it has long been argued that the quality of the therapeutic relationship is the best predictor (Horvath & Symonds, 1991). However, the ability to better identify, understand, and respond to the multitude of inimical self-actions may also play a substantial role. This argument forms the basis for further investigation and classification of the patterns of negative self-treatment as they present in therapy for socially anxious clients.

Aims, Questions and Hypothesis Guiding this Study

Aiming to bring further awareness and understanding to problematic intrapersonal dialogues, including their affective, cognitive, and behavioural modes, this investigation focused on the array of both obvious and subtle process indicators of negative self-treatment as they presented at the beginning stages of therapy. This study utilised outcome data identified and measured by the SRQ, an experimental instrument that has been tested and found to be a valid and reliable measure of the

self-relationship within the domains of self-affiliation, self-attack, self-control, and self-neglect. Previous unpublished introductory and developmental research on the SRQ (Faur et al., 2007), its inclusion in a later outcome review for EFT-SA (Elliott et al., 2013), and its further psychometric investigation and validation in the initial study of this thesis (see Chapter 3) have collectively demonstrated the instrument's effectiveness.

The outcome review for EFT-SA revealed two significant patterns of change in self-attack as measured by SRQ: a gradual steady decline from the beginning to the end of therapy, or a worsening at mid-therapy followed by a decline towards the end of therapy. While these notable patterns were used as part of the selection criteria, they were not the primary focus of this thesis; however, they do form part of future planned research. Irrespective of the SRQ change pattern reported by participants, this study aimed to examine the high levels of self-attack reported by them and how this, along with other aspects of NTS, manifested through in-session dialogue. It was hypothesised that expressions of negative self-treatment would be more prevalent and severe at the beginning of therapy compared to later stages.

Therefore, focusing initially on beginning stage therapy sessions (with the ending phase forming the final study of this thesis), the investigation, classification, and discussion of negative treatment of self in-session dialogues are presented, with the main research questions being:

a. How does the expression of negative self-treatment manifest in the beginning phase of therapy for six socially anxious clients, each of whom reported high levels of SRQ self-attack at the start of therapy and exhibited a significant pattern of change (either a gradual decline or worsening before declining) by the end of therapy?
b. Can the various obvious and subtle process indicators of negative self-treatment be categorised to reflect their cognitive, behavioural, and affective modes?

c. Does the preliminary model of NTS established by Capaldi and Elliott (2023) adequately apply to the present participants, or does it require refinement and adjustment? If modifications are needed, what specific elaborations and adjustments should be made?
d. Does the client's SRQ self-report converge with or conflict with their in-therapy expressions of negative self-treatment?

It was hypothesised that a variety of explicit and implied process indicators of different types of negative self-treatment would be observed, particularly related to self-attack, self-control or management, and self neglect. It was expected that a descriptive set of characteristics would delineate the spectrum of inimical self-actions, and that these would illustrate the interconnected, perpetuating cyclical pattern of negative self-treatment observed during therapy. Additionally, it was speculated that clients would present varying themes of negative treatment of self, and that these patterns would change over the course of therapy. Building on prior research (Capaldi & Elliott, 2023), it was predicted that the preliminary rational-empirical model of negative treatment of self would require elaboration and refinement to include numerous additional categories and subcategories. Furthermore, it was anticipated that clients' SRQ self-report questionnaires would reveal both consistencies and inconsistencies in their expressions of negative self-treatment during therapy.

Method

Philosophical Summary of Study 2

Following the analytical framework outlined in Chapter 1 (Philosophical Position of Studies 2 and 3), this investigation employed the generic descriptive-interpretive approach to qualitative research (GDI-QR) to examine how socially anxious clients express negative self-treatment during therapy sessions. The use of GDI-QR methodology supported the thorough description, interpretation, and classification of participant dialogues, focusing particularly on categorising problematic aspects of the

self-relationship. Grounded in a dialectical constructivist epistemology, the analysis revealed diverse patterns of engagement with negative self-treatment. By employing critical realist strategies, the study elaborated and refined the classification of communications and validated the preliminary model of NTS. This methodological approach encouraged creative exploration, resulting in an improved empirical model and offering valuable insights into how therapists can better identify and address harmful elements of clients' self-relationships.

Ethical Considerations

Approved by the University of Strathclyde's School of Psychological Sciences and Health Ethics Committee (see Appendix A), the Counselling Unit's EFT-SA research protocol investigates the effectiveness of EFT as an intervention for clients experiencing social anxiety. This nonrandomised comparative treatment study utilised a modified version of the Structured Clinical Interview for DSM-IV-TR Axis I Disorders (SCID-I; First et al., 2007). Prospective participants underwent initial screening for social phobia with those meeting the clinical criteria offered a 20-session protocol, choosing between EFT or PCT. In adherence to ethical research standards, participants not meeting social phobia criteria were offered support through an alternative PCT-oriented research protocol.

In alignment with the ethical framework of the EFT-SA study and with additional approval from its Chief Investigator, the present study was conducted. Participants were given the freedom to withdraw their consent partially or fully at any point, following a stringent informed consent procedure that respected specified data usage limitations. The study adhered rigorously to safeguarding procedures outlined in its ethical approval application. Participants were selected based on informed consent, specifying the use of therapy data (see Appendices B – Client Consent Form, and C - Release of Recordings Consent Form). To ensure utmost security, all client data was stored in a password-encrypted, multifactor-authenticated database. Confidentiality was maintained by redacting all potentially identifying information during transcription.

Participant Information

Researchers. The research team was led by the PhD candidate, who also served as a tutor for six postgraduate MSc Counselling and Psychotherapy students participating in the research group; however, they did not function as a therapist in the study. The tutor brought over 16 years of diverse clinical experience and advanced professional training in EFT, while the students were in the early stages of their counselling training and placements, with no prior knowledge or experience in EFT. The tutor's primary responsibilities included overseeing the research design, guiding the MSc students as they navigated their roles, and collaborating with each student as they analysed an individual client case for their respective dissertations.

Acting as both tutor and PhD researcher posed methodological and ethical considerations, requiring careful reflection and transparent management to maintain the integrity of the research. This supervisory role, spanning both the current and subsequent studies, involved supporting students in conducting their dissertation group projects while ensuring the research met rigorous academic and ethical standards. A more detailed reflection on these methodological and ethical considerations is provided in the limitations section in Chapter 6 (pp. 306–307).

Clients: Six participants were selected from the archival database of EFT cases in the SA study. Selection criteria were based on SRQ self-attack scores assessed at the beginning, mid, and end points of therapy. Three participants showed a significant, gradual decrease in self-attack scores, while three exhibited an initial increase in mid-therapy scores followed by a substantial decline by the end of therapy. Participants varied demographically (see Table 37 and Appendix N for detailed client profiles), and all demonstrated statistically significant change *(p* < .05) between their highest self-attack score (either at pre or mid-therapy) and their score at the end of therapy. Significance was determined using Jacobson and Truax's (1991) Reliable Change Index (see Table 38).

Therapists: The therapists involved in this study (and the subsequent one) were all qualified and experienced person-centred practitioners, with advanced professional training in EFT, except for one, who specialised in Gestalt psychotherapy, which incorporates techniques relevant to EFT. The therapists contributed a varied range of post-qualification expertise acquired across different clinical settings. The group was also demographically diverse, as detailed in the Therapist Profiles table (see Appendix O). It consisted of three male therapists and one female therapist, aged between 29 and 61, with an average age of approximately 46.5 years. Their general counselling experience ranged from 3 to 38.5 years, while their EFT experience varied significantly, from 1.5 years to over 25 years. Notably, one therapist brought substantial expertise, having worked as an EFT therapist, trainer, and co-developer since the 1980s.

Collectively, the therapists brought a broad spectrum of proficiency to the study, ranging from early-career practitioners to a highly experienced EFT trainer and developer, contributing a diverse array of professional perspectives. Additionally, the highly experienced therapist, who also served as an EFT supervisor, provided supervision to the other therapists. This dual role, along with the differences in experience levels, is discussed in the limitations section of Chapter 6 (pp. 307–308). It is important to note that the studies primarily focused on clients' expressions of negative self-treatment rather than on client-therapist interactions.

Table 37: Participant Demographics and SRQ Self-Attack Selection Criteria Scores

Client	Gender	Age	Beginning Therapy	Mid-Therapy	Ending Therapy
Gradual Decline:					
C1	Male	57	2.00 (*4)	0.43 (*8)	0.00 (*17)
C2	Male	49	1.43 (*1)	0.71 (*8)	0.00 (*19)
C3	Female	29	1.00 (*3)	0.57 (*8)	0.14 (*18)
Worsening to Decline:					
C4	Female	37	1.57 (*2)	1.86 (*8)	0.71 (*17)
C5	Female	57	0.57 (*3)	1.14 (*9)	0.14 (*17)

C6	Female	40	0.29 (*2)	1.00 (*9)	0.14 (*17)

Note: * denotes session number, with beginning therapy sessions defined as session 1, 2, 3, or 4, mid as 7, 8, 9, or 10, and end as 17, 18, 19, or 20.

Table 38: Jacobson Criterion C Clinical Cut-Off and RCI Values

SRQ Domain	(Caseness) Jacobson C	RCI = 1.96 *p* <.05	RCI = 1.29 *p* <.20
Self-Affiliation	1.312	0.579	0.381
Self-Attack	0.616	0.735	0.484
Self-Control	1.568	0.720	0.474
Self-Neglect	0.738	0.614	0.404

Note: *p* <.05 and *p* <.20 = 95% and 80% probability of reliable change.

Data Collection

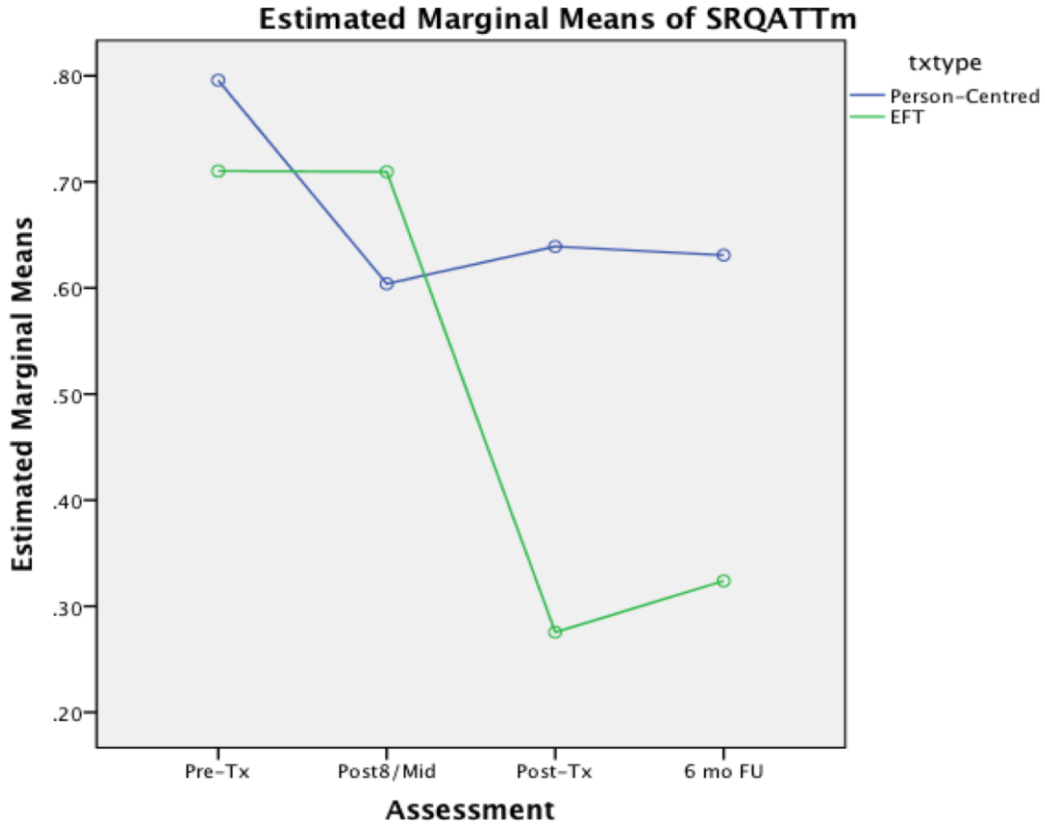
All data included in this study originated from the archive of EFT cases within the SA research protocol. Self-relationship data (SRQ; see Appendix E – Case Summaries) were collected from clients participating in the EFT-SA study at the beginning of therapy, mid-therapy (around session 8), and end of therapy (around session 20). The self-attack domain of this SRQ outcome data was used to inform participant and session selection. Initially, the focus of case selection was on identifying participants who exhibited a significant pattern of self-attack worsening at mid-therapy followed by improvement by the end of therapy. This pattern, previously observed in two EFT for Depression studies (Greenberg et al., 1990; Greenberg et al., 1998) and the EFT-SA effectiveness study (Elliott et al., 2013), involved a notable increase in self-attack around session eight followed by a statistically significant reduction by the end of therapy (see Figure 9).

According to Elliott et al. (2013), this pattern suggests that the most significant changes in EFT often occur in the second half of therapy. However, upon reviewing the outcome data, it became evident that many participants who showed significant

change in self-attack scores exhibited a different pattern, characterised by gradual steady improvement from the beginning to the end of therapy. For these cases, the majority of change occurred during the first half of therapy. Consequently, it was deemed appropriate to investigate processes related to negative self-treatment for both patterns of change.

It is important to note that while the current study focuses on patterns of negative self-treatment at the beginning of therapy, the subsequent and final study in this thesis examines their presentations and patterns of change observed at the end of therapy (thus encompassing criteria spanning the entire therapeutic process).

Figure 9: SRQ Self-Attack Outcome Data (Elliott et al., 2013)



Selection Procedure: Identifying NTS Using EFT Task Markers

The selection process for this study involved identifying a 30-minute segment from each participant's early therapy sessions (1, 2, 3, or 4), typically representing the introductory or exploratory stages of therapy. These sessions were chosen to capture key early moments of negative self-treatment, as indicated by participants' SRQ scores. To structure this process, EFT task markers were utilised, focusing specifically on conflict splits and self-soothing markers as precursors to the two-chair dialogue task—a method designed to facilitate self-to-self processes. Conflict splits, as defined by Elliott et al. (2004), are characterised by self-critical, self-coercive, and self-interruptive behaviours, while self-soothing markers signal a transition towards self-reassurance and self-acceptance.

Researchers carefully reviewed each participant's early sessions, taking detailed process notes to identify segments containing task markers as either forerunners (conflict splits) or outcomes (self-soothing) of prominent episodes of negative self-talk. The final selection centred on the 30-minute segment exhibiting the highest frequency of NTS, ensuring the data captured significant early moments of engagement with self-attacking behaviours. In instances where multiple segments met these criteria, the most salient episode was prioritised based on its intensity and duration, with final decisions made through consensus with a second team member and the research supervisor.

Selected episodes were timed from the onset of the task marker to the completion of the two-chair dialogue, typically within a 30-minute timeframe. Although some episodes were shorter, the decision was made to extract, transcribe, and analyse a consistent segment length for uniformity across participants. The conflict split task, central to EFT, enables clients to externalise and engage with conflicting parts of the self, such as the critical and experiencing selves. Conflict splits, marked by acute internal struggles and self-attack, were contrasted with self-soothing markers, which

became more prominent in later stages of therapy, indicating progress towards greater self-compassion.

This systematic approach enabled the research team to identify pivotal moments across early and later therapy sessions, aligning with the study's objective of examining participants' engagement with the negative aspects of their self-relationship over time. By concentrating on segments marked by intense self-attack and conflict splits in early therapy, the later end-of-therapy analysis captured significant transitions in participants' self-affiliation. The findings underscored how therapeutic interventions facilitated shifts in self-treatment patterns, moving from negative self-treatment towards more compassionate and self-accepting responses.

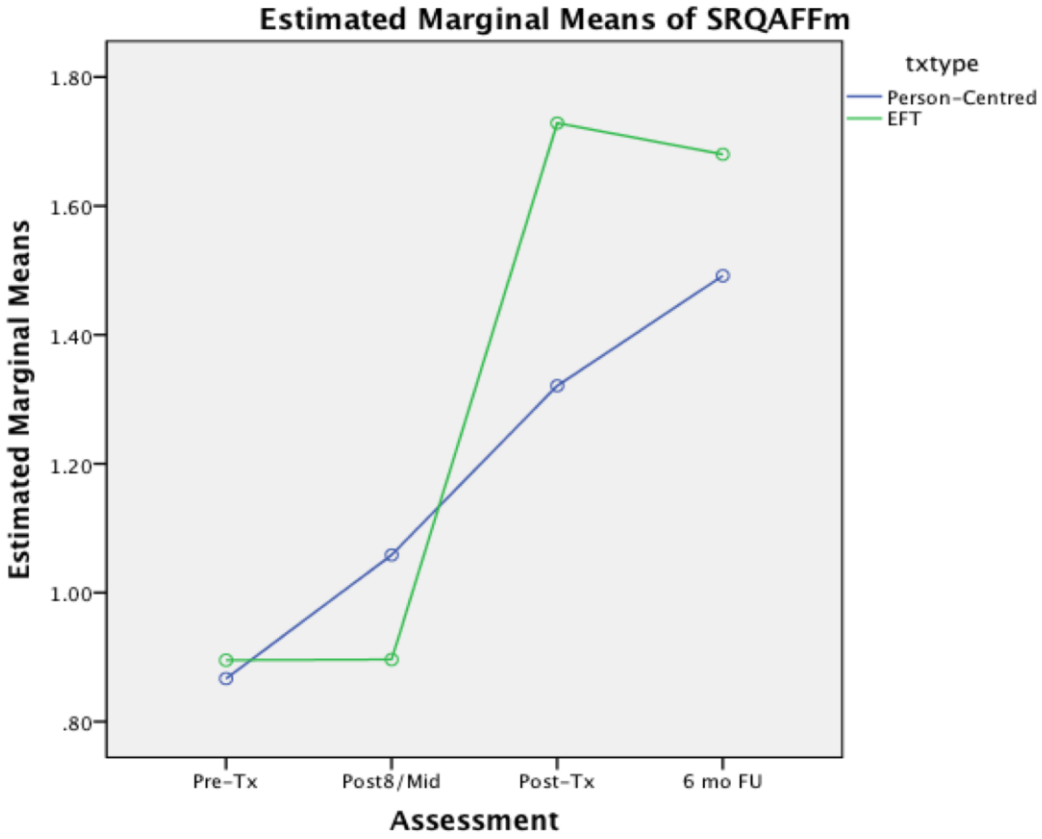
Incorporating task markers into the selection process enhanced methodological rigour by ensuring segments were selected based on both SRQ scores and identifiable moments of NTS (or its subsequent amelioration). However, this approach also introduced certain methodological limitations, which are outlined in Chapter 6 (pp. 308). Findings from both early and later therapy stages revealed an inverse relationship between self-attack and self-affiliation, consistent with prior psychometric research using the SRQ (see Appendix E – Case Summaries, and Figure 10). Participants initially showed reduced self-affiliation during heightened self-attack, but later therapy sessions revealed an increasing prevalence of self-soothing and self-affiliation behaviours, aligning with EFT's core aim of transforming self-criticism into self-compassion and fostering self-acceptance.

Data Preparation, Analysis and Validation

Transcript Preparation: Data familiarisation and immersion involved repeated and attentive listening to recordings to develop contextual and idiomatic understanding. Verbatim transcripts of each participant's selected 30-minute segment were prepared, focusing on content rather than interactional details and ensuring anonymisation of any potentially identifying information. Transcripts varied in length based on participants' speaking styles and were segmented into client speaking turns

and *meaning units*, as defined by Barker et al. (2016), aimed at identifying the expressed ideas.

Figure 10: SRQ Self-Affiliation Outcome Data (Elliott et al., 2013)



Data Analysis: Rooted in a discourse analytical approach, the study applied the GDI-QR (Elliott & Timulak, 2005; 2021) method, integrating process description and interpretative analytic modes. This method facilitated translation, categorisation, and comparison of clients' expressions of negative self-treatment, guided by a commitment to systematic analysis to allow for the emergence of new themes and categories. Expressions of negative self-treatment, both explicit and implied, were extracted, along with clients' endorsements of harmful-to-self observations provided by the therapist. Taking into account the micro-processes, meaning, and the directional force of clients'

naturally occurring discourse (Potter & Wetherell, 1987), the goal was to elucidate both explicit and implicitly conveyed meanings and assumptions that speakers intended within their context (Barker et al., 2016).

Employing a psychologically empathic and reflective approach informed by Wertz (1985; cited in Barker et al., 2016), and using Glaser and Strauss' (1967) constant comparative method, the analysis explored emergent types, foci, and modes of negative self-treatment. The analysis involved a descriptive layer to create categories and themes from complex communications and an interpretative layer comparing findings with the preliminary model of NTS (see Appendix M: Supplemental Tables, Table 5: Preliminary Rational-Empirical Model of Negative Treatment of Self: Categories and Frequencies). Organically evolving, the process involved the continual review of the fit within the overall structure, being mindful of researcher interpretation and bias. Using an inductive method involving meticulous observation and comparison of the various patterns and presentations (Rice & Greenberg, 1984), each new case analysed was used to test, elaborate, modify, and refine the structure until saturation was achieved.

Consistent with the SRQ and the Structural Analysis of Social Behavior (SASB) circumplex model (Benjamin, 1996), the variables in the data analysis mostly aligned with the negative half of the introject surface, spanning self-control, self-attack, self-neglect, and self-emancipation.

Data Validation: Findings revealed that some expressions of NTS were implied and required inference, while others were explicit. Data classification used a 4-point presence rating scale: 3 - Clearly Present; 2 - Probably Present; 1 - Probably Absent; 0 - Clearly Absent. 'Probably' and 'clearly absent' examples were excluded from the analysis. Additionally, the Elliott and Timulak (2021) frequency scheme was used to denote the general, typical and unique themes.

Individual analyses underwent auditing by a research team within a tutorial group project, later being combined into a coherent cross-case analysis (see Appendix

Q), which organised and structured the findings across all participants (McLeod, 2011). In accordance with the principles of best practices in qualitative research (Barker et al., 2016), the lead researcher conducted a self-audit of the revised combined structure prior to its review by the research supervisor.

Results

Revised Rational-Empirical Model of Negative Treatment of Self as it Manifests at the Outset of Therapy

Building on the preliminary research by Capaldi and Elliott (2023) on negative treatment of self, the current study's findings have further enriched and refined the initial model. This additional investigation contributes to validating and broadening the foundational framework established earlier. From the initial rational-empirical model of NTS, a revised version emerged, aligning with the four superordinate domains: (a) Objects of Negative Treatment of Self (Being, Doing, & Having), (b) Directness of Negative Treatment of Self (Direct vs Indirect), (c) Modes of Negative Treatment of Self (Behaviour), and (d) Emotional Effects of Negative Treatment of Self (Preceding & Reactional).

While the emerging structure somewhat aligned with the preliminary rational-empirical model, the explication of related aspects required detailed elaboration. This resulted in the creation of multiple additional categories and sub-categories identified during the analytical process. The previous higher-level domains, subdomains, categories, and subcategories required only minor revisions or additions and generally corresponded well with the current analysis. However, a notable development was the emergence of numerous lower-level subcategories, allowing for more finely tuned analytical descriptors.

The resulting comprehensively elaborated and refined structure is summarised in Figure 11 and illustrated in Figures 12 to 15. Results indicating general, typical, and unique themes are presented in order of within-domain/category frequency,

accompanied by participant quotes that exemplify general and typical occurrences. In these participant quotes, red font highlights aspects of the meaning unit pertinent to the respective category being discussed. The majority of these quotes represent typical themes, with the analysis revealing only two general categories concerning emotional effects: *Fear, Anxiety, Panic, Worry, or Tension*; and *Sadness, Grief, or Emotional Pain*.

Case examples are followed by their unique identifier code (e.g., C1:S4: MU22), indicating client number, session number, and meaning unit. Table 6 in Appendix M/Supplemental Tables provides the full revised rational-empirical model of negative treatment of self, detailing all domains, subdomains, categories, and subcategories alongside their relevant frequency ratings.

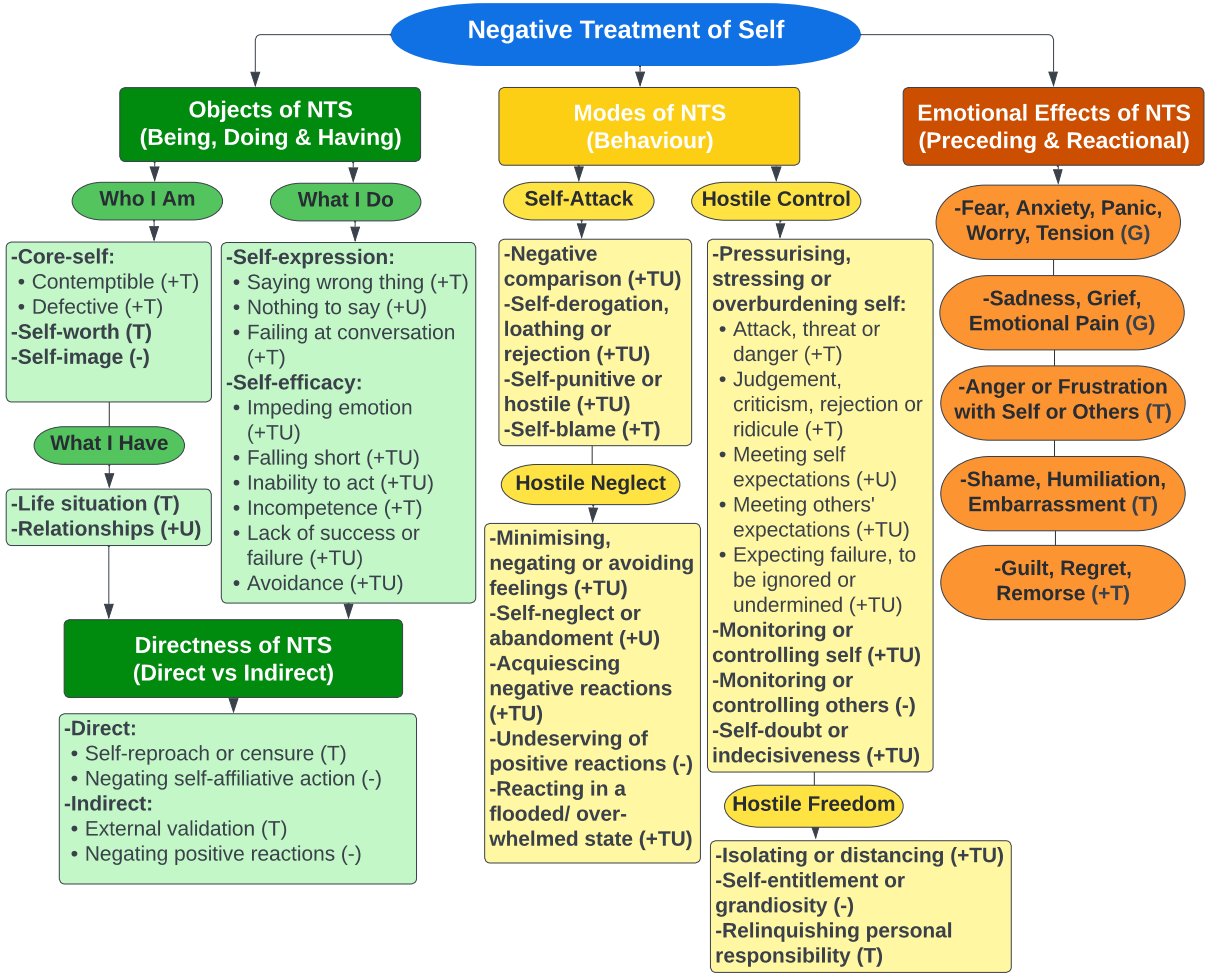
Objects and Directness of Negative Treatment of Self

As with the preliminary rational-empirical model, this revised analysis distinguishes between the *objects* and the *directness* of negative treatment of self. An overview of these NTS processes is presented Figure 12.

Objects of Negative Treatment of Self

Three broad sub-domains of *being*, *doing*, and *having* emerged as the objects of negative treatment of self, describing what individuals criticise or dislike about themselves. The concept of *being* previously differentiated self-dislike or self-criticism into a negative appraisal of the internal self (personality or core identity), inherent value (self-worth or self-esteem), and the external self (appearance and body or self-image). Interestingly, the current analysis further differentiated aspects of the internal personality or core identity, distinguishing between self-contempt, disgust, and loathing, as well as the belief that one is broken, flawed, or defective.

Figure 11: Revised Rational-Empirical Model of Negative Treatment of Self at the Outset of Therapy



Note: + denotes a new category, - signifies an absent category, U indicates a unique category, T represents a typical category, and G denotes a general category.

Emerging as typical themes across participants, the subcategories *Abhorrent, Contemptible, or Deplorable Self* and *Broken, Flawed, or Defective Self* further delineated the pervasive belief that something was fundamentally wrong with oneself. The target of the first type of self-dislike ranged from holding a negative impression of oneself and disliking the core of who they are, to perceiving aspects of their self as horrible, dark, or even evil and demonic. The latter self-critical process centred more on experiencing an irreparable, broken, or defective self, feeling abnormal and flawed due to inadequate or absent self-aspects, and fearing that others might perceive this brokenness and judge their character harshly:

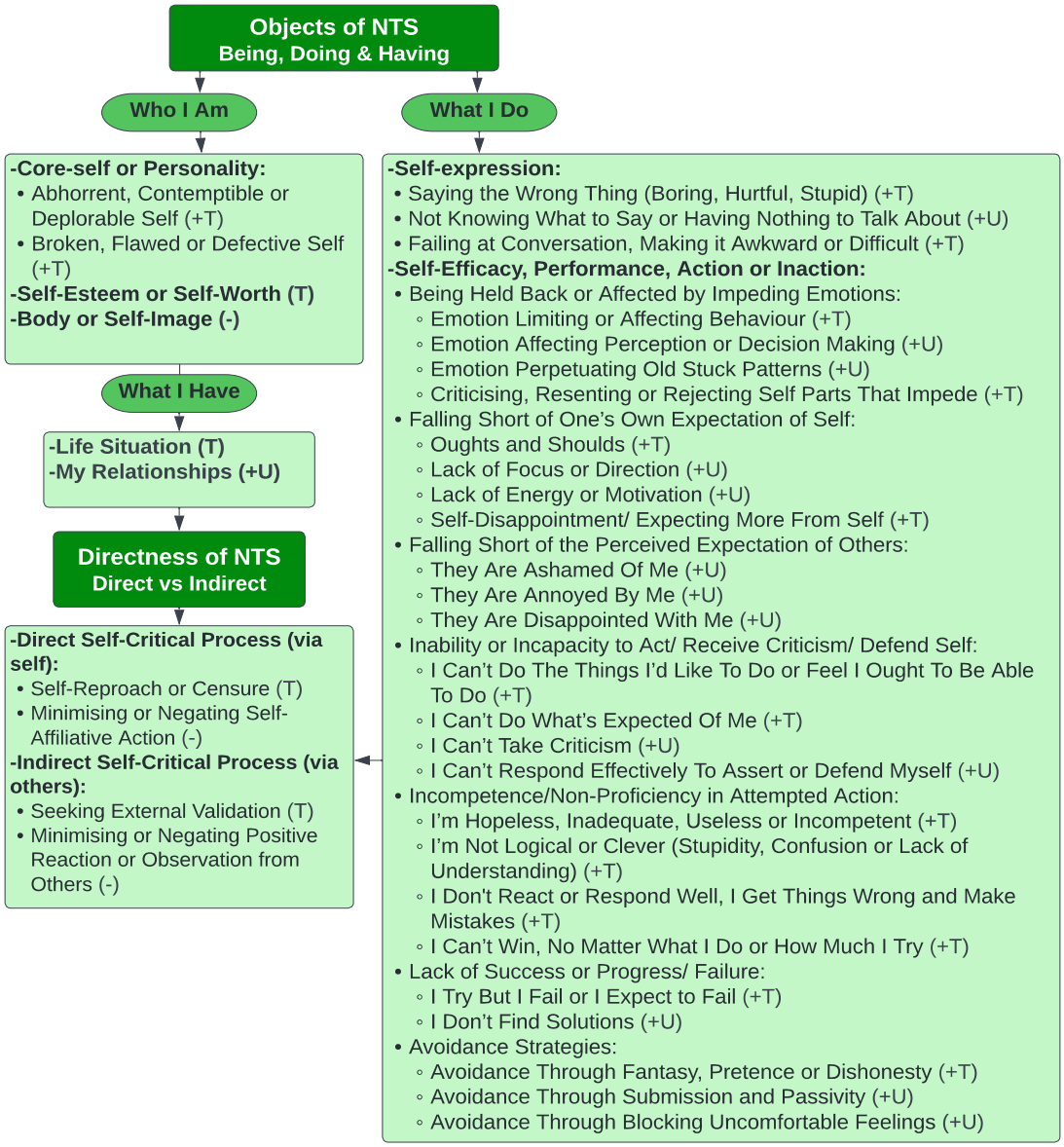
Abhorrent, Contemptible or Deplorable Self:

> **Client**: I think it's myself telling myself these things, but I would say probably that the devil, whatever you want to call him, uses that in me
>
> **Therapist**: Uhuh, ok sure, it can be hard to tell the difference between my own self-critical or judging voices and something that's more spiritually demonic right (C: Yeah) it's hard to tell where one ends and the other takes over (C3:S3: MU36).

Broken, Flawed or Defective Self:

> **Client**: That I've always been- that I've always (T: You're nobody) I've always (T: Can't do anything) been useless at it- at these things you know (T: Uhuh) you know what I mean I've always
>
> **Therapist**: And you've reached a sense of being broken
>
> **Client**: Oh aye, it's terrible
>
> **Therapist**: Where do you feel that in yourself (C: Erm), that brokenness in your body
>
> **Client**: Right up in here
>
> **Therapist**: Right in the pit
>
> **Client**: Aye, right in the centre of me
>
> **Therapist**: Yeah, someplace in there really feels broken (C5:S3: MU26).

Figure 12: Objects and Directness of Negative Treatment of Self (What I Dislike About Myself & How I Dislike Myself)



Note: + denotes a new category, - signifies an absent category, U indicates a unique category, T represents a typical category, and G denotes a general category.

Believing they are a waste of time and space, with minimal value and little to offer, participants typically expressed a negative evaluation of their *Self-Esteem or Self-*

Worth, experiencing a deep, pervasive sense of worthlessness or simply feeling not good enough:

Self-Esteem or Self-Worth:

> **Therapist**: And is it what, feelings of being worthless or
>
> **Client**: Aye, just being (T: Broken) worthless, inadequate, being useless (T: Uhuh) being less than, just not being able to (T: Not as good as other people) no, not being able to do just normal sort of things you know
>
> **Therapist**: Not being able to be normal
>
> **Client**: Just- just be normal (C5:S3: MU3).

Notably, while issues related to *Body or Self-Image*—often associated with deep-seated feelings of aversion and humiliation regarding one's appearance—were identified as a focus of negative self-treatment in the preliminary rational-empirical analysis, they did not appear in the initial stages of this subsequent analysis. However, these issues reemerge later in the final study of this thesis, during the examination of the concluding phase of therapy (see Chapter 5).

The concept of *doing* previously distinguished self-dislike or self-criticism in terms of actions or *what I do*—differentiating between negative appraisals of self-expression and self-efficacy—which is unsurprising given the participants' presentations of social anxiety. This differentiation also extended to negative evaluations of performance, action, or inaction. Initially, the latter generated six subcategories describing various ways in which self-efficacy might be a source of self-condemnation. Further analyses produced an additional subcategory that describes a series of avoidance strategies, along with numerous lower-level subcategories, enhancing awareness and understanding of each self-efficacy construct. Additionally, elaborating on how *Self-Expression* may become a target of self-dislike, differentiation emerged in terms of *Saying the Wrong Thing (Boring, Hurtful, Stupid)*, *Not Knowing What to Say or Having Nothing to Talk About* and *Failing at Conversation (Making it*

Awkward or Difficult). Concerns about saying something stupid during a conversation that might offend, hurt, upset, or bore others was a typical theme:

Saying the Wrong Thing (Boring, Hurtful, Stupid):

> **Therapist**: Ok, it's boring to talk about that again- tell her 'don't talk about mom because that's boring'
>
> **Client**: Yes, that's boring
>
> **Therapist**: Ok right, or (therapist) will be bored by it (C3:S3: MU42).

Fear of failing at conversation by making it awkward or difficult, causing it to become wooden or abruptly end, alongside subsequent self-berating, was typically expressed through statements such as:

Failing at Conversation (Making it Awkward or Difficult):

> **Therapist**: So, I might make it awkward, I might make it into something awkward and wooden (C: Yeah) or the conversation might just die (C: Yeah) in front of us, right
>
> **Client**: Or they might not want to talk to me
>
> **Therapist**: Or they might not want to talk to me, they might find me
>
> **Client**: Too boring (C3:S3: MU10).

Unique to one participant, the anxiety of not knowing what to say or having nothing to talk about was highlighted. This anxiety stemmed from wondering what to say about oneself or a particular subject, feeling stumped and fearful of having nothing to offer in conversation, and having little to contribute in response to others.

In the current analysis, the original subcategories of *Self-Efficacy, Performance, Action, or Inaction* were significantly expanded with more detailed lower-level descriptors, broadening their definitions and further distinguishing their individual characteristics, as outlined below:

The difficulty of *Being Held Back or Affected by Impeding Emotions* was differentiated between emotions that limited or affected behaviour, undermined

perception or decision-making, and those that perpetuated old stuck patterns. Furthermore, a self-critical and self-rejecting process was evident towards those parts that impeded and created the difficulties, resulting in a secondary reactive layer of self-dislike. The most typical presentation related to the impact of emotion on behaviour, including being held back by fear, panic, or upset; being scared of people or interactions with others; feeling incapable; and fearing messing up or getting things wrong:

Emotion Limiting or Affecting Behaviour:

> **Client**: And I don't go for a coffee by myself, so I don't even go- see when I am out by myself (T: Mhm) and maybe I go out for a shopping for something, maybe I feel like- I don't ever go into a cafe and just order a coffee and just go and sit down because what if somebody starts to talk to me
>
> **Therapist**: Right, so it's sounds like one of your fears is that I might give you some tasks to do outwith here
>
> **Client**: Yeah (C2:S1:MU54).

Criticising, Resenting or Rejecting Self Parts That Impede And Create Difficulties:

> **Therapist**: You would not want to be so overwhelmed by the hurtful feelings that you get
>
> **Client**: Yes, I am a bit overwhelmed by it you know- quite overwhelmed by it- but I also think there is the male culture of this kind of thing that men talk to each other, well in my experience it is or where I've worked- where I work there is a male culture of criticising each other- maybe you are not meant to take it too seriously, it's just the way men talk to each other, and I am not- I seem to be so sensitive (C2:S1:MU22).

Unique to one participant, emotions affecting perception or decision-making, and emotions perpetuating old stuck patterns described processes of either being blindsided by one's feelings or experiencing a sense of being stuck or trapped in persistent, familiar patterns of emotional difficulty.

Falling Short of One's Own Expectation of Self typically distinguished between feelings of believing one *ought* to know better and *should* know what to do, alongside a general sense of disappointment or anger when perceiving they had failed to meet their expected standards, having wanted more from oneself:

Oughts and Shoulds:

> **Client:** You've been blinded all your life by your own anger but quite frankly you should have dealt with it
>
> **Therapist:** Mhm, I'm quite angry with you now
>
> **Client:** Uhuh, I'm quite angry with you now (C1:S4: MU33).

Self-Disappointment/ Expecting More From Self:

> **Therapist**: So something inside- a voice is saying what's the matter with you, why can't you do these
>
> **Client**: Why can't you do them, you know what I mean, they're just normal things, everybody round about is doing it, why the hell can you just not do this
>
> **Therapist**: So something in you is quite unhappy or even angry with you, that you can't do these things
>
> **Client**: Uhuh (C5:S3: MU9).

Self-criticism regarding a lack of focus and direction, or energy and motivation was unique to one participant. This self-criticism appeared to serve either as justification for falling short of their goals or as an excuse for not pursuing the objectives they had set for themselves.

Falling Short of the Perceived Expectation of Others reflected a set of unique assumptions that others are ashamed of, annoyed by, or disappointed with the individual. This included not meeting perceived parental expectations and fearing the possibility of disappointing others or provoking their annoyance or irritation. These subcategories were clearly articulated through the anxious projection of one's fears.

Inability or Incapacity to Act/ Receive Criticism/ Defend Self typically reflected concerns about not being able to do what one wants or feels they ought to be able to do, alongside a sense of inadequacy in meeting expectations in a given situation. This was communicated through statements such as *it feels like I just can't*, *I don't know what to do with it*, *it should be instinctive,* and *I'd like to be able to deal with that situation*. Distinctions were drawn for situations where there was a perceived expectation, whether from oneself or others, to accomplish something the person felt incapable of doing:

I Can't Do The Things I'd Like To Do or Feel I Ought To Be Able To Do:

> **Therapist**: Okay, so then something inside- it feels like I just can't- but that doesn't make any sense either to you
>
> **Client**: That doesn't make any sense because why can I not do it- you know what I mean (C5:S3: MU10).

I Can't Do What's Expected Of Me:

> **Therapist**: You're put into situations where you feel you have to do something that you just can't do
>
> **Client**: And I can't do it and I feel so (T: Right) inadequate about it, you know- and again it just makes me go back to old stuff of I could never do these things- why can't I do these things, these are normal things, why can't I do them (C5:S3: MU8).

For one participant, an inability to bear actual or perceived criticism from others was a distinct source of self-dislike, alongside feeling incapable of standing up for and defending one's self. This subcategory reflected difficulties in responding effectively or spontaneously, often resulting in a tendency to go blank or be at a loss for words or actions.

The four subcategories within *Incompetence/ Non-Proficiency in Attempted Action* reflected a set of typical self-critical themes: feeling hopelessly incompetent in performing skilled or basic tasks, believing oneself to be illogical or lacking intelligence, frequently making mistakes or handling things poorly, and a pervasive sense of never achieving correctness no matter the effort expended:

I'm Hopeless, Inadequate, Useless or Incompetent:

Therapist: And is it what- feelings of being worthless or

Client: Aye, just being (T: Broken) worthless, inadequate, being useless (T: Uhuh) being less than, just not being able to (T: Not as good as other people) no, not being able to do just normal sort of things you know (C5:S3: MU3).

I'm Not Logical or Clever (Stupidity, Confusion or Lack of Understanding):

Therapist: So I mean it could be that I didn't explain it very well

Client: No, I don't know about that- I just take it that I can't understand that, so I take it that I am not (T: Yeah) very smart (C2:S1:MU42).

I Don't React or Respond Well, I Get Things Wrong and Make Mistakes:

Therapist: Your self-esteem drops

Client: Yeah, yes, (T: Mmm) uhuh- just if I felt another form of being wrong and things like that you know

Therapist: Which is felt like

Client: Like a downer (C2:S1:MU5).

I Can't Win, No Matter What I Do or How Much I Try:

Client: If I don't wash my hands, I'm accused of being dirty, if I do wash my hands, I'm accused of wasting water- I just (T: Mmm) can't win with you

Therapist: Whichever way it falls you always get attacked (C1:S4: MU28).

Lack of Success or Progress/ Failure encapsulates the typical experience of attempting to take action or achieve something without success or advancement, alongside the belief that one is inherently a failure and therefore destined to fail:

I Try But I Fail or I Expect to Fail:

Therapist: But you have this feeling that you just don't fit in

Client: I just don't, I just don't get it right (T: Yeah) you know what I mean

Therapist: Okay, I see, whenever you try it just feels like you don't- can't do it right, you can't get it right and so you try but it feels like you fail somehow

Client: Uhuh (C5:S3: MU1).

Another aspect within this category, though unique to one participant, involved not just trying and failing, but persistently and repeatedly attempting without ever finding solutions or achieving success.

A newly identified category, termed *Avoidance Strategies,* emerged from the analysis, highlighting various methods individuals use to evade confronting their realities. This often included resorting to fantasy, pretence, or dishonesty as primary mechanisms. Additionally, less commonly observed but significant are distinct forms of avoidance, such as *Submission and Passivity* or *Blocking Uncomfortable Feelings*. These illustrate tendencies towards apathy, indifference, resignation, and cowardice, or avoiding emotional discomfort by suppressing or bypassing it:

Avoidance Through Fantasy, Pretence or Dishonesty:

Client: Buying a lottery ticket- you seriously think you're going to win- you're a dreamer

Therapist: You're a dreamer how ridiculous

Client: How ridiculous it is to buy a lottery ticket, you think you're gonna win 5 million pounds (…) just part of your fantasy world (…) get into reality (…) stop fantasising (C1:S4: MU23).

The concept of *having*, a small but typical category that addresses self-dislike or self-criticism regarding shame or disappointment about one's life situation marked by a lack of possessions or minimal achievements, was expanded to include the unique

aspect of *My Relationships*. This theme reflects a life characterised by scarcity, emptiness, or marked by unreliable, disastrous, or unhappy relationships, resulting in a pervasive feeling of '*this is the story of my life*':

Life Situation:

> **Client**: I would like a relationship with my anger by the way I really would (T: laughs) I think I would actually, it would make it easier for me because my life is quite nothing, my life is quite nothing- because eh- I do feel anger but usually I feel anger when I am like by myself (C2:S1:MU46).

Directness of Negative Treatment of Self

Describing *how I dislike myself*, two broad sub-domains of *Self-reproach or Censure* and *Seeking External Validation* typically emerged as direct (through self) and indirect (through others) strategies for negative treatment of self. Interestingly, the preliminary rational-empirical model included two additional sub-domains that involved minimising or negating either self-affiliative action or positive reactions from others as direct and indirect strategies, which did not appear in the current analysis.

Self-reproach or Censure functions as a strategy for expressing self-dislike, where individuals directly criticise, blame, or disapprove of themselves, often as a way of coping with underlying feelings of inadequacy. This approach typically targeted one's reactions to people or situations, driven by a sense of having done something wrong, being immature, stupid, awkward, or clumsy. It served both as a symptom and a mechanism for carrying out and reinforcing negative self-perceptions:

Self-Reproach or Censure:

> **Client**: But I misunderstood and logged off the whole system and he sort of snapped at me and that sent me to the bathroom for a cry (T: Ok), which is so stupid I mean (C4:S2: MU17).

The indirect strategy of *Seeking External Validation*, as a means of expressing self-dislike, typically reflected a profound need for others' approval to bolster self-worth, especially when grappling with self-doubt, self-criticism, or low self-esteem. Driven by deep insecurity, the pursuit of reassurance—whether through attention, recognition, or approval—manifested notably in relation to one's actions, and was evident in the quest for positive regard or parental approval. This approach not only functioned as a mechanism for reinforcing negative self-perceptions but also served as a symptom of them:

Seeking External Validation:

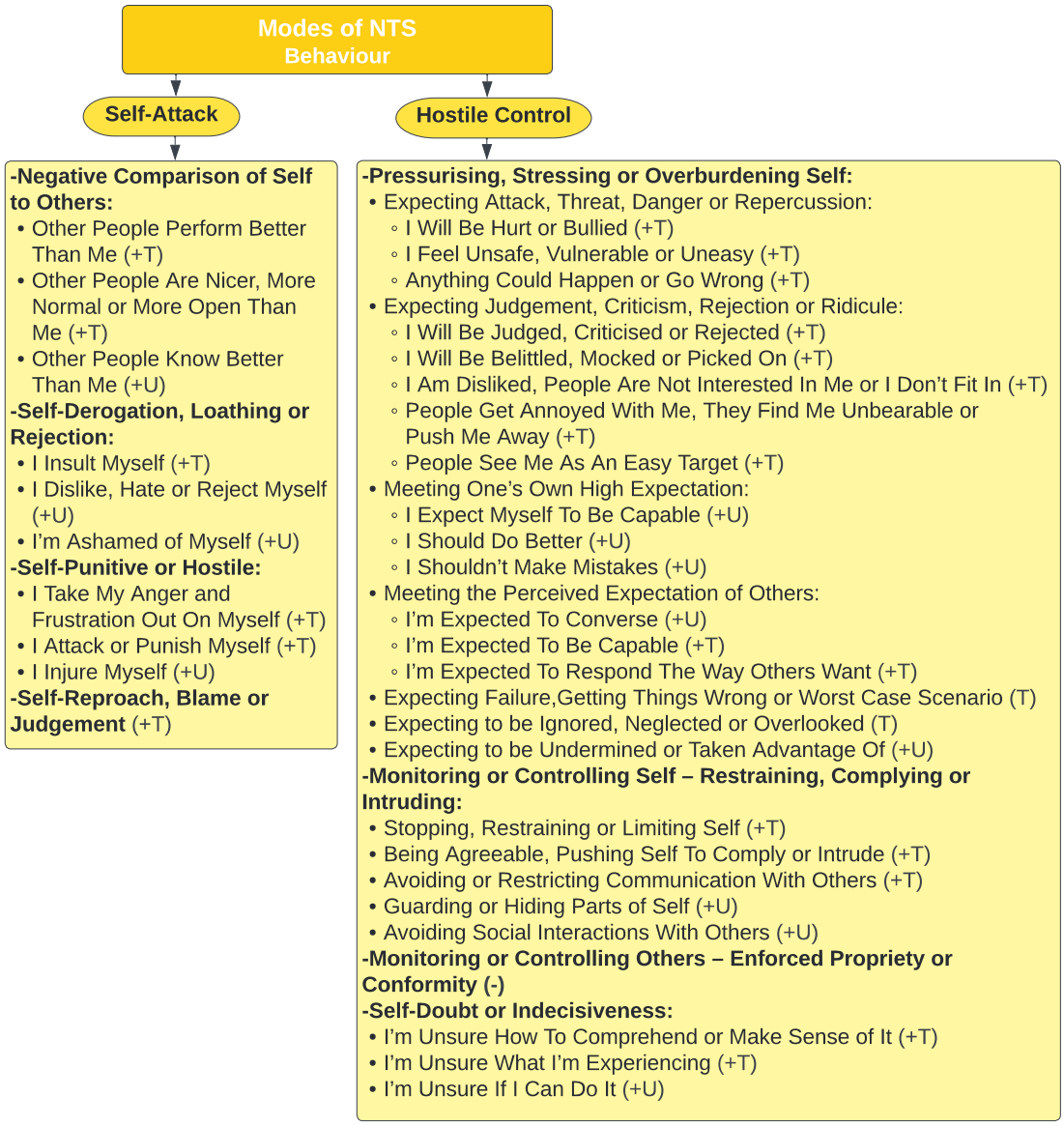
> **Client**: I just used to feel (inhales) try to compliment her and
>
> **Therapist**: You'd try and get on her good side and you'd try to get some caring from her
>
> **Client**: Aye, a lot of (T: And you'd)
>
> **Client**: Rubbish I would say, but it wasn't really, probably it was to get caring (C5:S3: MU38).

Modes of Negative Treatment of Self

Like the preliminary rational-empirical model, this empirical investigation distinguished between various inimical self-actions, identifying behaviours detrimental to oneself or *what I do that is bad for me* within the sub-domains of *self-attack*, *hostile control*, *hostile neglect*, and *hostile freedom or separation from others*. Notably, the current investigation further differentiated these harmful-to-self activities, greatly elaborating on each sub-domain. An overview of these findings is presented in Figures 13 and 14.

Self-attack was previously divided into three broad categories: *negative comparison of self to others*; *self-derogation, loathing or rejection*; and *self-punitive or hostile*. The current investigation further differentiates these categories, particularly concerning *self-reproach, blame, or judgement* (see Figure 13).

Figure 13: Modes of Negative Treatment of Self (What I Do That Is Bad For Me)



Note: + denotes a new category, - signifies an absent category, U indicates a unique category, T represents a typical category, and G denotes a general category.

Negative comparison of self to others is a common yet detrimental practice that significantly undermines self-esteem. Involving evaluating oneself against others and experiencing feelings of inferiority, this category further distinguished the beliefs that others perform better, are nicer, kinder, more 'normal', or more knowledgeable. This

downgrading and self-deprecating behaviour was characterised by the conviction that others are inherently superior, more capable, or generally better than oneself:

Other People Perform Better Than Me:

> **Client**: If you could just pack it in altogether- you're hopeless, other people can play far better than you (T: Mmm), other people can write far better than your writing (C1:S4: MU21).

Other People Are Nicer, More Normal or More Open Than Me:

> **Client**: If I am around other people I automatically think that I am not a nice person in this room but the people that are in the room are okay they are nice enough (C2:S1:MU30).

Other People Know Better Than Me:

> **Client**: I would like to say these people understand- there is a lot of people understand the way people work and they can see people- I can't, I don't have that (C2:S1:MU44).

Self-derogation, loathing, or rejection, which describe one's self-dislike or self-hatred, were further differentiated into themes such as insulting oneself, disliking, hating, or rejecting oneself, and being ashamed of oneself. The common strategy of self-insult was typically expressed through self-denigrating jibes, enacting a form of self-directed loathing and rejection:

I Insult Myself:

> **Client**: If I'd had the vocabulary you know and the- to describe myself to you when I was eleven- I would have said I'm stupid, I'm ugly, I'm clumsy, I'm a liar, I'm a thief, and I'm a dirty wee bitch (C5:S3: MU29).

Self-punitive or hostile behaviours, which compound one's self-loathing or rejection, manifested as self-punishment or acts of hostility towards oneself. These behaviours were further distinguished into themes such as attacking or punishing

oneself, self-injury, or directing anger inward. While self-injury, exemplified by scratching or digging fingernails into the skin to induce pain, was observed in only one participant, the most common manifestations in this sub-category involved self-attack or self-punishment resulting from internalised anger:

I Take My Anger and Frustration Out On Myself:

> **Client**: I get angry with the world (T: Mmm) but I also get angry with myself and direct my anger and frustration towards self (C1:S4: MU14).

I Attack or Punish Myself:

> **Client**: Or he's seen the horrible bit of me that I don't want other people to see (T: Yeah) so I start attacking myself
>
> **Therapist**: Right, so when you let your guard slip (C: Uhuh) and you let someone see that then something in you can really start punishing yourself, attacking yourself (C: Yeah) (C3:S3: MU23).

Self-reproach, blame, or judgement typically reflected themes of being overly critical or harsh towards oneself. This often involved disapproving or judgmental self-talk, with statements such as *so inadequate*, *really horrible*, or *bloody insecure*.

Self-Reproach, Blame or Judgement:

> **Therapist**: When you stop, you start thinking about what you're thinking about
>
> **Client**: Yeah, or just think for goodness sake pull yourself together or get really down on myself for it (C4:S2: MU27).

Hostile control was previously categorised into four areas: *pressurising, stressing, or overburdening self*; *monitoring or controlling self* (restraining, complying, or intruding); *monitoring or controlling others* (enforced propriety or conformity); and *self-doubt or indecisiveness*. The current analysis revealed all these categories except for the need to monitor or control others, which appeared in the subsequent study

utilising end of therapy sessions (see Chapter 5). Each category was further elaborated with a series of sub-categories (see Figure 13).

One of the most intricate categories, the theme *pressurising, stressing or overburdening self*, contained multiple sub and lower-level categories related to fear-based expectations. Insecurity and vulnerability in one's life were depicted through apprehensions about being attacked, threatened, or facing serious repercussions, as well as expectations of harsh judgement, ridicule, or rejection. Striving to meet one's own high expectations or the perceived expectations of others, often driven by a need for perfection, was a significant source of distress. Additionally, the expectation of failure, getting things wrong, or being ignored, undermined, or taken advantage of by others perpetuated this self-controlling and self-sabotaging pattern.

The typical theme of *expecting attack, threat, danger, or repercussion* reflected a pervasive sense of vulnerability and insecurity. This theme was further differentiated by distinguishing between a fear of the unknown and concerns about being physically harmed or mistreated:

I Will Be Hurt or Bullied:

> **Client**: I remember him saying like why can't you, like you need to trust me- and I'm like well because you're a person, like how can I trust a person that- I know you're going to hurt me, it's like I know that, I know you will
>
> **Therapist**: I know that with every fibre of my being right, so how could I, why should I trust you
>
> **Client**: Exactly (C3:S3: MU21).

I Feel Unsafe, Vulnerable or Uneasy:

> **Client**: I think it's also a bit pointless and it's also (T: Mmm), it doesn't go anywhere you know, people call it banter or something, I don't know, but no I am not comfortable with it, I am hurt by it so that's why I don't like men (C2:S1:MU24).

Anything Could Happen or Go Wrong:

> **Client:** And that's the bit that really stresses me out because I just think that if I make a mistake and I don't do it right (T: Uhuh), someone's going to get a job somewhere that they shouldn't and all sorts could happen (C4:S2: MU4).

Similar to the previous theme and pervasive across all its sub-categories, *expecting judgement, criticism, rejection, or ridicule* illustrated a common set of fear-based expectations. The analysis further refined this theme to highlight the projected belief that others dislike or disapprove of oneself, leading to the anticipation of harsh criticism, ridicule, or dismissal:

I Will Be Judged, Criticised or Rejected:

> **Client**: Rejection
>
> **Therapist**: Rejection, so just there, just rejection you're feeling, that's what is right at the bottom in your core sense is rejection
>
> **Client**: Mhm and fear of criticism, that's another big fear in my life
>
> **Therapist**: Fear, fear of being, fear of criticism
>
> **Client**: Because my father always criticised me (C1:S4: MU5).

I Will Be Belittled, Mocked or Picked On:

> **Client**: I think me having this feeling that I am not a nice person just makes me vulnerable- makes you vulnerable to people who can you know- can sense something in me so they sort of fire in (T: Mmm) because there are people who enjoy it, they enjoy it, they enjoy like I was gonna say picking on people, but they enjoy belittling people and that they enjoy it (C2:S1:MU32).

I Am Disliked, People Are Not Interested In Me or I Don't Fit In:

> **Client**: Just magnify this thing about me that I don't really, it's hard for me, I'm always trying to fit in and I just (T: Yeah) don't
>
> **Therapist**: You have this feeling that you just don't fit in

Client: I just don't, I just don't get it right (T: Yeah) you know what I mean (C5:S3: MU1).

People Get Annoyed With Me, They Find Me Unbearable or Push Me Away:

Client: Wasting your time

Therapist: Wasting my time, wasting (therapist's) time (C: Yeah) and that would mean what- how does that feel to be wasting my time

Client: You might get annoyed about that- I might get annoyed about that too

Therapist: So, I might get annoyed at you for wasting my time

Client: And I might get annoyed at myself for wasting your time (C3:S3: MU3).

People See Me As An Easy Target:

Therapist: They can have a sense that they can do that to you

Client: Yes, yes, yes they do, yes, and if I could just turn my mind around and going no it's actually them it's something wrong about them when they got to do that to somebody (C2:S1:MU33).

Meeting one's own high expectation presented a unique set of sub-categories involving an internal pressure to excel and avoid mistakes at all costs, fostering a perpetual need to exceed one's own standards. Similarly, *meeting the perceived expectation of others* presented two typical sub-categories describing a similar concept albeit projected onto others. This external projection entailed fearing that others expect constant capability, competence, and compliance. This fear-driven dynamic also included a unique sub-category extending to simple interactions, such as the expectation to engage in conversation:

I'm Expected To Be Capable:

Client: Don't give me that, that's distressing, that's no- that just distresses me when I go somewhere and they bring this thing out- they bring all this, I want you to make a mask (T: Uhuh) you know (C5:S3: MU22).

I'm Expected To Respond The Way Others Want:

Therapist: So what is your role- what is this part that you feel forced to play

Client: Passive-aggressive patterns I think, where if I sense some form of rejection, (T: Uhuh) I jump on it real quick, and I think, kind of, probably play the same (C6:S2: MU31).

The final three sub-categories contributing to self-imposed pressure and stress encompassed anticipating failure, things going wrong, or envisioning worst-case scenarios, and fearing neglect or being overlooked. Moreover, concerns unique to one participant, revealed fear of being undermined or exploited, causing significant distress and apprehension:

Expecting Failure, Getting Things Wrong or Worst Case Scenario:

Client: I think I always think of the worst case scenario so if it's going to Uni it's like you're just not going to be bright enough you'll make a fool of yourself

Therapist: Yeah, so you kinda plan out everything that's going to go wrong

Client: Yeah, and it's always it's not just you might have a bad day- it's gonna be a disaster (C4:S2: MU14).

Expecting to be Ignored, Neglected or Overlooked:

Client: I wasn't expecting bosom buddies but I think to be honest, from the whole office, I just didn't feel like I fitted in with people (T: Okay, so), in my previous job I had really good friends and we all had a similar age range and sense of humour and it was easy to talk to people there (T: Yeah), but with this job I felt a bit overlooked

Therapist: It's like I'm not sure I really fit in here

Client: Yeah (C4:S2: MU20).

A source of distress and inner conflict, the act of *monitoring or controlling self – restraining, complying, or intruding* revealed a spectrum of typical and unique themes. These included restraining oneself or holding back, being compliant or intrusive, and

controlling situations to avoid interpersonal communications or to shield aspects of oneself from shame. Additionally, there was a tendency to minimise or avoid social interactions altogether. Interestingly, while guarding or hiding parts of self and avoiding social interaction were an unsurprising find within socially anxious individuals, it was striking that the communication of each were distinct to only one participant during this early stage therapy. These themes manifested through meticulous self-monitoring, adaptive compliance, and adept avoidance or diversion tactics:

Stopping, Restraining or Limiting Self:

> **Therapist**: So that said, you are in definite need to react differently in this type of situation
>
> **Client**: I need to be myself, I would like to be myself (T: Mmm) I would like to just be myself actually but maybe I think of myself as not that nice a person or something so I don't let it out (C2:S1:MU15).

Being Agreeable, Pushing Self To Comply or Intrude:

> **Client**: I guess I'm so trapped and in a pattern with my mum (T: Mhm) that I feel- I can imagine how I'd like to respond (T: Wuh-hey!) but it's almost like however painful the way I respond is, I actually think she wants us to respond like that (C6:S2: MU17).

Avoiding or Restricting Communication With Others:

> **Client**: Yeah, so you can talk about this, but that's not safe, you can talk about that, but that's not safe (T: Ok) but then I don't have anything to talk about that's safe (C3:S3: MU38).

Notably, the related theme of *monitoring or controlling others – enforced propriety or conformity*, which involves the attempt to resolve perceived external conflicts by imposing one's own opinions, moral values, and needs onto others, was absent in the current analysis but was identified in the preliminary rational-empirical model.

Expressed by most participants, *self-doubt or indecisiveness* revealed a lack of self-awareness and a fluctuating sense of uncertainty or vagueness about oneself, experiences, knowledge, or a specific course of action. This inner conflict often involved navigating between different self-aspects or between self and the projected expectations, needs, or opinions of others. Distinctions emerged between challenges in self-appraisal and comprehension, confusion surrounding lived experiences, and uncertainties regarding personal competence:

I'm Unsure How To Comprehend or Make Sense of It:

> **Client**: I should take it quite as an insult
>
> **Therapist**: Mmm
>
> **Client**: But I don't know if it is, is it- I don't really know if it is- is that an insult- I think it, I would, I don't know maybe (C2:S1:MU7).

I'm Unsure What I'm Experiencing:

> **Therapist**: Weighs on your head maybe?
>
> **Client**: Is that what- don't know if that's- that (T: Yeah) yeah, it could be, yeah (C2:S1:MU28).

Hostile neglect previously differentiated five categories: *minimising, negating or avoiding one's feelings*; *self-neglect or abandonment* (not attending to important things); *acquiescing or affirming negative reactions from others; undeserving of positive reactions from others*; and *reacting in a flooded or overwhelmed emotional state*. All of these themes were identified in the current analysis except for feeling undeserving of positive reactions from others. Each category was further differentiated by a series of sub-categories (see Figure 14).

Significantly expanding on the category of *minimising, negating, or avoiding one's feelings*, multiple sub-categories illustrated how participants navigated emotional

distress by avoiding, downplaying, invalidating, or blocking their emotions. These efforts typically involved evading, diminishing, obstructing, or concealing emotions, particularly to avoid both experiencing distress and allowing others to perceive their feelings. Participants frequently expressed a strong preoccupation with avoiding emotional pain or perceived judgment from others, each revealing a unique yet challenging relationship with their emotions. For example, one participant struggled to identify or understand their feelings, another experienced negative self-judgment related to their emotions, while a third grappled with managing their emotional experiences:

I Don't Want Others To Know What I'm Feeling:

> **Client**: Maybe there is a feeling of a wee bit of anger at the time but I don't want to let people see that (T: Mmm) or let that out (C2:S1:MU38).

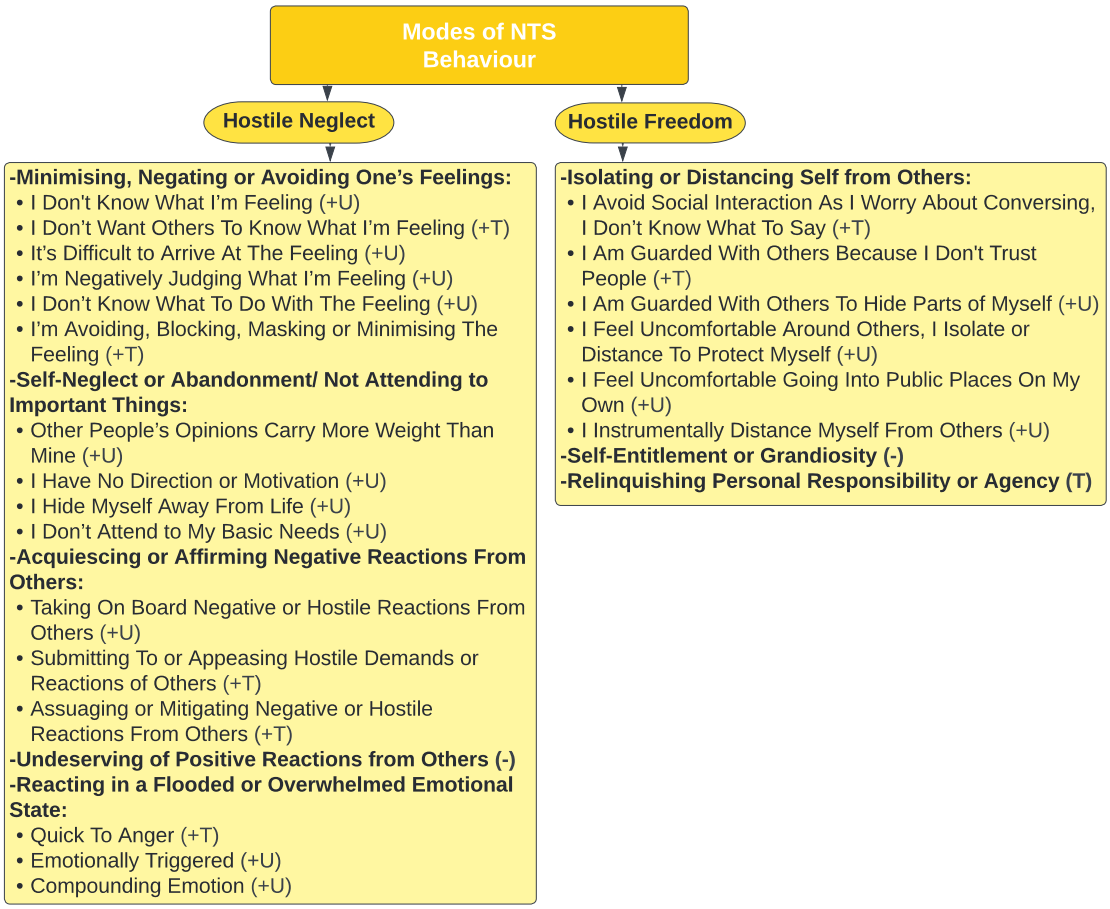
I'm Avoiding, Blocking, Masking or Minimising The Feeling:

> **Client**: I guess I feel that I spend so much of my life blocking them out because I was worried, well I mean, subconsciously at first but consciously now
>
> **Therapist**: Deliberately right
>
> **Client**: Blocking them out because I'm worried that they will just make me feel worse about myself
>
> **Therapist**: Well they do make you feel worse about yourself and even when you're blocking them out, I'm guessing, they're also making you feel, because they're still operating
>
> **Client**: Yes, they're still there (C3:S3: MU32).

Presenting a unique set of themes, *self-neglect or abandonment/ not attending to important things* included numerous examples of individuals overlooking their own needs and believing that the needs and opinions of others are more relevant, important, or valid. This behaviour manifested in various ways, such as withdrawing

from life, neglecting basic needs, or experiencing a lack of direction, motivation, or goals.

Figure 14: Modes of Negative Treatment of Self (What I Do That Is Bad For Me)



Note: + denotes a new category, - signifies an absent category, U indicates a unique category, T represents a typical category, and G denotes a general category.

Acquiescing or affirming negative reactions from others typically involved yielding to or appeasing hostile demands or behaviours, or attempting to defuse or mitigate them. Additionally, a unique theme emerged where individuals internalised these negative reactions or observations from others as valid or true:

Submitting To or Appeasing Hostile Demands or Reactions of Others:

Client: I give in- if somebody is angry at me I usually sort of just give in, they are angry at- I usually give in and let them have their own way or something when they are angry (C2:S1:MU43).

Assuaging or Mitigating Negative or Hostile Reactions From Others:

Client: Probably it was to get caring- but it was to get her to stop showing this

Therapist: Absolute disdain

Client: Disdain

Therapist: And dislike for you

Client: And intolerance because I- I drove her[L SEP]

Therapist: You drove her crazy

Client: Crazy (T: Yeah), my presence drove her crazy

Therapist: You could just tell she didn't want you (C: Uhuh) around (C5:S3: MU39).

Often rooted in self-neglect or abandonment, and previously identified in the preliminary rational-empirical model as a facet of passive-aggressive behaviour, *reacting in a flooded or overwhelmed emotional state* describes an eruption of tension that can no longer be contained. This state is characterised by quick-to-anger responses, heightened sensitivity to triggers, and the impact of accumulated emotions over time. The most prevalent and frequently expressed theme typically revolved around a tendency to become easily angered:

Quick To Anger:

Therapist: So, it's either a silence or shouting

Client: Yeah, pretty much, or just like- just superficial

Therapist: Superficial, right ok

Client: And- so

Therapist: So, is this ok to talk about

Client: Yeah (T: Ok, so this safe, ok) so that was my default- any kind of bad emotion just becomes anger straight away (C3:S3: MU19).

Hostile freedom or separation from others previously identified three categories: *isolating or distancing self from others*; *relinquishing personal responsibility* (or agency); and *self-entitlement or grandiosity*. The first category, isolating or distancing oneself, has been significantly expanded to include numerous sub-categories (see Figure 14).

Isolating or distancing self from others typically reflected a deep-seated mistrust of people, characterised by intentionally keeping others at a distance due to apprehension or fear of interaction and conversation. This behaviour stemmed from various underlying unique themes: guarding or distancing to conceal shameful self-aspects, protecting oneself, avoiding the fear of being alone in public places, or even manipulating situations to achieve a desired reaction or outcome. Ultimately, this avoidant stance perpetuated deep loneliness, isolation, and seclusion:

I Avoid Social Interaction As I Worry About Conversing, I Don't Know What To Say:

Client: Wanting to go away is quite strong- and not getting involved

Therapist: Mmm right, so that's what's happening right now

Client: It could be, yes it is, but it's also the sense of a criticism as well I am not very good at taking criticism and if you go out- if you are met with people you- to have people saying things to you- so (T: Ah) it's easier for me to sort of avoid criticism or having to say something (C2:S1:MU1).

I Am Guarded With Others Because I Don't Trust People:

Client: And I remember him saying like why can't you- like you need to trust me, and I'm like well because you're a person- like how can I trust a person that I know you're going to hurt me, it's like I know that, I know you will (C3:S3: MU21).

The typical theme *relinquishing personal responsibility or agency* reflected a perceived absence of personal authority, initiative, control, or power over one's life and experiences:

Relinquishing Personal Responsibility or Agency:

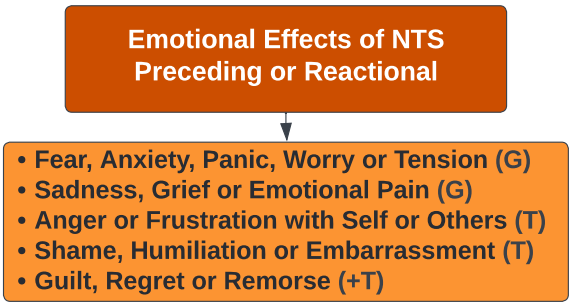
> **Therapist:** Occasionally it comes to the front of your mind, and you'll be like ah right I'll kind of wait for them, or you say oh I'll do it tomorrow, how do you feel then
>
> **Client:** I think I give myself permission then to just be really lazy I guess, I just sort of say it's okay, I can just lie here, I don't need to do anything (T: Okay), yeah (C4:S2: MU41).

Interestingly, the previously identified theme of *self-entitlement or grandiosity*—characterised by a perceived sense of entitlement, superiority, or privilege, often accompanied by feelings of unfairness, discontent, or disappointment—did not surface in the current analysis. However, this theme did re-emerge in the subsequent and final investigation of this thesis, specifically in the context of NTS within end-of-therapy sessions (see Chapter 5). This suggests that such attitudes may become more pronounced or relevant in the concluding stages of therapeutic work, warranting further exploration.

Emotional Effects of Negative Treatment of Self

Establishing a synergistic connection to self-dislike and inimical self-actions, five categories emerged that describe the range of challenging emotional processes within the domain of the *emotional effects of negative treatment of self.* This analysis builds upon the earlier preliminary rational-empirical model, which outlined the emotions experienced either prior to or in response to self-dislike and harmful self-actions (see Figure 15).

Figure 15: Emotional Effects of Negative Treatment of Self
(What I Feel Preceding Or In Reaction To My Self-Dislike & Inimical Self-Actions)



Note: + denotes a new category, - signifies an absent category, U indicates a unique category, T represents a typical category, and G denotes a general category.

Unsurprisingly, emotions such as *fear, anxiety, panic, worry, or tension*—commonly experienced by those suffering from social phobia—emerged as one of only two general themes identified in the analysis. These emotions were vividly expressed through statements like *I am scared*, *it's fear of*, *I'm even terrified*, *my hand was shaking*, *I just kind of panicked*, *my shoulders get really tight*, and *I'm really anxious*. The fears centred around various concerns, including fear of failure, criticism, attack, repercussion, rejection, making mistakes, or not knowing what to say or do:

Fear, Anxiety, Panic, Worry or Tension:

> **Client:** I got really anxious, felt a knot in my stomach, ended up getting weepy
>
> **Therapist:** Okay, so a knot in the stomach, getting weepy
>
> **Client:** And I think I got annoyed at being weepy because it was just a silly mistake (C4:S2: MU24).

The other general theme identified in the analysis was *sadness, grief, or emotional pain*—a finding that is unsurprising given the psychological distress often experienced by socially anxious clients. This theme was conveyed through expressions of clear emotional suffering, such as *it kind of hurts in a way*, *I just feel so sad*,

depressed and low, *like a downer*, *I feel hurt all the time*, *because it's painful*, *brings up the tears*, and *it's ripping the heart out of me*. These emotions frequently stemmed from experiences of criticism, rejection, loathing, or injury, whether self-inflicted or perceived from others. Additionally, the secondary reactive process of grappling with one's own difficult or painful emotions, coupled with an inability to manage them, seemed to perpetuate the cycle of psychological pain:

Sadness, Grief or Emotional Pain:

> **Therapist**: I'm aware that you're in a lot of pain right now
>
> **Client**: (crying) I don't know what to do with it do you know what I mean
>
> **Therapist**: Yeah, I mean sometimes its important just to acknowledge that it's there
>
> **Client**: I don't think I've- I feel choked with it
>
> **Therapist**: Okay, it's choking you
>
> **Client**: Inside, it's- it feels heavy inside (T: Yeah) and kinda like oh God (C5:S3: MU5).

Expressions of *anger or frustration with self or others* typically included phrases like *it's a bit frustrating*, *I got annoyed*, *really furious*, *the aggression and frustration*, *angry with myself*, or *anger against other people*. These emotions often arose from self-directed feelings about perceived personal flaws and fears of criticism, rejection, or repercussions, which could lead to negative self-treatment or, less commonly, self-injury. When directed at others, anger and frustration were generally conveyed in milder terms such as *I was frustrated,* or *I got annoyed*. Additionally, there was a tendency to conceal one's anger, with statements like '*maybe there is a feeling of a wee bit of anger at the time but I don't want to let people see that, let that out, but I know afterwards there could be strong feelings of anger*':

Anger or Frustration with Self or Other:

Client: I get angry with the world (T: Mmm) but I also get angry with myself and direct my anger and frustration towards self

Therapist: Mhm- so you're really noticing how you attack yourself

Client: Yes

Therapist: When you get angry and frustrated (C1:S4: MU14).

The category of *guilt or shame* from the preliminary rational model was refined into two distinct categories: *shame, humiliation, or embarrassment* and *guilt, regret, or remorse*. Both categories were commonly observed in the analysis. The first category was expressed through phrases like *hot and bothered*, *my face goes very, very red*, *ashamed*, *embarrassed*, *this awkwardness*, and *shaming myself*, often reflecting self-judgment and feelings of incompetence:

Shame, Humiliation or Embarrassment:

Client: This thing about being embarrassed about myself- I think that's my thing

Therapist: They made you- being shamed by them

Client: And I still feel that you know, nobody's- nobody in my life is saying anything to me now, it's me that's saying it

Therapist: You're embarrassing yourself (C5:S3: MU43).

Guilt, regret, or remorse was often expressed as self-reproach, typically conveyed through statements of 'oughts' and 'shoulds', such as *I should've got help*, *I should have looked at my frustrations*, *I should've got help for that instead of destroying your life*, *I really regret doing that*, or *I've just never seen it*:

Guilt, Regret or Remorse:

Client: I should have looked at my frustrations and gone for counselling or therapy and dealt with my own issues (T: Mmm) but I was cowardly and I didn't and I took it out on you

Therapist: Mhm, really seeing a side of myself that I should've got help for and, shouldn't have taken it out on you, I really regret doing that

Client: Really seeing a side of myself that I should've got help for instead of taking my warped view of the world out on you and I should've got help for that instead of destroying your life

Therapist: Mhm, and I regret that

Client: And I regret that (C1:S4: MU32).

Chapter Summary and Discussion

Driven by an interest in better understanding and enhancing awareness of the narratives used by socially anxious clients in the deployment and maintenance of negative self-treatment, this investigation sought to explore and elucidate the descriptive characteristics of NTS discourse expressed in the early stages of therapy. Viewed as a cyclical process, this exploration aimed to illuminate the various elements of NTS by bringing awareness not only to self-critical activities but also to the strategies employed in carrying out self-dislike, the corresponding inimical self-actions, and the resultant or preceding emotional effects. Building upon the preliminary rational-empirical model of NTS (Capaldi & Elliott, 2023), numerous supplementary categories and sub-categories emerged, creating a more elaborated and refined empirical structure. The chosen analytical methodology (GDI-QR; Elliott & Timulak, 2021) facilitated close observation of client and therapist discourse, organically revealing both obvious and subtle themes of negative self-treatment. The study acknowledged the complexity of underlying self-critical and self-harmful processes, highlighting the relevance of routinely allusive yet clearly implied expressions of NTS alongside their more distinct and unambiguous presentations.

This study sought to explore the consequences and antecedents of self-criticism (Werner et al., 2019), investigate its implicit outcomes and emotional processing for a more comprehensive understanding (Shahar et al., 2012), and examine not only the

content of self-criticism but also how it is enacted (Elliott et al., 2004). This research aimed to deepen the phenomenological understanding of the NTS process, as defined in the integrative summary of Chapter 1.2. It highlighted a diverse array of self-denigrating and harmful processes, expanding the scope beyond the typical focus on self-criticism related to perfectionism and its effects on personal goal achievement (Powers et al., 2011) or performance-based concerns (Whelton et al., 2007; Shahar, 2015).

Through close analysis of client self-talk, this inquiry uncovered a spectrum of detrimental self-actions, ranging from explicit self-hating attacks such as self-injury to the subtler processes like self-doubt, feelings of inadequacy, self-blame, idealistic expectations, and fear-based limitations. This propensity to '*victimize, attack, and even destroy*' oneself has long been recognised as a common, yet highly variable phenomenon, encompassing a spectrum from '*mild scolding to derisive and annihilating contempt*' (Whelton & Henkelman, 2002, p.88). In line with Elliott and Shahar's (2017) portrayal of socially anxious clients driven by deep-seated shame and fear in their attempts to hide a perceived broken or defective self, participants in this study vividly expressed patterns of negative self-treatment characteristic of social phobia. This was evident through statements affirming feelings of brokenness (T: *you've reached a sense of being broken*, C: *oh aye, it's terrible*), derogatory self-descriptions (C: *I'm stupid, I'm ugly, I'm clumsy*), as well as behaviours aimed at self-protection (C: *kind of isolating myself*), and expressions of fear and emotional distress (C: *I just panic*). These problematic patterns of self-relating align with Elliott and Shahar's observation that individuals with SA, shaped by early experiences of social degradation, internalise beliefs about their own brokenness. Interestingly, in each example from this study, the notion of a broken or defective self, along with the need to guard against others seeing this, was first proffered by the therapist through phrases like '*this sense of being irreparable*', '*where you face the most broken in you*', '*there's something really broken or defective*', and '*that's the thing you're afraid that people are*

going to see'. Clients consistently affirmed these suggestions, often making self-critical assertions about their core self, describing it as abhorrent, contemptible, or deplorable with matter-of-fact statements like '*the horrible bit of me*', '*I am not particularly nice*', or '*so awful*'. These assertions were frequently paired with derogatory statements reflecting low self-esteem or self-worth, conveying a deep sense of worthlessness linked to this perceived defectiveness, such as '*a waste of space*', '*not good enough*', or '*just being worthless*'.

To comprehensively outline the cognitive, behavioural, and affective idiosyncrasies of negative self-treatment, this study encompassed not only explicit self-dislike and self-attacking processes but also controlling, neglecting, and distancing narratives. This breadth of investigation stands in contrast to many studies that have focused solely on a particular aspect of self-criticism and its clinical implications. For instance, Werner et al. (2019) noted that clinical research often links self-criticism to various psychopathologies such as depressive disorders (Blatt et al., 1976; Gilbert et al., 2006; Shahar, 2015), underscoring the sparse exploration of self-criticism as a general and commonly occurring personality trait. In their exploration of women with eating disorders using EFT group therapy, Brennan et al. (2015) identified self-criticism as a prominent concern. Their analysis revealed six overarching themes, demonstrating participants' struggles with disentangling from their inner critic, recognising its destructive impact and protective functions, effectively managing emotions, acknowledging their unmet needs, and valuing support. Although the current investigation focuses on social anxiety, it argues that the taxonomy of negative self-treatment offers valuable insights into clients' self-relationships regardless of their presenting issues. Consistent with themes identified by Brennan et al., narratives from participants with social anxiety reflect similar experiences, as shown by statements like '*I think it's myself telling myself these things, but I would say probably that the devil, whatever you want to call him, uses that in me*' (difficulty separating from the critic), '*I know I can get round you by criticising you, bullying you and shoving you around*'

(recognising the destructive impact), '*really isolating myself or just protecting myself from that*' (acknowledging protective functions), '*feelings that I'm fed up having as if I've had forever*' (managing emotional processing), '*needs that were never met by them*' (accepting unmet needs), and '*I should've got help for that instead of destroying your life*' (valuing support).

The creation of numerous sub- and lower level categories of self-dislike or self-criticism, particularly focusing on personal actions (self-efficacy, performance, action, or inaction), aligned with definitions emphasising rigid expectations for high standards of achievement (Shahar, 2015). This tendency often leads individuals to harshly criticise themselves when these excessively lofty goals prove unattainable (Whelton et al., 2007). Discriminating among the wide range of self-critical presentations, critiques of personal performance included difficulties in communication, emotional inhibition, perceived shortcomings relative to both self-imposed and external expectations, struggles with initiating action or feeling incompetent despite efforts, as well as the adoption of avoidance strategies and anticipation of failure. Instances of *falling short of one's own expectation of self* created an *oughts and shoulds* category marked by hostile self-control, echoing Greenberg et al.'s (1993) identification of these internalised standards as catalysts for antagonistic and contemptuous styles of self-relating. This array of self-imposed pressures, stressors, and burdens reflects a monitoring and controlling hostility towards oneself, validating Shahar et al.'s (2015) proposition that individuals with social anxiety adopt a critical and vigilant stance towards themselves to shield against intense shame rooted in childhood experiences.

Describing social anxiety as a type of behavioural and experiential avoidance, where individuals experience distress over their impending social isolation (Elliott & Shahar, 2017), evidence for this phenomenon was found in the *avoidance strategies* category. This theme encompassed various tactics such as fantasy, pretence, or dishonesty, as well as submission, passivity, or the blocking of uncomfortable emotions. Additionally, the category of *hostile freedom or separation from others*

encompassed behaviours such as self-isolation or maintaining distance, driven by concerns about social interactions, a lack of trust, the need for self-protection, fear of public solitude, or strategic distancing to elicit a desired response. Notably, within the distancing category, participants sometimes expressed concurrent feelings of exclusion, neglect, or rejection by others. This emotional backdrop often prompted a reactive behaviour of withdrawing and disengaging in the hope of receiving attention. This behaviour supports Elliott and Shahar's (2017) observation that individuals with social anxiety often have '*greater than average needs for social contact*' (p.143). For instance, one participant expressed a longing for a supportive response, saying, '*my fantasy response would be somebody saying don't be silly, I'm an idiot, I'm sorry, come over here, or like, come give me a hug*'.

Considering the well-documented symptomology of experiential avoidance and distancing, it is unsurprising that Whelton et al. (2007) linked challenges in forming and maintaining a therapeutic alliance with high levels of self-criticism. In line with Blatt's (2004) recommendation that severe self-critics may benefit from longer and more intensive therapy to foster trust gradually, the study's findings corroborated this notion. This was evident in categories such as *I am guarded with others because I don't trust people* and *to hide parts of myself*, exemplified by statements like '*I remember him saying why can't you trust me, and I'm like well because you're a person, how can I trust a person*' and '*I'm afraid they're going to see that about me*'. Reviewing the clinical manifestation of inner critic process features, Stinckens et al.'s (2013a) taxonomy—outlining degrading, punitive, controlling, neglectful, distancing, and domineering styles of self-relating—was evident within the analysis. In particular, the *objects of NTS* domain offered pejorative examples of self-contempt and disapproval (C: *being worthless, inadequate, useless*), the *self-attack* domain reflected self-punitive hostility (C: *I kinda start attacking myself*), the *hostile control* domain displayed inflated demands and pressures (C: *why do you even bother sitting at your word processor and writing, no one would ever want to print your stuff*), *hostile neglect* described an array

of self-abandonment (C: *I must be wrong when they're angry, I must be wrong*), and the *hostile freedom* domain exhibited multiple ways of distancing and isolating (C: *I'm afraid they're going to see that about me, that's why I keep a lot of my friendships on a superficial level*). Interestingly, Stinckens et al.'s description of a domineering client presentation characterised by attention-seeking, arrogance, dominance, grandiosity, or manipulation was less apparent in the early stage of therapy. However, glimpses of these behaviours were discernible in categories like *instrumentally distancing* and *relinquishing personal responsibility* within the hostile freedom domain. Notably, although the preliminary rational-empirical model provided evidence for a *self-entitlement or grandiosity* category, no explicit examples were found in the current analysis. While it could be argued that these processes more clearly express interpersonal behaviours, the examples found previously also demonstrated harmful intrapersonal actions driven by feelings of unfairness, injustice, discontent, insecurity, and disempowerment (Capaldi & Elliott, 2023). Further supporting the relevance of such descriptors in understanding self-criticism, Kealy et al. (2012) highlighted connections between narcissistic grandiosity and vulnerable narcissism with themes of dependent depression and self-critical depression, respectively.

Similar to Stinckens et al.'s (2002a) observation that the inner critic's process during therapy does not necessarily adhere to a static pattern, the findings of this study recognised various forms of negative self-treatment emerging in a somewhat irregular or inconsistent manner. Conversely, aligning with Capaldi and Elliott's (2023) findings, distinct patterns of NTS within individual cases were also evident, underscoring the importance of acknowledging both common and atypical client themes. Offering reassurance in their study on the development of the inner critic during therapy, Stinckens et al. (2013a) suggested that it may not be necessary to address every form and manifestation of the inner critic to achieve therapeutic change. However, the need to identify and respond to the diverse presentations of negative self-treatment and their emotional effects was clearly evident in the current analysis. Notably, the only

two themes consistently appearing across all participants were related to the impact of self-dislike and inimical self-actions, manifesting as *fear, anxiety, panic, worry, or tension* and *sadness, grief, or emotional pain*. Emphasising the centrality of emotional processing, the cyclical nature of NTS appeared to be fuelled and sustained by feelings preceding or reacting to self-dislike and inimical self-actions. Unsurprisingly, these findings highlight the plight of socially anxious clients, who often present with crippling emotional pain related to their perceived defectiveness and a deep-seated fear of being recognised as flawed. In their exploration of emotion in self-criticism, Whelton and Greenberg (2005) highlighted the necessity of addressing emotional processes more comprehensively, noting that internalised voices of self-criticism from caregivers or significant others also carry the emotional tone of the criticism within their content. The various facets of the rational-empirical model of negative treatment of self, encompassing the objects and directness of NTS, modes of NTS behaviour, and emotional effects, resonate with Whelton and Greenberg's (2005, p.1584) assertion that '*emotion schemes are understood to synthesize affective, cognitive, motivational and motoric information, producing an experience that is unified, a sense of oneself in relation to the world*'.

In alignment with literature linking self-critical processes to early traumatic, critical, controlling, and neglectful experiences inflicted by parents or significant others, along with resulting attachment injuries (Elliott et al., 2004; Elliott, 2013; Elliott & Shahar, 2017; MacLeod et al., 2012; Stinckens et al., 2002a; 2013a), the data provided multiple examples of these dynamics. These were evidenced by statements such as '*being shamed by them (parents)*', '*they were a bit lower down the scale you know so my dad said well, I must have come from their gene pool* ', '*and (mum's) intolerance because I drove her crazy, my presence drove her crazy'*, and '*what will happen if we don't comply, she (mum) escalates passive aggression, the passive aggression just escalates and escalates*'. It was observed that many of these early relational difficulties with parents persisted significantly for some participants during therapy. Furthermore,

participants often described their inner critics as resembling their introjected critical parent (Blatt, 1995; Stinckens et al., 2013a), as seen in statements such as '*it's me that's shaming myself'* and *'nobody in my life is saying anything to me now, it's me that's saying it*'.

Often exiled, the self-critical process persists whether consciously acknowledged or operating beneath awareness, yet this exclusion perpetuates its impact. Moreover, despite the hostile and disparaging demeanour of the inner critic, as noted by Cornell (2005), beneath the surface lies deep-seated fear. Recognised to fulfil a protective role, bringing these patterns of harmful self-relating and their resulting emotional effects fully into consciousness can be challenging. However, it is through this process that they can be heard, understood, and ultimately addressed. The rational-empirical model of negative treatment of self proposed in this study aims to serve as a guide, facilitating the recognition, acknowledgment, and effective response to the myriad manifestations of negative self-treatment.

Limitations and Suggestions for Future Research

This inquiry faced a significant challenge in navigating the nuanced subtleties involved in identifying, interpreting, and classifying various types of negative self-treatment. A key limitation of this study was the subjective nature of labelling and categorising facets of harmful self-relating, which inherently involves a reflexive process susceptible to researcher bias (Mahtani et al., 2018). Although the person-centred tradition typically avoids interpretation (Rogers, 1951), a deep exploration of implicit meanings allowed for the inclusion of some *edge of awareness* (Gendlin, 1996) understandings of the client's process. This approach to reading and describing data is shaped by the researcher's perceptual style and theoretical framework (Elliott & Timulak, 2021), highlighting the potential for varying findings among different researchers. Despite striving to closely adhere to participant narratives and their underlying meanings, distinguishing between the objects and modes of NTS often

proved challenging, requiring repeated readings due to their closely interconnected expressions. The development of a labour-intensive microanalytical method led to evolving labels for each category and subcategory throughout the analysis. As such, these labels are tentative and likely to evolve further with ongoing research. Furthermore, the process of recategorising data during analysis, and its potential for future reclassification suggests that theoretical saturation may not have been fully attained.

While qualitative research may not conform strictly to generalisability theory, it provides the opportunity to explore diverse facets such as individuals, conditions, variables, occasions, and settings—either independently or at a conceptual level based on theoretical relevance (Barker et al., 2016). This study prioritised contextually relevant insights over universal truths, though the small sample size may have constrained the diversity of experiences represented. The identification of numerous unique themes could be critiqued as potentially specific to the sample group, limiting their applicability to other populations or contexts. Despite the potential for researcher bias and the influence of individual experiences, these unique themes provided valuable insights into the lived experiences of participants. It is noteworthy that while these themes were unique to individual participants, they often recurred across multiple instances within their narratives. Qualitative research emphasises depth and richness of understanding, focusing on contextually situated interpretations rather than broad generalisability. Therefore, the relevance of these unique findings is argued to be significant within the current context, while acknowledging their potential lack of universal applicability across diverse populations or situations.

Considered both a limitation and strength of this study, it is acknowledged that the current rational-empirical model of NTS in socially anxious clients may not fully represent other clinical presentations. However, evidence of similarities was found with other EFT research, such as studies on the impact of self-criticism in depression or eating disorders. This suggests some overlap in NTS processes across different clinical

conditions, albeit potentially slight, highlighting the universal challenges individuals face in their self-relationship regardless of specific diagnostic categories. Further exploration of negative self-treatment across diverse client populations and therapeutic modalities holds promise for enhancing the saturation and applicability of results. Standardising future investigations could benefit from a manualised taxonomy outlining the various manifestations of NTS, supporting objectivity among researchers and practitioners.

The process-guiding approach of EFT, utilising tasks such as conflict split markers and the two-chair dialogue (Elliott et al., 2004; Elliott & Greenberg, 2021), involves actively engaging clients in the enactment and exploration of self-critical processes to heighten awareness and evoke primary emotions. This approach facilitated the identification and classification of different configurations of NTS in this study. However, it is recognised that a challenge of such active therapeutic engagement is the client's state of readiness to disclose vulnerabilities. While the aim of techniques like the two-chair dialogue is to deeply explore these processes towards softening or resolving the inner critic, this proactive approach to negative self-treatment may differ significantly in other therapeutic modalities, potentially influencing therapeutic structure and outcomes.

The initial validation study of the SRQ in this thesis, which identified self-attack and self-affiliation as inverse measures, poses a potential limitation for the current investigation, which specifically focuses on negative treatment of self. While previous research has linked higher levels of self-compassion with psychological resilience and harsh self-criticism with depressive difficulties (Ehret et al., 2015), future studies on NTS should also consider clients' levels of self-affiliation in relation to their self-dislike and inimical self-actions. Furthermore, as proposed by Capaldi and Elliott (2023), although all participants in this study exhibited high SRQ scores in self-attack alongside narratives of negative self-treatment during sessions, client self-reporting was not consistently reliable for understanding their self-relationship. This underscores Shahar

et al.'s (2012) recommendation for future investigations of implicit self-critical processes to employ multiple methods, combining client self-reporting with more implicit measures. According to Gilbert et al. (2004), there remains much to uncover regarding the various manifestations of self-criticism, particularly in terms of personal feelings of inadequacy or more overtly antagonistic and hostile presentations.

Implications for Practice and Conclusion

This investigation has both validated and extended existing literature on self-criticism. Broadening the definition of NTS by acknowledging that self-criticism is only part of a broad spectrum of inimical self-actions encompassing self-attacking, coercive, and interruptive processes (Elliott & Greenberg, 2021), this study has enhanced our understanding of the self-relationship, particularly in its more harmful forms. It has provided a comprehensive view of the cyclical nature of self-dislike, inimical self-actions, and their emotional consequences in socially anxious clients, emphasising the importance of implicit process indicators of NTS. By enhancing awareness of clients' self-damaging narratives across a spectrum of possibilities, this rational-empirical model of NTS, when combined with client self-reporting, can potentially refine therapeutic practice. Furthermore, the model appears relevant in elucidating clients' patterns of self-relating across various difficulties and diagnoses. Nevertheless, the study also paints a clinical picture specific to social anxiety presentations, underscoring the necessity for further exploration of NTS across different client populations. Expanding the model to achieve greater saturation could lead to a more generalised understanding, while also shedding light on specific behaviours or strategies commonly observed in distinct clinical contexts. The intricate dynamics of NTS highlighted in this model advocate for a flexible therapeutic approach that prioritises effective emotional processing. This aligns with Stinckens et al.'s (2013b) assertion that successful therapeutic outcomes hinge on actively engaging with the critic in all its forms and manifestations.

This study is significant as it is possibly the first of its kind, expanding upon the preliminary rational-empirical model, to empirically investigate the nuances of negative treatment of self by integrating variables of self-dislike, inimical self-actions, and their emotional effects. By distinguishing and highlighting elusive and subtle forms of NTS alongside more overt manifestations, the findings vividly illustrate a diverse spectrum of negative self-relating. Through uncovering various types of harmful-to-self processes—whether direct or indirect, explicit or underlying—the study underscores the challenge of objectively understanding the complexity of the self-relationship in its myriad configurations. Whether negative treatment of self manifested internally or externally towards others, both strategies clearly caused significant psychological pain and distress. Rather than categorising or labelling clients, the study argues that its taxonomy can enhance practitioners' awareness of the range of harmful self-processes that may emerge in therapy. This heightened awareness is clinically relevant as it facilitates the recognition and effective response to these diverse forms of negative self-treatment, thereby supporting more comprehensive therapeutic interventions. Highlighting the multifaceted nature of the plural self (Cooper, 1999) and its multivoicedness in therapy (Elliott & Greenberg, 1997), the results demonstrate how multiple voices or configurations (Mearns & Thorne, 2000; Mearns, 2002) within clients' lives and narratives can be identified. This study offers a glimpse into the ebb and flow of negative self-treatment, providing an overview of the various struggles and inner conflicts experienced by socially anxious clients.

Returning to the inquiry into whether the various indicators of negative self-treatment can be captured effectively to provide insights into their intensity, especially in relation to changes over the course of therapy, the next and final study of this thesis is expected to shed light on participants' NTS dialogues towards the conclusion of therapy. It is anticipated that these evolving patterns can be assessed by closely examining how well the different categories and subcategories describe negative self-treatment in the later stages of therapy, offering potential for tracking client progress

through their narratives. By enhancing awareness and stimulating creativity in clinical practice, this study lays the groundwork for multiple lines of inquiry aimed at achieving more effective therapeutic outcomes. It promotes greater awareness of self-sabotaging patterns, fostering understanding and creating fertile ground for adopting more self-compassionate approaches. Offering a pathway towards greater self-knowledge and realisation, uncovering those harmful parts of oneself insidiously operating in the background and bringing attention to the resulting emotional pain is a process of self-discovery, and the antithesis of silenced or shunned self-aspects. Creating a more robust foundation for healing and transformation, this body of works has the potential to give recognition and voice to diverse facets of the self to emerge more freely and unabated, thereby supporting liberation from this self-imposed oppression.

Chapter 5: Negative Treatment of Self in Socially Anxious Clients as it Presents at the Ending Phase of Therapy

Introduction

According to Choi et al. (2016), and EFT theory in general, self-critical depressive states are interwoven with secondary reactive and maladaptive emotion schemes. These automatically occurring self-critical *schematic structures* (Greenberg & Watson, 2006) are connected to a *bad* or *defective* sense of self, coinciding with an array of hostile-to-self emotion schemes. This results in the activation of further maladaptive experiences of debasement and shame. EFT aims to change these reflexive self-critical processes by activating more adaptive primary emotions and needs, which, as Choi and colleagues observed, led to good resolution of self-criticism cases. Additionally, in their exploration of how core emotional pain can be transformed through engaging with this humanistic-experiential therapy, Dillon et al. (2018) observed that developing more assertive anger and greater self-compassion was a key facilitating factor. While EFT research often focuses on the transformation and classification of emotional processes to understand and measure effective change, less attention has been given to how negative treatment of self (NTS) discourse descriptors evolve and soften towards the end of therapy. However, it is argued that since emotional, cognitive, and behavioural intrapersonal processes are so closely interconnected, attempting to observe therapeutic change by scrutinising any of these self-to-self processes in isolation may be a redundant exercise.

As evidenced in the earlier empirical study and the previous rational investigation of negative treatment of self (Capaldi & Elliott, 2023), this study assumes that NTS comprises a synergistic spectrum of intricate negative self-schemes, incorporating the targets and directness of self-dislike, modes of inimical self-actions, and their emotional effects. While prior investigations classified the array and complexity of these cognitive, behavioural, and affective processes during the beginning phase of therapy, this study sought to further elaborate the range of

possibilities by examining the ending phase therapy in association with the rational-empirical model. Furthermore, this study focused on perceiving and describing the quality of negative treatment of self in its alleviated forms and manifestations at the end of therapy. Utilising the ending phase therapy sessions for those EFT-SA clients involved in the earlier study of this thesis (see Chapter 4), the aim of these qualitative case examinations was to not only test *saturation* levels (Corbin & Strauss, 2015) and fit of the existing structure, but to further challenge it and where necessary, elaborate the taxonomy of harmful-to-self discourse, behaviours, and affects. With all participants chosen for this study demonstrating reliable change in their levels of self-attack at the end of therapy, as measured by the Self-Relationship Questionnaire (SRQ; Faur & Elliott, 2007), verbatim transcripts of the client and therapist dialogue were used to challenge the main themes (see Appendix M: Supplemental Tables, Table 6: Revised Rational-Empirical Model of NTS) and create additional structures to depict the overall decrease in patterns of harmful self-relating. As with the earlier study, the descriptive-interpretative approach to qualitative research (GDI-QR; Elliott & Timulak, 2005; 2021) was adopted to extract and categorise detrimental intrapersonal processes for these later-stage therapy sessions, revealing notable amelioration of occurrence and severity in line with changes reported in the corresponding SRQ scores at the end of the therapeutic process.

While it was anticipated that saturation had been achieved in the earlier investigation of negative treatment of self, this latter study identified a small number of additional sub-categories, resulting in minimal alterations to the overall model. In accordance with Corbin and Strauss' (2015) *theoretical sampling*, this further process of replication aided the formulation of more robust descriptors to better incorporate the emerging findings. This theory-building rational-empirical approach to the analysis (Pascual-Leone, 1978) viewed the prior structures of NTS as rational models to be tested for regularities and inconsistencies across this differing time point of therapy. Aiming to further challenge, refine, and elaborate the model, a process of close

observation and induction (Rice & Greenberg, 1984) was undertaken using the rational-empirical model as a guide, allowing for greater dialogue between the constructs and the client's experiences (Timulak & Elliott, 2019). This theoretically informed approach enabled enhanced specificity and more refined elaboration, supporting the creative reflexivity required for further refinement and classification of the data. Providing robust evidence of the insidious and interdependent nature of the constructs of self-dislike, inimical self-actions, and their emotional effects, Capaldi and Elliott's (2023) formulation and definition of negative treatment of self has been elaborated and refined in line with the current findings. Building on the initial rational-empirical analyses of negative self-relating patterns observed at the start of therapy, this study not only challenges and refines this model but also highlights the differences in the frequency of NTS between the beginning and the end of therapy. Furthermore, it offers a detailed depiction of NTS in its more refined and ameliorated forms.

Literature Review and Rationale for Exploring Negative Treatment of Self in its Ameliorated Forms

Kramer and Pascual-Leone (2015) argued that individuals prone to anger often display elevated levels of self-contempt and have difficulty accessing their underlying needs, highlighting the pervasive nature of self-criticism. They underscored its association with various psychological challenges and its profound impact on emotional well-being. In their overview of the clinical practice implications, they concluded that simply challenging self-critical thoughts (Beck et al., 1979) or teaching more self-compassionate or assertive behaviours (Gilbert & Procter, 2006) might be insufficient, as it may overlook the affective aspects of self-criticism and its associated underlying unmet needs. Highlighting '*the centrality of emotional processing when working through self-criticism*' (Kramer & Pascual-Leone, 2015, p.328), their findings indicated the necessity of a process-focused approach to effectively alleviate hostile and punitive self-critical voices. Humanistic-experiential psychotherapies aim to access and change emotional components within therapy, rather than solely focusing on content.

Therapists encourage clients to directly experience and express their emotions, employing techniques like empty-chair dialogues and guided imagery. By concentrating on present emotions rather than narrative details, therapists delve into underlying emotional patterns and interpersonal dynamics. This process enhances clients' emotional awareness, regulation, and interpersonal skills, leading to deeper self-understanding and growth (Westwell, 2016). Supporting the use of the two-chair dialogue for conflict splits task (Elliott et al., 2004), which effectively separates opposing self-aspects and explores their emotional implications, intents, and needs, underscores the importance of differentiating inner critical voices. This facilitates the owning, understanding, and productive processing of both the hostile self-critic and the impacted, often highly anxious experiencing self-aspect (Greenberg, 1979).

In their exploration of self-esteem and its impact on general emotional processing in daily life, Kramer et al. (2022) distinguished between the trait and state aspects of self-esteem, highlighting its attributes as both a feature of stable personality and a fluctuating and changeable component in response to lived experiences. They linked primary maladaptive emotions with repeated negative feelings about oneself, citing Beuchat et al.'s (2021) assertion that fostering awareness of maladaptive emotional reactions and accessing more adaptive and productive emotional responses may help address self-criticism more effectively in therapy. An essential aspect of EFT is differentiating between primary maladaptive emotions (old, unresolved feelings from past trauma), secondary reactive emotions (responses to primary underlying emotions), and instrumental emotions (used to achieve a desired result). According to Elliott and Greenberg (2021), this therapeutic movement towards more primary adaptive emotional responses (initial, useful gut reactions) is crucial for effective practice and outcomes.

Investigating the interactive processes through which therapists respond to their clients' various self-critical positions, Muntigl et al. (2020) found that client self-criticism is often associated with reduced accountability, self-blame stemming from

unmet expectations or difficulties in fulfilling obligations, as well as weakened control and contemptuous self-evaluations. They observed that while therapists may respond to a loss of control or diminishing responsibility by focusing on the potential for change and positive outcomes, clients often resist these efforts during the process of working towards re-affiliation. Highlighting the challenges faced by therapists working with highly self-critical clients, they acknowledged the delicate balance required between validating the person's self-critical voice and resulting pain, while also supporting a more positive interpretation of their situation. They suggested that therapists use caution, employing hedging expressions such as *'there's something',* or *'kind of'* (Muntigl et al., 2020, p.804) to carefully support clients in reformulating their experiences. Furthermore, when reviewing the various response types used by therapists from different therapeutic modalities, Muntigl and colleagues distinguished between the cognitive-behavioural approach of challenging negative cognitions, the psychodynamic approach of highlighting client strengths and abilities, and the humanistic emotion-focused approach of developing a more empathic relationship with oneself. Drawing upon integrative principles for resolving self-criticism, they highlighted Kannan and Levitt's (2013) recommendations for utilising procedures that span a range of approaches, such as '*demonstrating empathy and compassion, strengthening the self, and enhancing client agency*' (Muntigl et al., 2020, p.812). These procedures are integral to humanistic-experiential therapies, which prioritise moment-to-moment empathic responses, focus on the client's felt sense, and are informed by task differentiation and emotion theory (Westwell, 2016).

Focusing specifically on clients with generalised anxiety disorder (GAD), O'Brien et al. (2019) identified a complex array of themes. These include emotional triggers such as rejection, harmful self-treatment like self-criticism or self-interruption, general distress, specific fears related to emotional pain and anticipated triggers, behavioural and emotional avoidance, core pain such as shame or sadness, and unmet underlying needs. Interestingly, regardless of their characteristic themes, all participants exhibited

an undifferentiated state of global distress and secondary reactive emotions. Some expressed concern about losing or lessening their process of active worrying, viewing it as a protective strategy to avoid becoming overwhelmed by their core pain. Considering the implications for treatment, O'Brien and colleagues asserted that clients actively try to avoid their known specific triggers and the associated emotional pain, which, rather than indicating a general emotional intolerance, points to '*specific chronic emotions of sadness/loneliness, shame and fear stemming from the clients' personal histories*' (O'Brien et al., 2019, p.537). They supported treatment approaches that help therapists respond to clients' undifferentiated emotional states and bring awareness to their more specific, idiosyncratic ways of being, including individual experiences, triggers, reactions, and fears. This suggests the need for therapeutic models that address the range of problematic presentations, helping to recognise and accommodate self-diversity and individual differences within the counselling room.

Exploring the interactive dialogue between therapist and client in facilitating the EFT two-chair self-soothing task, Sutherland et al. (2014, p.739) stated, '*self-soothing work is the antidote to self-criticism*'. They aimed to integrate the painful emotions underlying self-criticism by offering them empathic understanding and support, rather than suppressing the critical voices. Highlighting the contrasting yet interconnected nature of self-soothing and self-criticism, they suggested the need for a broader framework that encompasses both the two-chair dialogue for self-soothing and conflict split tasks. The similarities between these enactments and their processes—despite their bipolar nature—reflect the challenges of objectively observing and measuring changes within the self-relationship. While clients may present in a highly self-critical state at the beginning of therapy, movement on the continuum between negative self-treatment and more self-compassionate ways of being can be observed and described through scrutiny and surveillance within sessions or across therapy.

In their review of self-narrative reconstruction, Cunha et al. (2017) emphasised the need for therapists to actively facilitate clients' integration of cognitive, behavioural, and emotional changes to better support their developing sense of agency. Linking the transformation of emotions to the reprocessing of significant experiences into meaningful narratives of change (Angus et al., 2004; Cunha et al., 2017), they suggested that supporting clients' ability to self-observe and be self-reflexive is imperative for successful psychotherapy outcomes. Citing Angus and Greenberg's (2011) assertion that this self-narrative reconstruction process occurs during the concluding phase of EFT, Cunha and colleagues (2017) highlighted the therapists' key contributions that aided resolution for clinically depressed (and therefore highly self-critical) clients. They emphasised the importance of therapists providing encouragement and validation when clients express a newfound sense of self and agency. This includes affirming clients' experiences to facilitate ongoing exploration of residual difficulties and normalising lingering challenges as part of the gradual process of change toward the end of therapy. While the present study is not necessarily concerned with dissecting the process by which clients changed within their self-relationship, nor what the therapist did to facilitate this change, it does reflect clients' changed self-narratives and more self-compassionate states at the end of therapy. Although remnants of their inner critics and harmful self-relating persisted, they appeared in a more softened and less hostile form. Highlighting how these ameliorated negative self-treatments are expressed in clients' discourse can deepen clients' self-reflexivity and aid therapists in recognising the various harmful processes at play.

Focusing specifically on the process of change in socially anxious clients undergoing emotion-focused therapy, Haberman et al. (2019) explored how the experience of primary adaptive emotions during therapy sessions influenced their SA symptoms, levels of self-criticism, and ability to self-reassure in the following week. Throughout the treatment period, their findings revealed a notable reduction in shame

and an increase in assertive anger. This is theoretically significant because social anxiety is often considered a secondary response to underlying shame, which is internalised from early traumatic experiences such as bullying or severe criticism (Elliott, 2013; Elliott & Shahar, 2017). A fundamental premise of EFT is that shame must be accessed and transformed by eliciting primary adaptive emotions, such as assertive anger, adaptive sadness or grief, and self-compassion (Haberman et al., 2019). Interestingly, despite the overall decrease in shame observed, their results indicated that experiencing shame during sessions correlated with higher levels of self-inadequacy and self-reassurance in the subsequent week. Seemingly contradictory, this finding led the authors to suggest that while in-session experiences of primary adaptive emotions such as assertive anger or adaptive sadness reduced overall shame, they did not necessarily predict subsequent levels of self-criticism. Despite the overall decrease in shame, its presence during therapy and its subsequent impact on levels of both self-inadequacy and self-reassurance underscore a nuanced relationship between shame and self-perception. This complexity suggests that shame manifests diversely across different aspects of the self, influenced by the timing and context of its occurrence. Furthermore, while experiencing shame-reducing primary adaptive emotions during sessions does not directly predict later self-criticism levels, it highlights the intricate interplay of emotions in therapy and their effects on various dimensions of self-perception and self-criticism.

Aims, Questions and Hypothesis Guiding this Study

This investigation initially explored how negative self-treatment in intrapersonal dialogues manifested across affective, cognitive, and behavioural domains. It then examined the transition of these manifestations into their ameliorated forms, focusing on both overt and subtle process indicators during the therapy's concluding phase. As in the prior study, SRQ outcome data guided case selection to monitor changes in the self-relationship across the domains of self-affiliation, self-attack, self-control, and self-

neglect. While the earlier study focused on NTS during the initial phase of therapy, cases were selected based on demonstrable improvements in SRQ self-attack levels by the end of therapy. In this study's concluding phase therapy sessions with the same participant sample, analysis focused on these later in-session dialogues concerning negative self-treatment. The primary research questions were:

a. How does negative treatment of self manifest in the concluding therapy phase for six socially anxious clients, each demonstrating high levels of SRQ self-attack at the start of therapy with subsequent significant changes at the end of therapy (either gradual decline or worsening followed by decline)?
b. Does the current rational-empirical model of negative self-treatment (as refined in the previous study) fit for participant end-of-therapy data, or does it require further elaboration and modification?
c. Do clients' SRQ self-reports align with or diverge from their in-therapy expressions of negative self-treatment?
d. Is there significant change or reduction in the presence of client NTS discourse descriptors between the beginning and ending therapy phases?

It was hypothesised that explicit and implicit process indicators of various negative self-treatments would be observed, albeit in a subdued or ameliorated form, particularly concerning self-attack, self-control or management, and self neglect. It was expected that most of these NTS process indicators would align with the current rational-empirical model, possibly necessitating a few additional refinements to further challenge or develop the framework. Additionally, it was anticipated that many descriptors identified during the initial therapy phase (marked by high self-criticism) would no longer be present in the concluding phase analysis, where SRQ measures of self-attack had significantly improved. This study aimed to convey the cyclical and synergistic nature of NTS processes during therapy's concluding phase, assuming that participants' patterns of negative self-treatment would soften or diminish over time, with many no longer perceptible, thus indicating significant change. Consistent with

the prior study, it was expected that clients' SRQ self-reports would demonstrate both consistencies and inconsistencies relative to their in-therapy expressions of negative self-treatment.

Method

Philosophical Summary of Study 3

In line with the analytical framework outlined in Chapter 1 (Philosophical Position of Studies 2 and 3), this phase of the study adopted the generic descriptive-interpretive approach to qualitative research (GDI-QR) to enhance insights into NTS discourse during the final stages of therapy for socially anxious clients. Verbatim transcripts from therapy sessions were employed to facilitate the organisation and modelling of the data. By integrating elements of dialectical constructivist philosophy and empirical validation, the research employed critical realist strategies to compare recurring patterns, ensuring both replication and triangulation. The objective was to establish consistency, coherence, and consensus within the data, thereby advancing previous investigations by analysing end-of-therapy data. Starting with the rational-empirical model of NTS established in earlier studies, the current investigation aimed to refine and empirically validate the model through additional analyses.

Ethical Considerations

As with the earlier study, the current investigation adhered to the Counselling Unit's EFT-SA research protocol, which focuses on evaluating the effectiveness of EFT as an intervention for clients experiencing social anxiety. Initially approved by the University of Strathclyde's School of Psychological Sciences and Health Ethics Committee (see Appendix A), this study proceeded with additional departmental approval from the Chief Investigator of the EFT-SA study. In this non-randomised comparative treatment study, individuals meeting the clinical threshold for social phobia were offered a 20-session protocol and given the choice between EFT and PCT.

Participants who did not meet the criteria for social phobia received support through an alternative PCT-oriented research protocol. Adhering strictly to ethical research guidelines, participants were informed of their rights and could withdraw their consent partially or fully at any time. Rigorous informed consent procedures ensured that client data was used strictly in accordance with their specified limitations. Participants provided consent for the use of data arising from their therapy sessions (see Appendices B – Client Consent Form, and C - Release of Recordings Consent Form). To safeguard participant confidentiality, all data were securely stored on a password-encrypted, multifactor-authenticated database, and potentially identifiable information was redacted during the transcription process.

Participant Information

Clients: Six participants were selected from the EFT-SA protocol's archival database based on their SRQ self-attack scores assessed at the beginning, midpoint, and conclusion of therapy. Three participants exhibited a notable, gradual decrease in self-attack scores over the course of therapy, while three initially showed an increase at mid-therapy followed by a significant decline by the end of therapy. Participants were demographically diverse (see Table 37 in the preceding chapter and Appendix N for detailed client profiles), with all showing statistically significant changes ($p < .05$) between their highest self-attack score—recorded either pre-therapy or mid-therapy—and their score at the end of therapy, as measured by Jacobson and Truax's (1991) Reliable Change Index (see Table 38 in the preceding chapter).

Therapists: The therapists involved in this study, as well as in the preceding one, were qualified and experienced person-centred practitioners, all possessing advanced professional training in EFT, with the exception of one who specialised in Gestalt psychotherapy, a discipline that includes techniques relevant to EFT. The therapists contributed a varied range of post-qualification expertise acquired across different clinical settings. The group was also demographically diverse, as detailed in the

Therapist Profiles table (see Appendix O). The study prioritised the clients' expressions of negative self-treatment rather than the dynamics of the client-therapist interaction.

Data Collection

The data for this study was drawn from the EFT-SA protocol's archive, specifically chosen based on SRQ self-attack measurements (SRQ; see Appendix E – Case Summaries) collected from clients at the outset of therapy, mid-therapy (around session 8) and end of therapy (around session 20). As discussed in the previous study, the initial focus of case selection aimed to identify participants who exhibited a pattern of worsening self-attack scores at mid-therapy followed by improvement by the end of therapy—an observed trend noted in both earlier EFT for Depression studies (Greenberg et al., 1990; Greenberg et al., 1998) and the EFT-SA study (Elliott et al., 2013), where significant changes typically occurred in the latter half of therapy. Upon reviewing the SRQ outcome data, it became evident that many participants who showed significant change in self-attack scores exhibited a steady, gradual improvement from the beginning to the end of therapy. For this group, the majority of improvement occurred during the first half of therapy. Therefore, it was deemed appropriate to investigate negative self-treatment across both patterns of change. Although the current and previous studies are not concerned with measuring the change process as such, they do examine various presentations of NTS both at the beginning of therapy (as demonstrated in the previous study), and in their ameliorated forms toward the concluding phase of therapy. Thus, the selection criteria encompassed the entirety of the therapeutic process.

The selection process for this study involved identifying a 30-minute segment from one of the final therapy sessions (17, 18, 19, or 20), during which participants exhibited negative self-treatment, as reflected in their SRQ scores. Sessions were chosen based on EFT task markers, focusing particularly on conflict splits and self-soothing behaviours that precede the two-chair dialogue task, which supports self-to-self processes. Although self-soothing markers were more prevalent in the later stages

of therapy, the final-phase sessions were thoroughly reviewed, with detailed process notes taken to identify episodes of negative self-talk, albeit in its ameliorated form. The segment selected for analysis exhibited the highest frequency of NTS, capturing the most prominent instances of problematic self-talk. In cases where multiple segments met the criteria, the most salient episode was prioritised based on intensity and duration, with final decisions made through consensus with a second team member and the research supervisor. The selected episodes were timed from the onset of the task marker to the end of the two-chair dialogue, typically within 30 minutes, ensuring consistency across participants, before being extracted for transcription and analysis.

Data Preparation, Analysis and Validation

Transcript Preparation: Repeated attentive listening was conducted to develop contextual and idiomatic insights, facilitating data familiarisation and immersion. Verbatim transcripts of the selected 30-minute segment for each participant were prepared, focusing on content rather than interactional details, and ensuring the redaction of any potentially identifying information. Transcripts varied in length depending on the participants' modes of utterance and were first segmented into client speaking turns, then into meaning units. According to Barker et al. (2016), meaning units are a method for attempting to identify the ideas being conveyed.

Data Analysis: In line with the earlier investigation, this study employed the GDI-QR (Elliott & Timulak, 2005; 2021) descriptive and interpretative analytic modes to translate, categorise, and compare clients' expressions of negative self-treatment. Setting aside preconceived notions of NTS, the '*commitment to careful, systematic analysis of all relevant reports/observations'* (Elliott & Timulak, 2021, p.3) facilitated the emergence of potential new categories and themes. Both explicit and clearly implied utterances of negative self-treatment, along with client endorsements of therapist observations, were extracted to elucidate the meanings and assumptions understood in the context (Barker et al., 2016).

A psychologically empathic and reflective approach of '*entering and dwelling*'

(Wertz, 1985; cited in Barker et al., 2016) was used to explore the similarities and differences of the types, foci, and modes of negative self-treatment. The initial descriptive analysis involved breaking down complex communications into their underlying components to develop categories and themes. The subsequent interpretative analysis compared new findings with the previously revised rational-empirical model of NTS (see Appendix M: Supplemental Tables, Table 6: Revised Rational-Empirical Model of Negative Treatment of Self: Categories and Frequencies). Rather than creating a new hierarchical structure of domains, subdomains, categories, and subcategories, the *constant comparative method* (Glaser & Strauss, 1967) was used to empirically challenge the earlier model. Being mindful of researcher interpretation and bias, this inductive method involving the meticulous observation and comparison of various patterns and presentations (Rice & Greenberg, 1984) allowed for the organic modification, elaboration, refinement, and saturation of the model. Partly informed by the SRQ and consistent with previous findings, the variables identified in the data analysis were located within the negative half of the introject surface of the Structural Analysis of Social Behaviour (SASB) interpersonal circumplex (Benjamin, 1996), encompassing self-control, self-attack, self-neglect, and self-emancipation.

Data Validation: Expressions of negative treatment of self, while sometimes explicit, often required inference due to their subtlety. The analytical approach classified the data using a 4-point presence rating scale: 3 - Clearly Present; 2 - Probably Present; 1 - Probably Absent; 0 - Clearly Absent. 'Probably' and 'clearly absent' examples were excluded from the analysis. Additionally, the Elliott and Timulak (2021) frequency scheme was employed to categorise themes as general, typical, or unique.

Initially audited by a research team during a tutorial group project, individual analyses for each participant were later combined into a coherent cross-case analysis (see Appendix Q), organising and structuring the findings across all participants (McLeod, 2011). Following the principles of best practices in qualitative research (Barker et al., 2016), the researcher conducted a self-audit of the combined structure

before it was reviewed by the research supervisor.

Results

Rational Empirical Model of Negative Treatment of Self as it Presents at the Ending Phase of Therapy

Building on the earlier rational-empirical model of negative self-treatment observed at the beginning phase of therapy (see Appendix M: Supplemental Tables, Table 6), the current empirical model for the ending phase of therapy (see Appendix M: Supplemental Tables, Table 7) emerged consistent with the existing hierarchical structure. This structure comprises four superordinate domains: (a) Objects of NTS (Being, Doing & Having), (b) Directness of NTS (Direct vs Indirect), (c) Modes of NTS Behaviour (Self-Attack, Hostile Control, Hostile Neglect, & Hostile Freedom), and (d) the Emotional Effects of NTS (Preceding & Reactional).

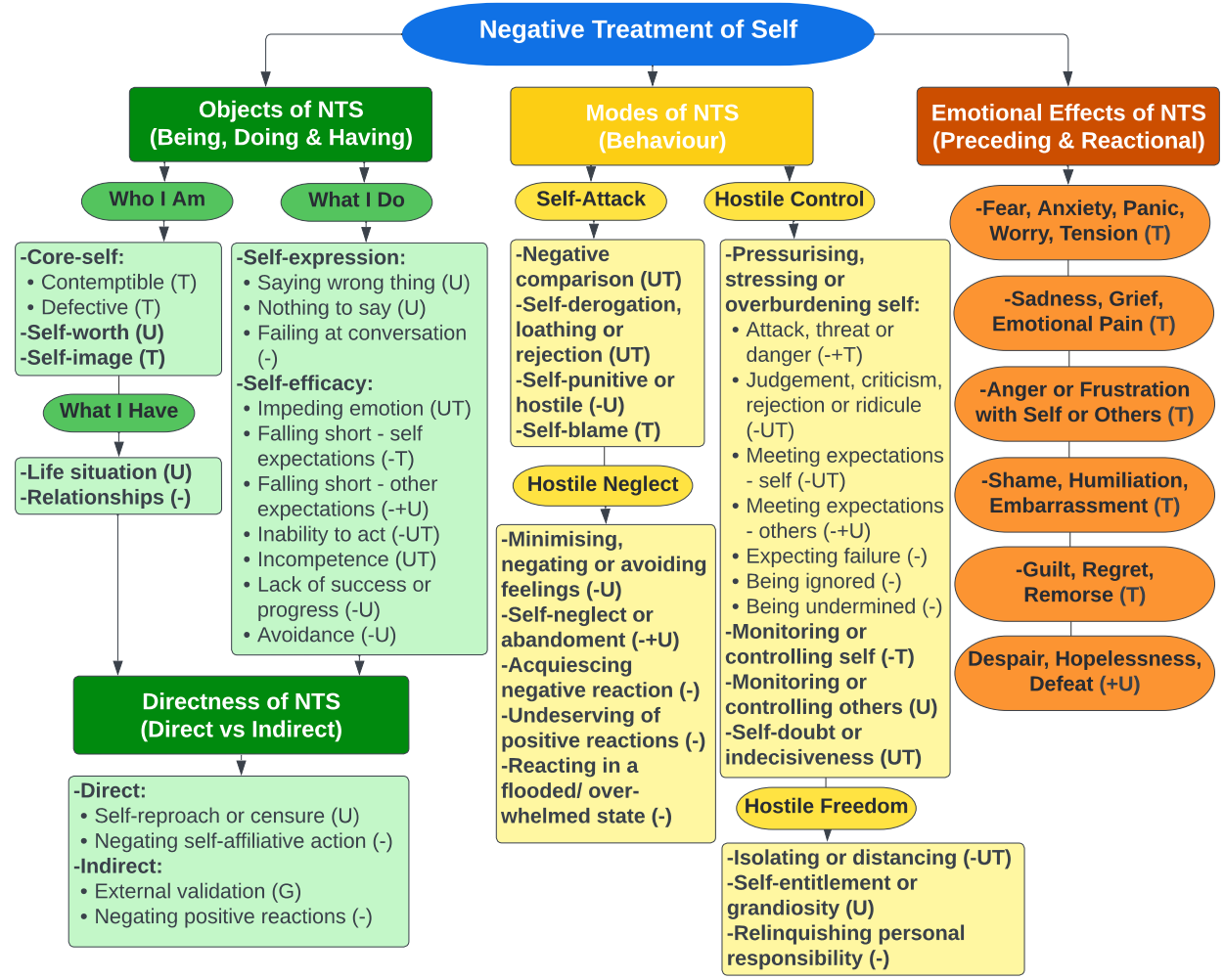
Although the emerging structure identified during the analysis in the final phase of therapy largely aligned with the previously established rational-empirical model, a few new categories and sub-categories emerged (n=5), and some existing ones required minor elaborations (n=9). This suggests a degree of saturation within the model (see Table 39). Additionally, numerous subdomains, categories, and subcategories present at the beginning phase of therapy—when participants' SRQ self-attack levels were high—were ameliorated and thus absent during the ending phase of therapy, as reflected in participants' end-of-therapy SRQ self-reports (n=38; see Table 40). Providing a scattering of more finely tuned analytical descriptors while rigorously challenging the existing rational-empirical model, the combined results yielded a thoroughly elaborated and refined empirical structure that integrates both the beginning and ending phases of therapy (see Appendix M: Supplemental Tables, Table 7, and Figure 16 for a diagrammatic summary).

The themes identified in the present empirical model at the ending phase of therapy (n=70) encompassed most findings from the previous study. This analysis

focuses on newly emerging or elaborated concepts, presented in order of frequency within each domain/category, along with participant quotes exemplifying general, typical, and unique occurrences. General themes applied to all six participants, typical themes to two to five participants, and unique themes to only one participant. Further endorsing the efficacy of EFT-SA in resolving NTS, it is notable that among all the present themes, most were unique (n=36), with the remainder being typical (n=33), and only one general category (n=1) was found in this ending phase analysis.

Therefore, in addition to the numerous NTS themes that were absent towards the conclusion of therapy, indicating improvements in the self-relationship, the persistent themes predominantly pertained to just one participant, accounting for over half of the remaining themes. Providing robust evidence for the effectiveness of emotion-focused therapy in treating social anxiety and improving the quality of the self-relationship, the rational-empirical model themes of NTS that were absent at the ending phase of therapy (n=38) are presented alongside corresponding excerpts. These excerpts reflect the apparent improvements in the participants' self-relationship, as indicated by their SRQ self-reports. Case examples are followed by their unique identifier code (e.g., C3:S18: MU13) indicating client number, session number, and meaning unit. Finally, the strength of the relationship between participants' beginning and end-of-therapy variables and the significance of changes in the presence or absence of their NTS themes are presented using the Phi coefficient and McNemar's test of significance. The McNemar's test examines the significance of the changes found between the two time points, assessing both the connection and differences between participant variables at the beginning and ending phases.

Figure 16: Empirical Model of Negative Treatment of Self Incorporating the Ending Phase of Therapy



Note: + denotes a new category, - signifies an absent category, U indicates a unique category, T represents a typical category, and G denotes a general category.

Table 39: Emergent or Elaborated Empirical Model Themes of Negative Treatment of Self at the Ending Phase of Therapy

Domains, Subdomains, Categories & Subcategories		Frequency
A.	**Objects of Negative Treatment of Self - Being, Doing & Having (What I Dislike About Myself)**	
A.2.	***What I do (Doing)***	
A.2.2.3.	Falling Short of the Perceived Expectations of Others:	
A.2.2.3.4.	They Are Bored With Me or Disinterested	*Unique*
A.2.2.5.	Incompetence/Non-Proficiency in Attempted Action:	
A.2.2.5.1.	I'm Hopeless, Inadequate, Useless, Incompetent or Talentless	*Unique*
A.2.2.5.2.	I'm Not Logical or Clever (Stupidity, Confusion, Lack of Understanding, I Don't Know How)	*Typical*
A.2.2.5.4.	I Get Stuck, I Can't Win, No Matter What I Do or How Much I Try	*Typical*
C.	**Modes of Negative Treatment of Self - Behaviour (What I Do That Is Bad For Me)**	
C.1.	***Self-Attack***	
C.1.1.	Negative Comparison of Self to Others:	
C.1.1.2.	Other People Are Nicer, More Normal, More Tolerant or More Open Than Me	*Unique*
C.1.1.3.	Other People Are Better or Know Better Than Me	*Typical*
C.2.	***Hostile Control***	
C.2.1.	Pressurising, Stressing or Overburdening Self:	
C.2.1.1.	Expecting Attack, Threat, Danger or Repercussion:	
C.2.1.1.4.	There Will Be Consequences	*Typical*
C.2.1.3.	Meeting One's Own High Expectations:	
C.2.1.3.2.	I Should Do or Be Better	*Typical*
C.2.1.4.	Meeting the Perceived Expectations of Others:	
C.2.1.4.4.	I Try To Be Nice To Be Accepted	*Unique*
C.3.	***Hostile Neglect***	
C.3.1.	Minimising, Negating or Avoiding One's Feelings:	
C.3.1.1.	I Don't Know What I'm Feeling or Why	*Unique*
C.3.1.3.	It's Difficult to Arrive At or Express The Feeling	*Unique*
C.3.2.	Self-Neglect or Abandonment/ Not Attending to Important Things:	
C.3.2.5.	I Don't Know What I Want or Need	*Unique*
C.4.	***Hostile Freedom or Separation from Others***	
C.4.1.	Isolating or Distancing Self from Others:	
C.4.1.4.	I Feel Uncomfortable In Relationships or Around Others, I Isolate or Distance To Protect Myself	*Typical*
D.	**Emotional Effects of the Negative Treatment of Self (What I Feel Preceding or in Reaction to my Self-Dislike & Inimical Self-Actions)**	
D.6.	***Despair, Hopelessness or Defeat***	*Unique*

Note: Themes include both client self-report (acknowledging) and observational (expressing) data. *General* means that this phenomenon applied to all six participants; *Typical* means that this phenomenon applied to two to five of the participants; *Unique* means that this phenomenon applied to only one participant. Red indicates the elaborations to the preliminary rational model (depicted in Black) following the beginning phase analysis, and Blue indicates the elaborations following the ending phase analysis.

Objects of NTS – Being, Doing & Having (What I Dislike About Myself)

What I Do (Doing)

Consistent with the earlier study and describing *what I dislike about myself*, the objects of NTS again fell within the three broad subdomains of being, doing, and having. To further clarify this phenomenon, three elaborations were necessary within the *what I do* subdomain, particularly in the area of *self-efficacy, performance, action or inaction*, with one new sub-category emerging. In line with the rational-empirical model from the beginning phase of therapy, the current investigation at the ending phase further refined the model to include additional subcategories related to *falling short of perceived expectations of others* and *incompetence/non-proficiency in attempted action*.

While the notion of *falling short of the perceived expectation of others* previously encompassed assumptions that others are ashamed of, annoyed by, or disappointed with the individual, the current analysis identified an additional, distinct assumption: that others are disinterested or bored. This reflects a belief that one lacks appeal, having little personality and being too dull to attract or hold others' interest. This was expressed through the projection that others find the individual tiresome and unappealing, which is reinforced by a lack of friendships and reflects the common experience of isolation in social anxiety processes:

They Are Bored With Me or Disinterested:

> **Therapist**: It sounds like you had quite a hard time over the last month or so
>
> **Client**: Yes, very hard time actually (T: Mhm), for me it's, it's like social anxiety but for other people I am just boring- boring that's what happens when like you know- if I go some place new it's a lot for me and I just clamp up (C2:S19: MU3).
>
> **Client**: I didn't have any friends or that but (T: Mhm), or they would find me boring, you know, so boring and not much personality or whatever (C2:S19: MU9).

Client: I don't feel safe when I go out and that really (T: Aha), but then it seems to be, I seem to, when I go out, just I don't know what it is but anyway, I am not appealing to people anyway (C2:S19: MU10).

Incompetence/non-proficiency in attempted action previously outlined typical objects of self-dislike, suggesting that the actions taken were perceived as inadequate. Driven by unrealistic expectations of perfection and underpinned by a fear of inadequacy and a deep-seated belief of not measuring up, the current analysis elaborated on three rational-empirical subcategories: *I'm hopeless, inadequate, useless, or incompetent*; *I'm not logical or clever (stupidity, confusion, or lack of understanding)*; and *I can't win, no matter what I do or how much I try*.

The first self-critical theme *I'm hopeless, inadequate, useless, or incompetent* suggests a deep sense of being unable to adequately perform even basic or skilled tasks. This was further expanded to include a unique conviction of one's lack of talent, leading to a life perceived as doomed to disappointment:

I'm Hopeless, Inadequate, Useless, Incompetent or Talentless:

Therapist: Mhm, so I've no talent, talentless, so it's disappointment

Client: Mmm, fear as well

Therapist: Fear, what's the fear

Client: That I'm doomed to a life of poverty and obscurity

Therapist: Mmm, poverty and obscurity, so this sense of doom about that

Client: Mhm

Therapist: Mmm, so that's a huge shift, yeah, I'm just trying to, so the feeling is doom and the thought is, I can't do this, I've no talent

Client: Mhm (C1:S17: MU10).

The second self-critical theme *I'm not logical or clever (stupidity, confusion, or lack of understanding)*, indicates a belief in one's deficiency in logical reasoning and intelligence, as well as impaired clarity of thought and difficulty comprehending

information or ideas. This was expanded to include the typical assertion of *I don't know how*:

I'm Not Logical or Clever (Stupidity, Confusion, Lack of Understanding, I Don't Know How):

> **Client**: I'm doing this writing course that I enrolled on about 2 years ago and I haven't completed the 1st assignment which is to write a short story as a kind of preparation ground for writing novels later on
>
> **Therapist**: Uhuh
>
> **Client**: And I get stuck with the short story, I don't know where to go with it, I don't know how to end it (T: Okay), I don't know how to create the characters
>
> **Therapist**: Okay
>
> **Client**: And I get, I get frustrated and despairing and think I just haven't got this, oh hell this is terrible (C1:S17: MU8).

The third self-critical theme *I can't win, no matter what I do or how much I try*, reflects a pervasive belief that despite earnest efforts, success remains elusive and things never align as planned. This sentiment encompasses a profound sense of futility and expectation of failure, regardless of the amount of exerted effort. This theme was further developed to include the typical assertion of becoming stuck, where progress seems halted and solutions appear out of reach, reinforcing the overarching feeling of being perpetually thwarted despite striving diligently:

I Get Stuck, I Can't Win, No Matter What I Do or How Much I Try:

> **Therapist**: You like keeping me unhappy and stuck
>
> **Client**: Yeah, you like to keep me sort of stuck, you are very strong, you keep me unhappy, you keep me stuck (C2:S19: MU46).
>
> **Therapist**: It's like, it feels like you're just completely with this it's- you just get to a completely stuck place
>
> **Client**: Mhm
>
> **Therapist**: Mmm, it's like a loop you go round again and again

Client: Mhm

Therapist: Is it, is that what happens

Client: Yep

Therapist: And the same outcome every time

Client: Yes (C1:S17: MU13).

Modes of NTS – Behaviour (What I Do That Is Bad For Me)

Self-Attack

In line with the earlier study, the self-attack domain once again identified four main categories: *negative comparison of self to others*; *self-derogation, loathing, or rejection*; *self-punitive or hostile*; and *self-reproach, blame, or judgement.* Expanding on the category of negative comparison of self to others, two further elaborations were required within the subcategories: *other people are nicer, more normal, or more open than me* and *other people know better than me*.

While the notion that *other people are nicer, more normal or more open than me* outlined a set of assumptions about unfavorably comparing oneself to others, alongside feelings of inferiority, and the perception that others are generally kinder, more conventional, and easier to approach, the current analysis additionally identified a unique assumption that other people are also more tolerant. This suggests a perception that others possess a greater capacity for understanding, acceptance, and patience towards both themselves and others, further deepening the sense of inadequacy or perceived deficiency in comparison:

Other People Are Nicer, More Normal, <u>More Tolerant</u> or More Open Than Me:

Client: What I find really invasive (T: Mhm), the sounds that people- that everybody else around me doesn't seem to, they don't even seem to be like hearing it. Whereas my reaction is sometimes you know (T: Uhuh), I virtually want to put my hands over my ears and I suppose people like react on different levels- I have different levels of tolerance (C6:S17: MU1).

Elaborating the subcategory *Other People Know Better Than Me*, this form of self-deprecation involves the belief that others possess superior knowledge and capabilities compared to oneself. This was expanded to include the typical conviction that not only do others know more and are more skilled, but they *are* inherently better. This encompasses a broader perception of others as more competent, knowledgeable, and perhaps even morally superior, intensifying feelings of inadequacy and the inclination to defer to others' judgments and abilities:

Other People Are Better or Know Better Than Me:

> **Therapist**: You said changes are really difficult for you
>
> **Client**: Yes they are
>
> **Therapist**: When they come up and (C: Yes), you don't feel relaxed at all
>
> **Client**: Aha (T: Mhm) it has taken me a long time to get to realise this kind of- right but then I'm also, I'm busy trying to be nice as well in these situations and do the right thing, and be nice and stuff like that, and thinking that people are maybe better than me (C2:S19: MU7).

Hostile Control

Previously distinguishing multiple forms of *pressurising, stressing, or overburdening self*, three of the existing hostile control subcategories were elaborated upon to provide deeper insights into this phenomenon. This resulted in broader descriptors and the identification of two additional lower-level subcategories.

Expecting attack, threat, danger, or repercussion encompasses the pervasive experience of feeling vulnerable and unsafe, often accompanied by fears of the unknown and physical harm. Within this framework, a typical lower-level subcategory emerged: the deep-seated conviction that one will inevitably face severe consequences as a result of these perceived threats. This belief intensifies feelings of apprehension and reinforces a sense of being at risk, whether emotionally, physically, or socially:

There Will Be Consequences:

> **Therapist**: Anxiety about finances okay, is that the gut feeling
>
> **Client**: Mhm
>
> **Therapist**: Just check and just wait (pause), so anxiety, the anxiety there, is there an image or a quality about that
>
> **Client**: Just images of letters arriving at the door saying this bill is overdue, if you don't pay it we'll take legal action and all this stuff
>
> **Therapist**: So an image of being hounded by letters
>
> **Client**: Mhm
>
> **Therapist**: Threatening legal action (C1:S17: MU23).

Meeting one's own high expectations previously encompassed a set of subcategories where individuals pressured themselves to demonstrate exceptional competence and achieve perfection without making mistakes. Concurrently grappling with feelings of inadequacy, participants experienced a self-imposed pressure to excel in tasks, which was broadened to include the belief that one should also strive to *be* a better person. This pursuit of personal improvement intensified the burden of meeting exceedingly high standards, both in achievements and in developing one's character:

I Should Do or Be Better:

> **Client**: I think that is why I keep thinking no I should, I don't know if I keep thinking I should be better than I am or I don't know, keep trying to say to people no I'm ok, I'm feeling a lot better, but maybe I'm not
>
> **Client**: Yeah, I don't know, I just kind of keep, I don't know, it's like the doctor when she said maybe I'm not ready to get back to work anyway and that was kinda like, but I thought I was, I just- I don't know
>
> **Therapist**: That's yeah, that was quite hard news (C: Yeah) that kind of felt like oh maybe I'm not doing as well as I thought
>
> **Client**: Yeah (C4:S17: MU48).

Meeting the perceived expectation of others previously reflected a set of subcategories concerning a type of self-imposed pressure, where individuals believed that others expected specific actions or behaviours from them. The ending phase analysis further distinguished a new and distinctive lower-level subcategory: individuals ingratiating themselves with others in an attempt to secure acceptance and approval. This reflects a deeper level of social adaptation and highlights the lengths some go to meet external expectations, demonstrating a complex interplay between the self-relationship and social conformity:

I Try To Be Nice To Be Accepted:

> **Therapist**: Put yourself under pressure to be nice
>
> **Client**: Yeah, and I am putting myself under pressure, right
>
> **Therapist**: Trying to be as good as them, although actually now you are realising that you don't need that
>
> **Client**: No, I don't need it, maybe I don't, I don't know (C2:S19: MU8).

Hostile Neglect

Previously distinguishing five different types of hostile neglect, two existing descriptors within the category of *minimising, negating, or avoiding one's own feelings* required expansion, while a new lower-level subcategory emerged under *self-neglect or abandonment/not attending to important things*.

Containing multiple subcategories portraying a variety of ways in which participants sought to circumvent emotional distress through avoiding, downplaying, invalidating, or blocking their feelings, the *minimising, negating, or avoiding one's own feelings* category required elaboration of the *I don't know what I'm feeling* subcategory to include the aspect of not understanding *why* certain emotions arise. Additionally, *it's difficult to arrive at the feeling* was expanded to encompass not only the challenge of identifying emotions but also the difficulty in *expressing* them once identified:

I Don't Know What I'm Feeling or Why:

Therapist: Ok, so you're noticing when you're feeling angry when you say that, and you notice that you really want to do that, and then you start feeling angry at yourself

Client: Yeah, well I don't know if I'm just imagining things or, I don't know I just- I don't know why I feel like that, there's nothing wrong but just- I don't know, I shouldn't be thinking like that I guess- I don't know (C4:S17: MU2).

It's Difficult to Arrive At or Express The Feeling:

Therapist: I can kind of hear you saying you're kind of feeling a bit lonely, it seems like it's something that's hard for you to say (C: Yeah), actually I'm a bit on my own (C: Yeah) so would you be able to say that to her, I'm a bit on my own

Client: I do feel a bit out of things like I don't know, I sometimes feel like an inconvenience I guess, yeah (C4:S17: MU82).

Within the *self-neglect or abandonment/not attending to important things* category, various manifestations were previously observed, including overlooking one's own needs in favour of prioritising others, withdrawing from active engagement in life, neglecting basic necessities, and lacking clear direction, motivation, or goals. A unique lower-level subcategory emerged, indicating a fundamental challenge in discerning one's desires or necessities: simply not knowing what one wants or needs. This subcategory underscores a profound disconnection from personal aspirations or essential requirements, contributing to a broader understanding of self-neglect and its complexities:

I Don't Know What I Want or Need:

Therapist: How

Client: I don't know (helplessly)

Therapist: Yeah, how would you like to

Client: Umm

Therapist: I don't know either, but let's see what would you like to do

Client: Umm, I just need to calm down about things

Therapist: That's what you know you need

Client: Yeah

Therapist: What happens when I ask you, what would you like- what happens in you

Client: I don't know, it's like fog you know (C6:S17: MU11).

Hostile Freedom or Separation From Others

Previously, three hostile freedom categories were distinguished: *isolating or distancing self from others*; *relinquishing personal responsibility* (or agency); and *self-entitlement or grandiosity*. The first category needed elaboration, particularly within its lower-level subcategory *I feel uncomfortable around others, I isolate or distance to protect myself*, to include the typical experience of discomfort in relationships and around people in general. This behaviour reflects a deep-seated mistrust not only of individuals but also of relationships as a whole. It is characterised by maintaining interpersonal distance, often stemming from apprehension or fear of having to relate, interact, or engage in conversation. This mistrust leads to a pattern of self-isolation and avoidance, driven by anxiety about vulnerability and potential emotional harm. As a result, individuals may struggle to form meaningful connections, perpetuating a cycle of loneliness and detachment:

I Feel Uncomfortable In Relationships or Around Others, I Isolate or Distance To Protect Myself:

Client: I haven't been out for years and years with anybody (T: Uhuh), when I did go out with people it has just not worked out

Therapist: So when you did it's not worked out and that's made you feel

Client: Yeah, very isolated, and also I think (T: Maybe angry) (C2:S19: MU24).

Therapist: So the fighter said I want to stay on my own and be safe

Client: Yeah, and be miserable

Therapist: And be miserable

Client: Aye (C2:S19: MU42).

Emotional Effects of the NTS (What I Feel Preceding or in Reaction to My Self-Dislike & Inimical Self-Actions

Providing a synergistic link to self-dislike and inimical self-actions, five categories describing the array of difficult emotional processes previously emerged in the domain of the *emotional effects of negative treatment of self*: *fear, anxiety, panic, worry, or tension; sadness, grief, or emotional pain; anger or frustration with self or others; shame, humiliation, or embarrassment;* and *guilt, regret, or remorse.* Following the analysis of the ending phase of therapy, a sixth unique category emerged, distinguishing *despair, hopelessness, or* defeat. This new category was communicated through statements such as *there's no hope here*, *I feel really defeated*, *and despairing*:

Despair, Hopelessness or Defeat:

Therapist: What were you feeling when you thought that

Client: That I've got no chance

Therapist: So hopelessness

Client: Mhm

Therapist: You're thinking that I can't- this, it's not gonna work

Client: Mhm

Therapist: There's no hope here

Client: Mhm

Therapist: This is not gonna happen

Client: No (C1:S17: MU1).

Therapist: So could you ask your felt sense what it could do to make this okay

Client: Reality okay

Therapist: Yes

Client: (Long pause) Very, very difficult

Therapist: Tune into your gut feeling and just wait, don't rush in with an idea or a thought, how does it feel down there

Client: I want to sort of just sink my shoulders and let my head hang and really, feel really defeated

Therapist: Mmm, just feeling a sense of slumping and hanging your head and being defeated

Client: Mhm (C1:S17: MU29).

Rational-Empirical Model Themes of NTS Absent at the Ending Phase of Therapy

Enhancing the overall quality of the self-relationship, this study provides evidence supporting the efficacy of emotion-focused therapy in treating social anxiety and facilitating improvements in self-to-self relating. Many of the themes from the rational-empirical model of negative self-treatment, which were absent during the therapy's final phase (n=38; see Table 40), are examined to glean insight into the apparent softening of NTS and enhancements in self-relating. Although not the main focus of the analysis, the following example excerpts demonstrate self-affiliating improvements in participants' self-relationships as reflected in their SRQ self-reports. Statements indicating improvements are highlighted in red, providing evidence of the absence of many NTS constructs as outlined in Table 40. Many of the missing subcategories have been illustrated through a descriptive and interpretative narrative of participant self-affiliative statements, with their unique identifier codes indicated in brackets (e.g., C.3.2.4.).

Table 40: Rational-Empirical Model Themes of Negative Treatment of Self Absent at the Ending Phase of Therapy

Domains, Subdomains, Categories & Subcategories		Frequency
A.	**Objects of Negative Treatment of Self - Being, Doing & Having (What I Dislike About Myself)**	
A.2.	***What I do (Doing)***	
A.2.1.	Self-Expression:	
A.2.1.3.	Failing at Conversation, Making it Awkward or Difficult	*N/a*
A.2.2.	Self-Efficacy, Performance, Action or Inaction:	
A.2.2.2.	Falling Short of One's Own Expectations of Self:	
A.2.2.2.2.	Lack of Focus or Direction	*N/a*
A.2.2.2.3.	Lack of Energy or Motivation	*N/a*
A.2.2.3.	Falling Short of the Perceived Expectations of Others:	
A.2.2.3.1.	They Are Ashamed Of Me	*N/a*
A.2.2.3.2.	They Are Annoyed By Me	*N/a*
A.2.2.3.3.	They Are Disappointed With Me	*N/a*
A.2.2.4.	Inability or Incapacity to Act/ Receive Criticism/ Defend Self:	
A.2.2.4.3.	I Can't Take Criticism	*N/a*
A.2.2.6.	Lack of Success or Progress/ Failure:	
A.2.2.6.2.	I Don't Find Solutions	*N/a*

A.2.2.7.	Avoidance Strategies:	
A.2.2.7.2.	Avoidance Through Submission and Passivity	*N/a*
A.2.2.7.3.	Avoidance Through Blocking Uncomfortable Feelings	*N/a*
A.3.	***What I have (Having)***	
A.3.2.	My Relationships	*N/a*
B.	**Directness of Negative Treatment of Self – Direct vs Indirect (How I Dislike Myself)**	
B.1.	***Direct Self-Critical Process via Self***	
B.1.2.	Minimising or Negating Self-Affiliative Action	*N/a*
B.2.	***Indirect Self-Critical Process via Others***	
B.2.2.	Minimising or Negating Positive Reaction or Observation from Others	*N/a*
C.	**Modes of Negative Treatment of Self - Behaviour (What I Do That Is Bad For Me)**	
C.1.	***Self-Attack***	
C.1.3.	Self-Punitive or Hostile:	
C.1.3.2.	I Attack or Punish Myself	*N/a*
C.1.3.3.	I Injure Myself	*N/a*
C.2.	***Hostile Control***	
C.2.1.	Pressurising, Stressing or Overburdening Self:	
C.2.1.1.3.	Anything Could Happen or Go Wrong	*N/a*
C.2.1.2.	Expecting Judgement, Criticism, Rejection or Ridicule:	
C.2.1.2.5.	People See Me As An Easy Target	*N/a*
C.2.1.3.	Meeting One's Own High Expectations:	
C.2.1.3.3.	I Shouldn't Make Mistakes	*N/a*
C.2.1.4.	Meeting the Perceived Expectations of Others:	
C.2.1.4.2.	I'm Expected To Be Capable	*N/a*
C.2.1.5.	Expecting Failure, Getting Things Wrong or Worst Case Scenario	*N/a*
C.2.1.6.	Expecting to be Ignored, Neglected or Overlooked	*N/a*
C.2.1.7.	Expecting to be Undermined or Taken Advantage Of	*N/a*
C.2.2.	Monitoring or Controlling Self – Restraining, Complying or Intruding:	
C.2.2.2.	Being Agreeable, Pushing Self To Comply or Intrude	*N/a*
C.2.2.4.	Guarding or Hiding Parts of Self	*N/a*
C.2.2.5.	Avoiding Social Interactions With Others	*N/a*
C.3.	***Hostile Neglect***	
C.3.1.	Minimising, Negating or Avoiding One's Feelings:	
C.3.1.2.	I Don't Want Others To Know What I'm Feeling	*N/a*
C.3.1.5.	I Don't Know What To Do With The Feeling	*N/a*
C.3.2.	Self-Neglect or Abandonment/ Not Attending to Important Things:	
C.3.2.2.	I Have No Direction or Motivation	*N/a*
C.3.2.4.	I Don't Attend to My Basic Needs	*N/a*
C.3.3.	Acquiescing or Affirming Negative Reactions From Others:	
C.3.3.1.	Taking On Board Negative or Hostile Reactions From Others	*N/a*
C.3.3.2.	Submitting To or Appeasing Hostile Demands or Reactions of Others	*N/a*
C.3.3.3.	Assuaging or Mitigating Negative or Hostile Reactions From Others	*N/a*
C.3.4.	Undeserving of Positive Reactions from Others	*N/a*
C.3.5.	Reacting in a Flooded or Overwhelmed Emotional State:	
C.3.5.1.	Quick To Anger	*N/a*
C.3.5.2.	Emotionally Triggered	*N/a*
C.3.5.3.	Compounding Emotion	*N/a*
C.4.	***Hostile Freedom or Separation from Others***	
C.4.1.	Isolating or Distancing Self from Others:	
C.4.1.5.	I Feel Uncomfortable Going Into Public Places On My Own	*N/a*
C.4.3.	Relinquishing Personal Responsibility or Agency	*N/a*

The absent rational-empirical model themes of NTS in the *objects of self-criticism* in relation to *what I do* domain reflects numerous missing subcategories, suggesting a shift towards a more positive and less critical relationship with self. Specifically, the lack of the *falling short of the perceived expectations of others* category, particularly in relation to believing that others are *ashamed* (A.2.2.3.1.), *annoyed* (A.2.2.3.2.), or *disappointed with me* (A.2.2.3.3.), is evident. This shift is implied in the self-affiliating statements from Participant 2, as follows:

C2:S19: MU9:

Therapist: Now you've seen that they are not- that you are just as good as other people

Client: Well hopefully (laughs), yes hopefully

C2:S19: MU17:

Therapist: That's been a kind of a shift because it feels like from your childhood and from the past you'd always assume that it's you that's not nice

Client: Of course

Therapist: But now you're kind of recognising that it is sometimes other people, it's other people that can be not nice

Client: Well aye, yes

C2:S19: MU20:

Therapist: That sounds like it brings you this kind of I am not good enough or

Client: Well nah, I don't now really have that as much now anymore

Therapist: Okay

Client: Quite honestly I don't

In addition to indicating greater levels of self-acceptance and feeling adequate in the eyes of others, Participant 2 expressed taking the first step in accepting a social invitation. This suggests a softening in the previously absent *avoiding social interactions with others* (C.2.2.5.) subcategory of the *monitoring or controlling self* behavioural mode of NTS:

C2:S19: MU28:

Client: Those people were going out, and I was invited out, I would always say no because that was safe (T: Mhm), I was safe (T: Yeah), but this year I said yes- it's a first for me (T: Mmm) but it was not quite what (laughs)

Therapist: But you've learnt something from that experience, it sounds like it was not (C: Aye), it's not led to

Client: I don't think I'm any worse than any other people that were there- the way they treat each other you know

Following a pattern of worsening to decline in their reported SRQ self-attack scores (Pre: 0.57, Mid: 1.14, End: 0.14), Participant 5 demonstrated significant improvement from mid to end of therapy, transitioning from a disparaging and self-critical relationship with themselves towards greater levels of self-affiliation and acceptance. The 7-minute excerpt (from 48:10 to 55:19) below illustrates the client's improved self-relationship, revealing the implications of several missing subcategories. Self-affiliative statements are highlighted in red, and I have once again sought to document many of these missing subcategories through a descriptive and interpretative narrative, with the implied absent unique identifier codes indicated:

C5:S17: MU50-58:

Therapist: Because that's where it starts, that's where your sense of the self that you hide, you know you wanna hide, and you see other people as dangerous and harmful and judging yourself as defective and all those things (C: Mmm) that's all grounded back in that

Client: Back, as far back as

Therapist: As you can remember

Client: As I can remember, do you know what I mean (T: Right, yeah) as far back as I can remember (T: So) that thing- I think this is what I'm realising from doing that focusing different times, and feeling what I've felt- it is really as if (lightly hits hand off thigh) there's- there's somebody of- there's like the

real me underneath here (T: Mhm) you know and it's a kinda okay person sorta thing

Therapist: It's an okay person (C: Uhuh) it's at least okay right, yeah

Client: Yeah, uhuh

Therapist: Maybe you're not eh it's brilliant, wonderful but

Client: No, but don't even need to get to brilliant and wonderful (T: Uhuh) just kinda get down to this

Therapist: This relief to feel okay- I see you're a bit teary

Client: Yeah, yeah

Therapist: Because it's such a powerful (C: Aye) experience

Client: It is

Therapist: To feel okay (C: Uhuh)

The client's recognition of this deeper aspect of self, where they see themselves as an 'okay person', suggests not only a softening of the tendency to guard or hide parts of the self (C.2.2.4.) in the *monitoring or controlling self* category, but also implies success or progress towards finding a solution (A.2.2.6.2.) to their difficulties. Furthermore, the improvement in the client's self-relationship potentially indicates the absence of the belief that they are *falling short of the perceived expectations of others*, specifically the notions that others are ashamed of them (A.2.2.3.1), annoyed by them (A.2.2.3.2), or disappointed in them (A.2.2.3.3).

C5:S17: MU50-58:

Client: Just to feel (T: Yeah) and not, not (T: Uhuh) feel- and realise that I'm not who I kinda learned I was (T: Yes, yes) if you know what I mean (T: Yes) I'm not who I learned I was (T: Yes) I'm really

Therapist: Someone else, I'm still discovering who it is (C: Uhuh) in here (C: Aye)

Client: There's somebody in there (T: Yeah) and that person is coming f- not fighting to get out (T: Yeah) but just sorta coming- it's as if this other person's got (rubs hands together) see that fan there and it's- you can see

through it (T: Mhm) well this other person is not closed any more, it's open work (T: Yeah, yeah)

Therapist: It's accessible (C: Uhuh) yeah

Client: Underneath the me, that me is kinda shining

Therapist: Through

Client: Through, just bits but letting (T: Mhm) me know that

Therapist: I'm here too, I'm here (C: Mhm)

Client: She's there kinda thing and that's

Therapist: It's not blocked and its not trapped and that's not a- it's not a blank wall or

Client: No it's not

Therapist: Buried

Client: Uhuh, or getting smothered (T: Yeah) or- so that's erm, feels kinda (T: Mhm) nice, so this has been- so this is the relationship that I need to

Therapist: This relationship with yourself

Client: Uhuh, that I need to sorta

Therapist: Nurture more

Client: Sorta concentrate on a wee bit (T: Yeah, yeah)

By recognising that they are not the defective person significant others led them to believe, the client indicates a reduction in *acquiescing or affirming negative reactions from others* within the *hostile neglect* category. Specifically, this reduction pertains to *taking on board* (C.3.3.1.), *submitting to or appeasing* (C.3.3.2.), and *assuaging or mitigating* (C.3.3.3.) *negative or hostile reactions from others*. The client's assertion that 'this other person is not closed anymore, it's open work' reinforces the diminished *guarding or hiding of parts of self* (C.2.2.4) within the *monitoring or controlling self* category. Acknowledging that they are no longer blocked, trapped, buried, or 'getting smothered' implies a reduced reliance on *avoidance strategies*, particularly concerning *submission and passivity* (A.2.2.7.2.) and *blocking uncomfortable feelings* (A.2.2.7.3.). Furthermore, one might deduce a reduction in *hostile neglect* in the form of *self-neglect or abandonment/not*

attending to important things, particularly concerning *direction or motivation* (C.3.2.2.) and *attending to one's basic needs* (C.3.2.4.). This softening of self-neglect is further supported by the client's assertion that they need to 'sorta concentrate on' and nurture their self-relationship.

C5:S17: MU50-58:

Client: And erm, but there's times over the past weeks that I've been so sorta in touch with really something that it's actually (lightly hits hand off thigh), it's kinda exciting (T: Yeah, no, I see) you know, I feel

Therapist: I see it on your face, yeah, yeah

Client: It's actually quite kinda exciting

Therapist: Way cool right

Client: And I feel- I feel (laughs) quite young (T: Yeah, yeah) you know what I mean (T: Yeah, yeah) (chuckles) I feel quite (T: Yeah) kinda

Therapist: This is new

Client: Aye, kinda girlish (T: Uhuh, uhuh) not err

Therapist: It's like some part of you is coming alive (C: Uhuh) and it's a young part because it didn't get to develop (C: Uhuh, uhuh)

Client: But it's kinda like a (laughs) it's a young part (laughs) (T: Yeah, yeah) and err- but it's just

Therapist: And it's free and it's

Client: It's free

Therapist: And it feels okay

Client: But it's not anything that I need to take- it's not anything that's making me reckless, oh dear goodness no (laughs), not yet

Therapist: Not too much chance of that huh

Client: (Chuckles) No, not yet, no (T: Uhuh) not yet, it's not making me reckless, it's not anything (T: Uhuh) that I need to

Therapist: It's something you can trust then

Client: Yup, uhuh, it is something I can trust, it's not anything reckless, it's not that it's making me feel

Therapist: It's not gonna take you to danger or

Client: No, and it's not going to take me (T: Right, yeah) anywhere silly, it's no- it's not pushing me to go to a discotheque or (T: Yeah) erm (T: Yeah) you know to

Therapist: You can trust it

Client: Yup, or to push myself into being reckless in any way (T: Mhm)

Here, the client expresses a sense of excitement, feeling youthful, alive, and free—not recklessly, but in a way that she can trust. This indicates an easing of *pressurising, stressing, or overburdening self* within the *hostile control* category. It could be argued that this new found freedom and trust is the antithesis of *fearing anything could happen or go wrong* (C.2.1.1.3.).

C5:S17: MU50-58:

Client: It's as if it's- this is erm- it's enough for us to kinda develop (T: Yeah) you know I- probably as I'm telling you this I'm thinking if I had to take who this person that I'm, this person is just now

Therapist: Emerging, yeah

Client: Into the world (claps hands) she'd get squashed (laughs)

Therapist: You have to protect her still don't you, yeah

Client: Yeah, I think it's- she'd get

Therapist: It's like a tender shoot coming up and it needs not to be stepped on (C: Mhm) it needs to be protected (C: Uhuh)

Client: So it's no- but it's young and it makes me (T: It's young) feel kinda

Therapist: It's a source of great energy (C: Yup, uhuh) it doesn't take you into bad places (C: No) right and you can protect it and so now instead of a critic you have kind of a nurturing, caring gardener almost pers- part

Client: Kind

Therapist: You know

Client: Oh aye (T: Yeah) that's nice (T: Yeah, yeah) mhm so that's

Therapist: And that's a wee- now with yourself (C: Mhm) yeah

Acknowledging a need to protect this newly emerging, tender, and younger part of herself, the client expresses nurturing self-kindness instead of her previous harsh self-criticism. Indicating a reduction in *self-attack*, she demonstrates an apparent self-care rather than being *self-punitive or hostile* by *attacking or punishing* herself (C.1.3.2.).

C5:S17: MU50-58:

Client: So I think- I'm talking to you now as if three- there's three of us (T: Mhm) you know what I mean when I think about it

Therapist: Okay, so what are the three, there's

Client: Well there's, well I don't know who's the me, there- there's

Therapist: There's the young part

Client: There's this young part and then there's this part

Therapist: Which is more like the

Client: The, what's this part, this part's erm

Therapist: This kind of nurturing, protective kind of

Client: Uhuh, maybe

Therapist: What fits

Client: What fits- I- it's- I'm feeling the holder of it, the keeper the

Therapist: The keeper the holder

Client: The keeper, the

Therapist: It holds

Client: Aye, it's like

Therapist: It holds this part (C: Mhm) kind of, okay

Client: The keeper (T: The keeper) and then there's erm

Therapist: But not in a- in a kinda controlling way

Client: No, just kinda

Therapist: A protective way

Client: Uhuh, just kinda (T: Yeah, yeah) holding it (T: Uhuh) so strange (T: Uhuh) maybe uhuh

Therapist: So there's a holding part

Client: And then there's that rascal (laughs) (T: The rascal) the rascal that keeps (laughs)

Therapist: That- that's basically the part that is still the social anxiety

Client: Yup, yup

Therapist: That's still there (C: Yup) may probably be there right, in fact because it's a deep, it's deep written into you in a deep kinda way but the question is now what you do with it (C: Mhm) when it comes up right

Client: That's right, you know (T: Yeah) that kinda thing (T: Yeah) so that's err (T: Uhuh) but it is- it's- I mean it really is quite exciting

Therapist: You just feel really excited yeah (C: Mhm)

Recognising three aspects of herself—a youthful part, its protector or holder, and another part that experiences social anxiety—the client acknowledges these facets while nurturing her sense of excitement. By addressing *avoidance strategies* related to *submission and passivity* (A.2.2.7.2.) and *blocking uncomfortable feelings* (A.2.2.7.3.), she demonstrates increased acceptance and appears more at ease with the part of herself that can feel scared in social situations. No longer *guarding or hiding* this aspect of herself (C.2.2.4.), she reduces *hostile control* dynamics, becoming more capable of embracing her socially anxious self-aspect in the awareness of her other nurturing and youthful qualities that she can rely on and trust. This growing acceptance also signifies a decrease in hostile control beliefs such as *I shouldn't make mistakes* (C.2.1.3.3.) and *I'm expected to be capable* (C.2.1.4.2.). Furthermore, there is a softening in hostile neglect, as the client is no longer *minimising, negating, or avoiding her feelings*, and is exhibiting less concern with others knowing what she is feeling (C.3.1.2.). She also demonstrates improved emotional regulation and enhanced ability to know what to do with her feelings (C.3.1.5.) when they arise. Based on this overview, Participant 5's end-of-therapy narratives clearly illustrate an improved self-relationship, as indicated by her SRQ self-report. It is evident that they transitioned from a self-disparaging and self-critical stance to higher levels of self-affirmation and acceptance.

Applying McNemar's Test to Explore the Statistical Significance of Changes in Participant NTS Between the Beginning and Ending Phases of Therapy

The qualitative data presented in this study demonstrates evidence supporting the effectiveness of EFT-SA and its impact on improving the quality of the self-relationship. The NTS variables, whether present or absent at the beginning and ending phases of therapy, were analysed using McNemar's test to evaluate the significance of any changes. This test is suitable for analysing nominal paired values, and is helpful when assessing and comparing the direction of changes in participant scores (Field, 2018). Each participant's NTS variables at both time points reflect related dichotomous values. The McNemar's test compared changes in one direction (scores increased or became present) versus the opposite (scores decreased or became absent), using the beginning phase as a baseline. An own control design was employed to compare NTS presence or absence between the two time points. The McNemar significance test results are shown in Table 41, comparing the presence or absence of NTS between the beginning (T1) and ending (T2) phases of therapy for each participant. The table details participant identification, NTS frequency at T1 and T2, mean and standard deviation of NTS scores, McNemar's test statistic (ρ McNemar), 95% confidence interval (CI) for the difference in proportions, and effect size (Φ or Phi) indicating the association strength. The table includes the sample size (N) and reports exact significance levels (p-values). Lower.CI and Upper.CI denote the 95% CI's lower and upper limits, respectively, providing a range for the true difference in proportions between groups with 95% confidence (e.g., Lower.CI of 5.47% indicates that, with 95% confidence, the true difference in proportions between the two groups is expected to be at least 5.47%).

Although the frequencies of NTS themes per participant were originally recorded at the beginning and end of therapy, the decision was made to transform the data into paired dichotomous values, where 0 represented absence and 1 represented presence. This decision was motivated by variations in the length of qualitative meaning units across participants, making direct frequency comparisons impractical. McNemar's test, a type of Chi-square test suitable for dependent

(paired) data, was employed to evaluate significant differences in these dichotomous variables between the therapy's beginning and end for each participant. A McNemar's test p-value greater than .05 suggests no significant difference between false negatives and false positives, while a p-value ≤.05 indicates a significant change. Additionally, to assess the relationship between the beginning and ending phases, the Phi coefficient was used, akin to interpreting Pearson's correlation, ranging from -1 to 1. A Phi coefficient of 0 denotes no relationship. Generally, a Phi coefficient of r = 0.1 signifies a small effect, 0.3 indicates a medium effect, and 0.5 represents a large effect (Field, 2018).

Table 41: McNemar's Test of Significance of NTS Between the Beginning and Ending Phases of Therapy

	f		***f***						
	Beginning (T1)		**End (T2)**		***M(sd)***	***M(sd)***	***ρ***	**95% CI**	***Φ***
P	**Ab.**	**Pr.**	**Ab.**	**Pr.**	**T1**	**T2**	**McNemar**	**L.CI & U.CI**	**Phi**
1	98	44	109	33	.31(.46)	.23(.42)	.09	[-1.14, 16.50]	.28
2	78	64	87	55	.45(.50)	.39(.49)	.18	[-2.94, 15.44]	.36
3	82	60	110	32	.42(.50)	.23(.42)	<.001*	[10.24, 28.71]	.26
4	73	69	87	55	.49(.50)	.39(.49)	.04	[0.31, 19.12]	.33
5	92	50	112	30	.35(.48)	.21(.41)	.002*	[5.47, 22.47]	.34
6	90	52	93	49	.37(.48)	.35(.48)	.66	[-7.38, 11.54]	.28

N=142, *Exact Sig. (2-sided), binomial distribution used. P = Participant, Ab. = Absent, Pr. = Present.

Many researchers caution against using SPSS for calculating the McNemar's statistic (Newcombe, 1998). It applies an overly conservative correction known as Yates' Correction for Continuity (Yates, 1934). This correction has led to mixed acceptance in practice, with various texts and software packages differing in their recommendations (Hitchcock, 2009). Unfortunately, SPSS does not allow users to obtain McNemar test results without applying Yates' correction. To address this limitation, Professor Marta Garcia-Granero, a biostatistician and SPSS expert at the Universidad de Navarra, developed a macro (see Appendix P). This macro provides McNemar results with and without Yates' correction, along with 95% confidence intervals for changes in proportions or percentages. Although authored by Garcia-

Granero, the confidence intervals in the macro follow a method outlined by Newcombe (1998). Yates' correction aims to prevent overstating statistical significance in small samples. Despite the small sample size being a challenge in this study, some argue that Yates' correction is unnecessary because it tends to overcorrect, potentially failing to reject the null hypothesis when appropriate. Consequently, the decision was taken to utilise Garcia-Granero's macro to report McNemar significance statistics without Yates' correction. It is worth noting that in two cases (*), the Exact Sig. (2-sided) results indicate identical corrected and uncorrected values. As anticipated, the Phi correlation analysis revealed a positive relationship between participants' initial and concluding therapy sessions, showing moderate correlations ranging from r = .26 to r = .36. While the frequencies of NTS at the beginning and end of therapy indicated a noticeable decrease across all participants, McNemar's test detected significant changes between these phases for only half of the participants, with p-values ranging from <.001 (2-sided) to .04.

Recognising the statistical challenge posed by non-independence, it is important to note that multiple observations per participant lack independence, thereby violating certain assumptions of significance tests. Despite stable parameter estimates and effect sizes, the lack of independence among participant observations introduces uncertainty in significance levels. Nonetheless, participants demonstrated independence from each other, distinguishing between samples, yet consistently exhibited comparable effect sizes. To address the issue of non-independence and enhance statistical significance, the six participants were treated as independent entities, and their samples were pooled. The mean Phi coefficient, averaging a medium effect size, was calculated as 0.31 (SD = 0.04), with a standard error of 0.016. The associated t-value of 19.27 ($p < .05$), used to assess the significance of the Phi coefficient, indicates robust statistical significance, affirming a strong association between the two binary variables. This approach ensured statistical rigor by mitigating the issue of non-independence among client observations. Furthermore, the consistent nature of Phi coefficients bolstered the reliability of the mean, which is statistically significant and clearly greater than zero.

Chapter Summary and Discussion

Investigating expressions of negative treatment of self during the final phase of therapy, this study aimed to determine whether the earlier rational-empirical model of NTS (as described in Chapter 4 of this thesis) remained applicable to participant data at therapy's end or required further refinement. The findings revealed a few minor elaborations and new subcategories, suggesting potential saturation of the model. Particularly noteworthy were the numerous absent categories and subcategories at this ending phase of therapy, indicating reduced NTS and enhanced self-relating. While qualitative analysis indicated substantial changes in negative self-treatment across all participants, as reflected in their SRQ self-reports, quantitative analysis showed significance in only half of the individual assessments. However, significance emerged when the data were aggregated across the entire sample. Building upon the preliminary rational model developed by Capaldi and Elliott (2023), and conducting additional validation and refinement of the rational-empirical model as previously expanded, led to a more nuanced and refined empirical framework.

While the qualitative methodology applied to comprehend and analyse NTS themes (GDI-QR; Elliott & Timulak, 2021) supported the emergence of additional characteristics of negative self-treatment, the analysis was both bolstered and challenged by clients' self-reports and statistical quantitative outputs. Embracing Smith et al.'s (2021) pluralistic perspective on psychotherapy research suggesting that multiple convergent and divergent findings carry equal weight, the multiple and sometimes conflicting observations and interpretations employed in this study underscored the relevance of methodological pluralism (Klein & Elliott, 2006). Citing Levitt et al.'s (2020) assertion that differing perspectives from varying sources contribute to a dialectical process offering greater differentiation or synthesis, Smith et al. (2021) concluded that '*multiple answers to a research question have the potential to make findings not less, but more relevant for policy and practice*' (p.6).

Taking a pluralistic view of depression research, Smith et al. (2021) highlighted widespread challenges in its measurement, understanding, and definition. They noted the common practice of narrowly focusing on self-report measures to assess change, often neglecting broader qualitative outcomes (Stänicke & McLeod, 2021), and emphasised the uniqueness of each individual's narrative regarding their recovery process and pathways. Similarly whilst this end of therapy study reflected good outcome cases, sole reliance on participants' SRQ self-reports would have overlooked the diverse range of self-relationship discourse descriptors, in both their adaptive and maladaptive forms. Furthermore, without quantitative significance tests, it might have been tempting to overstate the overall significance of self-report and qualitative findings.

Efforts to capture relevant aspects of the NTS phenomenon revealed the complexity of interpreting varying viewpoints, highlighting the challenge of adequately describing the self and its experiences. Recognising that clients' experiences of successful therapy may not always align with outcome measures (McElvaney & Timulak, 2013), existing research underscores discrepancies between client self-reports and qualitative interviews (Elliott et al., 2009), as well as differences between therapist observations and client self-perceptions (Cuijpers et al., 2010). These findings emphasise the significant implications of the multiplicity of self, supporting Stänicke and McLeod's (2021) perspective on '*paradoxical outcomes in psychotherapy*' (p.115). They also underscore the importance of identifying contradictory patterns, aligning with Shedler et al.'s (2003) concept of '*illusory mental health*' (p.635), which suggests that self-reporting may blur genuine psychological difficulties with defensive strategies and illusions. Acknowledging that effective psychotherapy fosters integration, where different aspects of self engage in adaptive dialogue rather than defensive conflict, provides insight into how client self-reports can fluctuate wildly between contradiction and stability (Stänicke & McLeod, 2021). This underscores the need for research strategies that incorporate multiple viewpoints and analytical methods.

The absence of numerous NTS themes in this late phase of therapy indicated improvements in the self-relationship, as evidenced by participants expressing self-affirming statements such as '*I don't think I'm any worse than any other people*' and '*there's like the real me underneath here you know and it's a kinda okay person*'. This shift towards greater self-affiliation alongside reduced levels of negative self-treatment appeared contradictory to Werner et al.'s (2012) findings, which suggested minimal correlation between self-compassion levels and severity of social anxiety. As NTS frequency decreased and self-affirming statements increased, one participant noted progress in their SA by saying '*I was invited out, I would always say no because that was safe, I was safe, but this year I said yes, it's a first for me*'. However, Werner et al. (2012) also noted that social anxiety was weakly linked to difficulties with self-compassion, as observed in one participant who developed a 'protective' and 'kind' self-relationship while acknowledging the persistence of their socially anxious self, referred to as '*that rascal*'. Nevertheless, the development of higher levels of self-compassion enabled this participant to foster a more adaptive relationship with their socially anxious self-aspect, reducing fear of it and enhancing their ability to respond self-affirmatively. In line with Werner et al.'s (2012) findings on the strong association between lower self-compassion and heightened fear of negative evaluation, another participant demonstrated increased self-affirmation and reduced fear of evaluation by stating, '*well this other person is not closed any more, it's open work*'.

While emerging elaborations and subcategories enriched the empirical model of NTS themes, this study avoided a reductionist approach to theory building, retaining omitted categories and subcategories from the ending phase of therapy within the overall structure while acknowledging their absence. These absent themes were positively correlated with NTS levels at the beginning of therapy, as indicated by Phi coefficients, providing insight into improvements in participants' self-relationships. Consistent with Honos-Webb and Stiles' (1998) assimilation model, all participants' dialogical selves transitioned from an undifferentiated constriction at therapy's outset towards '*experiencing the self as composed of a cast*

of characters' (p.25) at the end (explicitly illustrated in the 7-minute excerpt for Participant 5 in the Results section). By bringing awareness and expression to clients' problematic voices or self-aspects, therapy facilitated their acceptance into '*the community of selves*' (p.25), representing a positive shift in their self-relationship and acceptance of these experiences (Honos-Webb & Stiles, 1998). This dialectical constructivist approach to change (Elliott et al., 2004; Greenberg et al., 1993; Mearns & Thorne, 2000) aimed to restore flexibility and dynamic interaction among different self-aspects, evident in the end of therapy discourse. Stinckens et al.'s (2013a) inner critic process stages of '*experiencing opposition and conflict, assimilation and differentiation, and accommodation and integration*' (p.72) were observed in the data, with assimilation and integration of problematic voices and experiences leading to fewer utterances of NTS. This reduction in self-critical, controlling, neglectful, and distancing voices and behaviours, coincided with the emergence of a more accepting and compassionate organismic or experiencing self-aspect. Harsh or dominant 'I' positions moved towards greater collaboration and synthesis, demonstrating readiness to accommodate needs by better recognising, hearing, and understanding other self-aspects.

Returning to Haberman et al.'s (2019) study on the impact of primary adaptive emotions on self-criticism and social anxiety symptoms, it was observed that although assertive anger increased and shame decreased, their findings indicated that experiencing shame during a session was a predictor of higher levels of self-inadequacy or self-reassurance in the following week. Although it may appear contradictory, the authors proposed that experiencing assertive anger or adaptive sadness during sessions reduced overall shame without necessarily predicting subsequent levels of self-criticism. In contrast, this study on NTS in-session dialogues during the concluding phase of therapy seems to contradict Haberman et al.'s (2019) findings, particularly concerning the decrease in shame and increase in assertive anger, as well as the perceived disconnect between shame and self-criticism levels. As detailed in Supplemental Table 7 (see Appendix M), the data revealed significant reductions in both self-criticism (Time 1: n=161; Time 2:

n=112) and anger (Time 1: n= 21; Time 2: n=6) across all participants, alongside a slight increase in expressed shame (Time 1: n=5; Time 2: n=6) from the beginning to the end of therapy. However, qualitative data indicated an increase in assertive anger and simultaneous decrease in shame, as exemplified below by Participant 2, who began the session by stating, '*for me it's like social anxiety, but for other people I am just boring*':

> **Therapist:** And it feels like all of this having tried and made the effort, that feeling's knocked you back
>
> **Client:** Well in one way it has knocked back, in another way I'm like oh fuck off then really- quite honestly I don't take it you're much up to- it's like fuck I am not bothered- and there is another way I am not bothered by them really because I think it's pretty pathetic to be judgy people and that it's- you're not particularly that nice really
>
> **Therapist:** So that's been a kind of a shift because it feels like from your childhood and past, you'd always assume that it's you that's not nice (C: Of course) but now you're kind of recognising that it is sometimes other people- it's other people that can be not nice
>
> **Client:** Well aye, yes (C2:S19: MU16-17).

Similar to Stinckens et al.'s (2013a) analysis of the inner critic's process of change, the frequencies of NTS at the end of therapy reflected an increasing presence of adaptive, self-affiliating attitudes and themes. Nonetheless, maladaptive patterns of NTS persisted, albeit in reduced forms across all participants, with only half showing significant change based on McNemar's test of significance. Interestingly, Stinckens et al. (2013a) also noted instances whereby in '*almost half of the episodes there was no evolution or a negative evolution in level of information processing, self-attitude and self-schemes*' (p.75). Similarly, Watson and Greenberg (2017), in their exploration of EFT for generalised anxiety, reported a response rate of around a fifty percent among clients receiving short-term therapy. The pathways to change were shaped by both the therapist's approach and the manifestation of the inner critic during therapy. This underscores Stinckens et al.'s

findings and highlights the importance of integrating various approaches to enhance recognition and processing. Even at the end of therapy, NTS continued to be a complex and multifaceted issue, manifesting in various forms despite positive outcomes. In line with Stinckens et al.'s (2013a) findings on the inner critic, manifestations of NTS included conflicting self-aspects involving body image, self-worth, personality traits, self-efficacy, and avoidance strategies. Behavioural themes observed included hostile and self-depreciating attitudes, perfectionism, neglect of feelings and needs, and interpersonal isolation. Notably absent in the beginning phase study of NTS, Stinckens et al.'s (2013a) descriptors of an attention seeking, arrogant, dominant, grandiose, or manipulative client presentation appeared more prominent in this later-stage therapy, particularly within the *self-entitlement or grandiosity* category of the hostile freedom domain. Just as Stinckens et al. (2013a) highlighted the multifaceted and complex nature of the inner critic, the same complexity applies to NTS, albeit as a broader concept. While NTS can be viewed as an interconnected gestalt, where each aspect influences or sustains the others, it is crucial to maintain vigilance and sensitivity toward its diverse presentations and effects for effective processing. Despite sometimes appearing rigid and entrenched, NTS's ability to morph and change—often lying dormant only to re-emerge prominently later—demonstrates its adaptability in response to individuals' evolving states and moment-to-moment experiences.

Limitations and Suggestions for Future Research

Similar to the earlier study at the beginning phase of therapy, a significant challenge of the current investigation was the subtlety involved in identifying, interpreting, and classifying various types of negative self-treatment. Although repeating the prior investigation allowed for a more refined methodology, the labelling and categorisation of the NTS facets remained a significant limitation, subject to interpretation and potential researcher bias (Mahtani et al., 2018). Although the limited emergence of new categories and subcategories suggests saturation, the current NTS model is presented tentatively and is expected to evolve

with ongoing research. This evolution is evident from the progression through the initial preliminary model (Capaldi & Elliott, 2023), the second rational-empirical model, and now this third empirical investigation. The current model addresses negative self-treatment in socially anxious clients and may vary with other presenting issues. However, the observed similarities—such as those found between research on the inner critic, depression, eating disorders, and NTS—suggest some overlap, highlighting the model's broad relevance. As previously recommended, exploring negative self-treatment across diverse client populations and therapeutic modalities will be essential for evaluating the model's applicability and testing for further saturation.

While the primary focus of this study was on testing and developing the rational-empirical model of NTS, examining the ending phase of therapy highlighted the bipolar relationship between self-attack and self-affiliation, as identified in the initial study of this thesis. As quantitative frequency data showed a decline in negative self-treatment, qualitative data revealed an emergence of self-affiliative narratives, indicating improvements in the self-relationship. Similarly, Watson and Greenberg (2017) noted the absence of self-soothing strategies in maintaining problematic self-relating and emotion regulation styles in their study of EFT for generalised anxiety. In EFT, two-chair enactments of the self-critical process and self-soothing tasks are designed to address and soften the inner critic by fostering protective and supportive self-affirming and self-soothing strategies (Elliott et al., 2004; Elliott & Greenberg, 2021). Therefore, future research on NTS should also emphasise the quantification, classification, and understanding of self-affiliation and self-soothing narratives in addition to negative self-treatment.

Implications for Practice and Conclusion

Building upon existing literature on self-criticism, perfectionism, and self-efficacy, this investigation has validated and expanded the existing model of negative treatment of self. By broadening our understanding of NTS beyond the narrowly focused concept of the inner critic, this study has enhanced knowledge of

the self-relationship in its problematic forms. Through an in-depth exploration of the interplay between self-criticism, self-destructive behaviours, and the resulting emotional responses of socially anxious individuals, this research underscores the significance of implicit indicators of negative self-treatment. By highlighting client NTS narratives, this empirical model reveals a range of potential therapeutic interventions, particularly when considered alongside clients' self-reports. Furthermore, empirical evidence suggests that the model's applicability extends beyond specific issues or diagnoses, offering valuable insights into clients' self-relational patterns. This research not only depicts a clinical profile of common SA presentations but also emphasises the need for further exploration of negative self-treatment across various clinical contexts. Refining and expanding this model can contribute to developing a more comprehensive framework, highlighting specific activities or strategies prevalent in certain clinical settings. The intricate and diverse dynamics of NTS highlighted by this model support the need for a flexible and adaptable therapeutic approach that prioritises effective emotional processing. This aligns with Stinckens et al.'s (2013b) assertion that successful therapeutic outcomes require an adaptive and engaged response to the critic in all its manifestations.

This study is significant as it likely represents a pioneering effort, building upon an initial rational-empirical model, to explore the intricacies of negative self-treatment. By integrating the NTS domains of self-dislike, inimical self-actions, and their emotional effects, the model distinguishes and emphasises both the subtle and overt forms of negative self-treatment. The findings vividly illustrate a broad spectrum of self-relational challenges, revealing diverse manifestations of intrapersonal processes, along with their direct and indirect strategies and emotional consequences. The research underscores the complexities involved in objectively discerning the multitude of harmful configurations and manifestations within an individual's self-relationship. Whether NTS manifests through internalised self-criticism or externalised projections in relation to others, it is evident that both approaches significantly contribute to emotional distress and suffering.

Importantly, this framework does not seek to categorise or label clients and their difficulties. Instead, it serves as a valuable tool for enhancing practitioners' awareness of the diverse NTS processes that may emerge during therapy sessions. This increased awareness is clinically significant, as it aids in recognising and addressing various forms of negative self-treatment, thereby supporting more effective and holistic therapeutic interventions. Additionally, this study underscores the multifaceted nature of the self and its capacity for multiple voices or self-aspects (Elliott & Greenberg, 1997; Cooper, 1999). The results reveal how clients' lives and narratives can encompass a range of diverse and conflicting voices. By providing insights into the ebb and flow of negative self-treatment, this study offers a comprehensive overview of the numerous struggles and inner conflicts faced by socially anxious clients in their many forms. Furthermore, it demonstrates that the various indicators of NTS can be effectively measured to shed light on their intensity, providing insight into participants' negative self-treatment during the concluding phase of therapy. By closely analysing their discourse, it offers the potential to monitor therapeutic change in clients. Enhancing awareness fosters creativity and effectiveness in therapeutic outcomes, serving as a foundation for various avenues of investigation. Aiming to promote awareness of self-sabotaging tendencies, this study empirically validates a framework for understanding NTS and fostering greater self-compassion. This approach paves the way for increased self-awareness and self-realisation, uncovering hurtful or harmful aspects of oneself that operate insidiously in the background, and acknowledging the emotional pain they cause—a process of self-discovery that stands in contrast to suppressing or ignoring these harmful self-aspects. Ultimately, this body of work seeks to establish a more solid foundation for healing and transformation, potentially allowing various aspects of the self to emerge more freely and unhindered. It aims to liberate individuals from self-imposed oppression by recognising and giving voice to the multifaceted aspects of the self.

Chapter 6: The Self-Relationship and NTS - Insights & Future Directions

Introduction

The primary objectives of this series of studies were to empirically validate the Self-Relationship Questionnaire (SRQ; Faur & Elliott, 2007) and the rational empirical model of negative treatment of self as proposed by Capaldi and Elliott (2023). At the time of conducting this research, the SRQ remained an unpublished experimental measure of the self-relationship, showing potential for broader clinical use. Additionally, there were no existing studies on the wider self-relationship concept of negative treatment of self beyond the author's preliminary study. To address this gap, further psychometric testing of the SRQ was undertaken, along with challenging the rational empirical model of NTS using both beginning and end of therapy data. These efforts aimed to systematically and empirically investigate and validate these existing frameworks, leading to the development of a condensed 26-item self-relationship questionnaire and an elaborated, refined empirical model of negative self-treatment.

These studies closely examined the self-relationship of socially anxious clients from both quantitative and qualitative perspectives, considering therapeutic change throughout the therapy duration. The research highlighted the dichotomous yet bipolar connection between self-attacking and self-affiliating processes. By gaining insights into social anxiety presentations in therapy and their manifestations of NTS discourse, the outcomes of this research demonstrated potential relevance across various types of difficulties. Offering a meaningful and clinically relevant contribution to knowledge on the self-relationship and negative treatment of self, this research constitutes an important addition to humanistic-experiential literature and more generally, self-psychology.

Building upon the detailed discussions in the preceding chapters dedicated to each of the three studies and incorporating broader debates and conclusions, this chapter offers a comprehensive exploration of the insights gleaned from this research endeavour. Consistent with the dissertation's structure, this concluding

chapter begins with an overview of the three main studies. The first part examines primary insights obtained from testing and validating the SRQ and their relation to the existing literature, the second segment evaluates outcomes from constructing the empirical model of negative self-treatment, and the third segment explores supplementary insights from end-of-therapy discourse. The chapter delves into the complexities of measuring the self-relationship, investigating the emergence of self-attack and self-affiliation as a bipolar construct, as well as the nuances of self-control as a distinct aspect of self-relating. It underscores the importance of addressing persistent self-doubt and enhancing self-awareness and knowledge. Additionally, it sheds light on the elusive nature of self-neglect within the NTS process, emphasising the necessity for further research to substantiate its identification and resolution.

Establishing validity in these studies involved assessing the extent to which the theoretical framework underpinning the SRQ instrument and empirical NTS model aligned with existing theory. Each section pinpoints key discoveries related to the concept of the self-relationship, its measurement, or negative treatment of self, examining how they advance our comprehension within the realm of process-experiential theory. The chapter offers reflections on the potential applications of the SRQ and the possibilities unlocked through the establishment of the NTS model. It also investigates the constraints and consequences of this project within the context of existing scholarly literature. Furthermore, there is a discussion on the potential ramifications for research and clinical practice, suggestions for prospective avenues of inquiry, and, lastly, a reflection on my personal journey as a psychotherapy practitioner and researcher.

Summary of Main Findings, Discoveries, and Implications for Theory

Study 1: Testing and Validating the SRQ

This initial study explored the psychometric properties of the Self-Relationship Questionnaire (SRQ), aiming to assess its reliability and validity as a measure of various aspects of the self-relationship. Findings revealed that SRQ

scores displayed excellent temporal consistency in a nonclinical population and generally exhibited good reliability, validity, and inter-item consistency in both nonclinical and clinical samples. The instrument demonstrated substantial correlations with constructs such as self-criticism, self-esteem, self-compassion, and psychological distress. Notably, it exhibited weak correlations with the distinct construct of social desirability, indicating discriminant validity. Exploratory factor analyses merged self-affiliation and self-attack into a bipolar construct, providing evidence for a three-factor solution that measured the multidimensional components of self-relating. The first factor integrated self-affiliation and self-attack, whilst the second and third factors differentiated the controlling and neglectful aspects of the self-relationship. Elaborated upon later in this chapter and meriting further investigation, the results suggested that self-control represents a distinct type of self-relationship, as evidenced by the weak correlations observed between self-control, other SRQ subscales, and domains of other measures.

Overall, the SRQ demonstrated good psychometric qualities and confirmed its multidimensional structure. Although the reliability of the original 36-item measure was acceptable, suggestions were made for revision to simplify the instrument by removing overlapping and redundant items. Clinical cut-off points and reliable change indices were established to facilitate its clinical use. Further recommendations were made for future confirmatory factor analyses on the revised 26-item SRQ to further test its structure. Regardless of these future recommendations, the SRQ was deemed a valuable clinical instrument for assessing the quality and state of an individual's self-relationship, thus aligning with the goals of psychotherapy.

Study 2: Development of the Empirical Model of NTS

The second study of this thesis presented an in-depth exploration of the characteristics of negative treatment of self in the early stages of therapy, with a focus on understanding the problematic self-narratives engaged in by socially anxious clients. The study aimed to shed light on various aspects of NTS, including self-critical activities, strategies employed in self-dislike, inimical self-actions, and

their emotional effects. Building upon the preliminary rational-empirical model of NTS (Capaldi & Elliott, 2023), the research identified multiple additional categories and sub-categories, providing an elaborated and refined empirical structure. Deviating from the quantitative methodology employed in the first study of this thesis, this investigation utilised the GDI-QR qualitative approach (Elliott & Timulak, 2021), allowing for close examination of client and therapist discourse, revealing both explicit and subtle themes of NTS. The analysis recognised that negative self-treatment is a complex phenomenon involving multifarious expressions, from overt self-criticism to more implicit manifestations.

This investigation significantly advanced our understanding of NTS by delving into its intricate connections with self-criticism (Stinckens et al., 2013), perfectionism (Powers et al., 2011), and performance-related concerns (Whelton et al., 2007; Shahar, 2015). The inquiry not only reinforced these associations but also suggested that there is much more to discover about the broader landscape of the self-relationship and self-criticism in general. Building upon the foundation established by Werner et al. (2019), which underscored the imperative for thorough investigation into the origins and ramifications of self-criticism, the development of the NTS framework aligns with these pivotal observations by delineating a sequential and responsive progression. Unveiling negative self-treatment as a cyclic process, this study illustrated how antecedents and consequences manifest within the cycle, giving rise to behavioural responses or emotional impacts that perpetuate its recurrent nature. Further aligning with the empirical model of NTS, Shahar et al. (2012) proposed that researchers should not only scrutinise the overt or explicit outcomes of self-criticism but also delve into its implicit consequences and explore how individuals navigate their emotions within the self-critical framework. Similarly, this NTS study underscored the need for research to go beyond merely understanding the factors that drive individuals toward negative self-treatment and discerning its outcomes. It advocates for a more comprehensive exploration of the mitigating factors involved in this complex interplay.

The study identified numerous sub-categories within NTS, highlighting

various targets of self-dislike, including aspects of identity, actions, and possessions, all shaped by unattainable standards. Negative self-treatment manifested in multiple forms, such as attacking, controlling, neglecting, and distancing behaviours toward oneself. Participants experienced a wide spectrum of emotions—fear, anxiety, panic, sadness, grief, anger, guilt, and shame—all stemming from a perceived sense of defectiveness. This study illuminates the cyclical nature of NTS, reflecting its cognitive, behavioural, and affective dimensions. Emotional processing played a pivotal role in this cycle, with emotional effects either preceding or following episodes of self-dislike and harmful self-actions.

The analysis illuminated signs indicative of a typical social anxiety presentation, where clients exhibited a profound sense of brokenness, employed derogatory self-descriptions, utilised self-protective strategies, expressed fear, and endured emotional pain (Elliott & Shahar, 2017). This investigation unveiled a broad spectrum of self-denigrating and harmful-to-self processes, providing a comprehensive insight into the complexities of NTS in social anxiety presentations. Elliott et al. (2004) stressed the importance of examining not just the content of self-criticism, but also how it is expressed or enacted, pointing out that self-criticism can manifest in various forms, as evidenced by the research findings. These manifestations included annihilating self-contempt, self-blame, feelings of inadequacy, self-doubt, idealistic expectations, and fear-based limitations, among others. The evidence underscored that while some individuals may express self-criticism through their thoughts or words, others may externalise it through their behaviours or interactions with others. The myriad expressions of negative self-treatment emphasised the imperative to comprehend the mode of enactment for a more profound understanding of the underlying processes.

In consonance with established literature linking self-criticism to early traumatic experiences and critical parenting (Elliott et al., 2004; Elliott, 2013; Elliott & Shahar, 2017; MacLeod et al., 2012; Stinckens et al., 2002a; 2013a), the study further accentuated the pivotal role of attachment injuries in shaping NTS experiences. Participants frequently recounted the impact of critical, controlling, or

neglectful parents or significant others, describing experiences of shame, intolerance, and passive aggression. These relational difficulties often persisted and were evident in participants' expressions of NTS.

For a comprehensive understanding of negative treatment of self, the study incorporated narratives concerning controlling, neglecting, and distancing behaviours, in addition to self-attack and self-criticism. This approach deviated from previous studies that traditionally concentrated on specific facets of self-criticism and their clinical outcomes (Stinckens et al., 2013a). The research proposed that the taxonomy of NTS could provide valuable insights into a client's self-relationship across various presenting issues. The findings revealed both commonly occurring themes and unique within-case patterns, underscoring the importance of therapists being attuned to a broad spectrum of NTS expressions.

Effectively situating the research outcomes within the existing literature, this study underscored the necessity for comprehensive investigations into negative self-treatment, spanning its causes, effects, implicit outcomes, and modes of expression. Exploring these facets promises a more nuanced understanding of the complex phenomena of the self-relationship and NTS, with profound implications for psychological well-being. In conclusion, this research involved a thorough exploration of NTS during the initial phases of therapy, offering detailed insights into its various dimensions and emotional impacts. It emphasised the importance of recognising and responding to the diverse manifestations of NTS in therapy. The rational-empirical model of negative treatment of self delineated in the study stands as a reliable and valid guide for comprehending and addressing the complexities inherent in NTS.

Study 3: Insights Gleaned From the End of Therapy NTS Discourse

The third and final study in this research aimed to explore the manifestations of negative self-treatment during the concluding phase of therapy. The objective was to evaluate the continued relevance of the rational-empirical model of negative self-treatment established earlier in this thesis and to determine whether it required further refinement, based on insights drawn from data

collected at the conclusion of therapy. The investigation revealed minor elaborations and a few new subcategories, suggesting the model's ongoing relevance and potential saturation. Notably, the absence of several NTS categories and subcategories at this stage indicated a reduction in negative self-treatment and an improvement in self-relating. Analysing data from this later time point offered a more nuanced understanding of NTS and valuable insights into treatment progress and its long-term effects. This approach allowed for the observation of how negative self-treatment evolved throughout therapy and its variations between the beginning and end phases. It facilitated both qualitative and quantitative assessments of EFT's effectiveness in addressing NTS, especially for socially anxious clients. Examining individual differences in NTS trajectories not only strengthened the model but also provided insights into treatment progress, longitudinal effects, and complex interactions, ultimately enhancing knowledge and informing clinical practice.

While the qualitative methodology (GDI-QR; Elliott & Timulak, 2021) facilitated the identification of additional NTS characteristics, the analysis also took into account client self-reports and statistical analyses. The study adopted a methodologically pluralist approach (Klein & Elliott, 2006), acknowledging the significance of both convergent and divergent findings (Smith et al., 2021). This approach recognised the intricate nature of individual narratives, emphasising the necessity for diverse perspectives and analytical methods, particularly given instances where the client's SRQ self-report did not consistently align with their expressions of NTS during therapy.

The absence of various NTS themes toward the conclusion of therapy signified positive transformations in the self-relationship of socially anxious clients. Participants exhibited a decrease in NTS utterances and expressed heightened self-affiliating statements, demonstrating an increased sense of self-compassion in contrast to the elevated levels of self-criticism observed during earlier phases of therapy. These findings challenged previous research that showed limited correlation between the severity of SA symptoms and levels of self-compassion

(Werner et al., 2012), emphasising the distinctiveness of each individual's narrative and recovery journey. The study preserved omitted categories and subcategories in the overall structure but acknowledged their absence as signals of an enhanced self-relationship. The participants' dialogical self appeared to evolve, transitioning from an undifferentiated constriction to the recognition of a diverse cast of characters within the person (Honos-Webb & Stiles, 1998). This transformation reflected an acceptance and integration of problematic voices and experiences, cultivating a more compassionate and adaptive relationship with self.

Highlighting the intricacies of NTS, the subjective nature of experiencing, and the relevance of methodological pluralism, the quantitative results indicated notable reductions in the frequency of self-criticism and anger, accompanied by an increase in expressed shame. Conversely, qualitative findings suggested an increase in assertive anger and a simultaneous decrease in shame. These results presented a quantitative contradiction and a qualitative confirmation of the findings by Haberman et al. (2019), who observed a significant rise in assertive anger and a corresponding decrease in shame during therapy. In essence, the relationship between levels of self-criticism, anger, and shame appeared to be intricate and potentially contradictory, prompting this study to further explore these dynamics through both quantitative and qualitative analyses. The complexity of these outcomes supported the notion that clients possess a multiplicity of selves, and effective therapy facilitates their integration (Elliott et al., 2004; Greenberg et al., 1993; Mearns & Thorne, 2000). This concept of multiplicity acknowledges the diverse aspects of human identity, encompassing roles, beliefs, emotions, and desires that may coexist or conflict within an individual in response to their moment-to-moment experiencing. Psychotherapy aims to integrate these different selves, fostering self-awareness, acceptance, and wholeness. However, this process can be challenging, as individuals often grapple with conflicting needs, values, and emotions, leading to internal struggles.

In summary, this study delved into negative treatment of self during the concluding phase of therapy, uncovering indications of positive shifts in the self-

relationship. It underscored the significance of incorporating diverse perspectives and analytical approaches in psychotherapy research. Despite the apparent complexity of NTS, the prevailing pattern among participants revealed a decrease in negative self-treatment and enhancements in self-affiliation and self-compassion. Nevertheless, a lingering sense of self-doubt persisted—an unexpected discovery that will be explored in greater detail later in this chapter.

Concluding this comprehensive summary of each study and its relation to the existing literature, the collective body of research in this series unequivocally affirmed the legitimacy of utilising and interpreting scores on the self-relationship questionnaire as a reliable measure of the self-relationship. Furthermore, the empirically validated model of NTS is demonstrated to be reflective of problematic self-processes. Whilst making these assertions, it is crucial to acknowledge potential limitations, a topic that will later be explored more extensively.

Complexities in Effectively Measuring the Self-Relationship

When embarking on this series of studies, I held a somewhat naive assumption that the self-relationship and its constructs could be easily captured and measured. However, the process of observing, describing, and measuring the self-relationship in psychotherapy research, unfolded as a complex and multifaceted task. This complexity arose not only from the subjective and abstract nature of the concept and its various definitions (Leary & Tangney, 2012; Kay et al., 2021) but was also compounded by the challenging task of self-knowledge (Shahar, 2015), a topic that will be elaborated upon later in this chapter. By conceptualising the self as a collection of psychological processes and mechanisms that facilitate conscious self-reflection, the self-relationship significantly influences how individuals perceive, understand, feel about, and act toward themselves (Leary & Tangney, 2012). Affecting the quality of the working alliance, the self-relationship plays a crucial role in psychotherapy outcomes (Horvath & Bedi, 2002; Rumpold et al., 2005), yet there remain several difficulties associated with effectively conceptualising and measuring this construct.

Due to its highly subjective nature, the self-relationship among participants in this research exhibited significant variation from person to person, underscoring diverse perspectives on what each individual might perceive as a positive or improved self-relationship or a favourable outcome (Elliott, 2008). This inherent subjectivity poses challenges in developing a standardised measurement tool capable of capturing the nuanced experiences of each individual (Byrne, 1996). Instead of constituting a monolithic entity, the self-relationship is multi-dimensional, encompassing aspects such as self-esteem, self-compassion, self-acceptance, self-efficacy, self-monitoring, and the inner critic, amongst others (Byrne, 1996; Leary & Tangney, 2012). Baumeister (1998) asserted that the '*self is not really a single topic at all, but rather an aggregate of loosely related subtopics*' (p. 681), supporting Leary and Tangney's (2012) claim that effectively defining and measuring all these facets of the self-relationship within a single instrument poses a formidable challenge. Rather than focusing on these widely researched self-relationship concepts in isolation, this series of studies embodied a holistic approach by viewing self-relating within the four broader quadrants of self-attack, self-affiliation, self-neglect, and self-control, thereby effectively capturing the previously narrower concepts.

Delving into facets of the self-relationship, such as self-attack or self-worth was a delicate matter for the individuals involved in this research. It is crucial for practitioners and researchers to carefully consider the ethical implications of exploring these areas. Whilst acknowledging the vulnerability of clients and being attuned to their needs, it is vital to ensure that the assessment process does not cause psychological harm (BACP, 2018). Exploring sensitive topics and emotions can leave clients feeling vulnerable, making it crucial to approach such discussions with sensitivity and empathy. Prioritising client well-being and autonomy, it is imperative to respect the clients' natural inclination to self-protect, establishing a safe and trusting environment. This involves observing client confidentiality and working within their boundaries, allowing them to dictate the pace of the conversation based upon their state of readiness. Moreover, it is acknowledged that

psychotherapy clients and research participants may exhibit self-report bias, presenting themselves in a socially desirable manner (Byrne, 1996). They might offer responses they believe align with therapists' or researchers' expectations, rather than authentically expressing their sentiments regarding their self-relationship (Paulhus & Vazire, 2007).

Unlike objective measurements like blood pressure or heart rate, the subjectivity of the self-relationship arguably complicates definitive objective criteria for assessment. Researchers often rely on self-report measures, interviews, or observations, all susceptible to influences from participants' mood, memory, or cognitive biases (Paulhus & Vazire, 2007). As the self-relationship is dynamic and subject to change due to various factors, including therapy itself, measuring these changes necessitates repeated assessments, which can be resource-intensive and lead to participant attrition (Paulhus & Vazire, 2007). Cultural and contextual factors further impact an individual's self-relationship, with varying definitions of what is considered healthy or desirable across cultures and contexts (Markus & Kitayama, 1991). Developing universally applicable measurement tools becomes challenging due to these variations, and existing instruments often lack validity and reliability across different cultures and languages (Margison et al., 2000). Researchers and clinicians face difficulties in reaching a consensus on the most suitable measures for capturing the self-relationship, hindering effective comparison across studies and constructing a comprehensive understanding of the construct (Leary & Tangney, 2012).

Despite facing these challenges, on-going efforts in psychotherapy research strive to enhance the precision of methods used to measure and comprehend the self-relationship (Leary & Tangney, 2012). Whilst the SRQ will benefit from confirmatory factor analyses and subsequent work to assess its cross-cultural applicability, it is anticipated that the instrument will prove valuable and become widely accepted as a standardised measure of the self-relationship in both research and clinical settings. Advances in assessment tools, such as the on-going work to validate and refine the SRQ, along with the utilisation of mixed-methods

approaches and qualitative research, contribute significantly to overcoming these difficulties (Creswell & Creswell, 2017). These efforts show promise in offering a more comprehensive understanding of the self-relationship and the ways in which psychotherapy shapes it.

Self-Attack and Self-Affiliation as a Bipolar Construct

Central to the domain of self-psychology and bearing significant implications for mental health and well-being, self-attack and self-affiliation surfaced as contrasting poles on a spectrum of attitudes and behaviours related to the self, as unveiled by the exploratory factor analyses of the SRQ. Portraying a recurrent pattern of negative self-evaluation, self-criticism, and self-treatment, individuals prone to self-attack exhibited a tendency to be harsh and unforgiving toward themselves, particularly in instances where they perceived they had made mistakes or fallen short of their own or societal standards (Capaldi & Elliott, 2023). These inimical self-actions manifested as negative self-talk, self-blame, perfectionism, and a tendency to ruminate on past failures or shortcomings, often resulting in more severe forms of self-harm (Firestone, 2010). According to Neff (2003) and Gilbert and Irons (2005), self-attack is associated with several negative psychological outcomes, including increased levels of stress, anxiety, depression, and reduced self-esteem.

Similar to self-compassion, self-affiliation on the other hand, involved treating oneself with the same kindness, understanding, acceptance, and care that one might offer to a close friend in times of suffering or difficulty. Based on Neff's (2003) framework, self-compassion comprises three key components: self-kindness, common humanity, and mindfulness. Elements of these components were found within the variables associated with self-affiliation in the SRQ. Self-kindness encourages self-soothing and self-nurturing rather than self-criticism (SRQ - *I treat myself with love*). Common humanity recognises that suffering and imperfection are part of the human experience, fostering a sense of connectedness (SRQ - *even though I know I have some faults I am happy with myself as I am*). Mindfulness

involves observing one's thoughts and feelings without judgment (SRQ - *I am comfortable with listening to my innermost feelings*). Neff (2003) and MacBeth and Gumley (2012) have shown that self-compassion is linked to numerous positive outcomes, including greater psychological well-being, lower levels of depression and anxiety, and improved resilience.

The bipolar nature of these constructs lay in the way participants related to themselves. Where self-attack involved a critical and punitive stance toward the self, often accompanied by feelings of inadequacy and worthlessness, self-affiliation in contrast, involved a nurturing and supportive stance toward the self, fostering feelings of self-worth and acceptance. Apparent in both the quantitative and qualitative outputs of this research, it is important to note that participants often oscillated between self-attack and self-affiliation, with attitudes varying across different situations and over time. Representing opposing ways of responding to one's own suffering or imperfections, these two poles clearly emerged as an inverse measure of each other during the exploratory factor analyses conducted on the SRQ. Furthermore, a similar pattern emerged when viewing qualitatively, the apparent changes in participant self-relating, which was often in accordance with their SRQ self-report. As therapy progressed, a noticeable shift towards increased self-affiliation and decreased self-attack was observed, indicating a dynamic interplay rather than fixed progression along the spectrum. This trend suggests that an individual's responses to personal struggle are influenced by situational factors and evolve over time. The results indicated that as one attitude strengthens, the other tends to diminish. However, it is important to note that this shift appeared contextual, with participants developing greater self-affiliation in certain aspects of their experience whilst still expressing self-attack in others. This highlights the dynamic and complex nature of individuals' self-perceptions.

The effectiveness of emotion-focused therapy for social anxiety (Elliott et al., 2013) was clearly demonstrated in the SRQ measurements of self-attack and self-affiliation, and through the qualitative observations between the beginning and ending phases of therapy. While participants were initially selected based upon

having high SRQ self-attack scores at the beginning of therapy, it was noted that as measures of self-attack declined toward the end of the therapeutic process, corresponding measures of self-affiliation increased. According to Neff (2003), cultivating self-compassion through mindfulness-based interventions and therapeutic approaches proves particularly advantageous for individuals prone to self-attack. Consequently, self-attack and self-affiliation can be seen as opposing ends of a spectrum depicting how individuals relate to different aspects of themselves. Recognising and addressing these concepts through interventions aimed at promoting self-affiliation and mitigating self-attack is pivotal for mental health and personal growth, given their significant impact on psychological well-being and overall quality of life.

Self-Control as a Distinct Self-Relationship Construct

Exploring the concept of self-control holds relevance across a wide range of human behaviours. Warranting additional investigation, the weak correlations identified between self-control and other self-relationship constructs in the SRQ, as well as across various domains in other measures, suggested that self-control might signify a distinct form of self-relating. While linked to positive outcomes such as secure attachment, good adjustment, and beneficial psychological states, insufficient self-control is associated with higher occurrences of psychopathological difficulties including increased susceptibility to substance abuse and eating disorders (Tangney et al., 2004). Highlighting the importance self-regulation, Baumeister et al. (2006) observed that difficulties in one's capacity to self-regulate are central to the majority of personal and social problems affecting individuals in contemporary societies. Comprising emotional, behavioural, and impulse control issues, self-control entails the capacity to adjust one's responses, aligning them with standards such as ideals, societal expectations, morals, and values to facilitate long-term goal pursuits (Baumeister et al., 2007). While some writers alternate between the terms *self-control* and *self-regulation*, others distinguish them, viewing self-control as a more conscious and deliberate component within the broader, often

unconscious, concept of self-regulation. Consequently, self-control is recognised for its ability to intentionally override or restrain responses, creating opportunities for alternative actions. Essential for understanding one's self-relationship, an excess or deficiency in self-control is associated with diverse challenges that affect relationship dynamics, persistence and achievement outcomes.

Termed as hostile control by Capaldi and Elliott (2023), the array of difficult processes associated with self-control involved the challenges of self-monitoring and over-regulation. In the context of this research, participants grappled with the meticulous scrutiny and supervision of their own thoughts, feelings, and behaviours, leading to a heightened risk of excessive control in an attempt to conform to perceived expectations or societal norms. The overarching theme of hostile control encompassed the dynamics of self-management and the potential pitfalls that arise from an overly regulated approach to one's own actions and responses. In accordance with Baumeister et al. (2006), self-monitoring involved the on-going observation of one's thoughts, feelings, and actions, whereas over-regulation manifested when individuals excessively controlled their emotions and behaviours, often driven by fear of perceived negative outcomes. Despite the apparent difficulties associated with self-monitoring and over-regulation, finding a balance between adaptive self-control and flexibility is crucial. Although one might posit that heightened self-monitoring contributes to enhanced self-awareness, the results illustrated that it can also instigate self-critical tendencies, stemming from the stress and anxiety associated with continual self-evaluation. The apparent over-regulation evident in this group of socially anxious participants, led to emotional suppression and avoidance, resulting in rigid adherence to self-imposed rules, stifling spontaneity and authentic expression, and contributing to inner conflict. The notion of self-control potentially concealing authentic emotions is suggested to impede the development of a more genuine and harmonious self-relationship, posing a potential threat to authenticity.

In light of the empirical qualitative hostile control findings of the second study of this thesis, categories indicative of compromised authentic functioning

encompassed behaviours such as *restraining, complying or intruding*, as well as instances of *self-doubt or indecisiveness*. Delineated by Capaldi and Elliott (2023) in their earlier preliminary study, a form of hostile control emerged highlighting the harmful effects of self-restraint to meet others' demands, including obedient compliance and forcing oneself into action. This involved vigilant screening and sifting of behaviour, attempting to mimic others, conforming to perceived expectations, and reluctantly compelling oneself to act. On the other hand, self-doubt and indecisiveness represented uncertainty about oneself or experiences, marked by a perceived lack of self-awareness and confidence in decision-making. This self-handicapping aimed to control or avoid responsibility, often expressed through passive hesitancy, indicating inner conflict and fear in navigating interactions with oneself and others (Capaldi & Elliott, 2023).

While considering self-control as a distinct aspect of self-relating, it is noteworthy that the initial study in this thesis found a moderate correlation between the HEXACO conscientiousness domain and SRQ self-control. This implies a positive connection between individuals demonstrating conscientious traits—characterised by discipline and organisation—and their capacity for self-control. Tangney et al. (2004) also link self-control with conscientiousness, proposing that self-control is better understood as self-regulation, involving strategic management in alignment with objectives, priorities, and external demands. Conversely, individuals with excessive control issues, such as those with obsessive-compulsive disorder or anorexia, face challenges in directing their self-control effectively. These over-controlled individuals seem to lack the flexibility to regulate their self-control. In contrast, individuals with more adaptive self-control can easily apply or suspend it as needed. Irrespective of the conceptual framework applied to self-control, and meriting further exploration, this research underscored the discernible impact of self-control on authenticity. This influence becomes evident through the outward manifestation of incongruence, highlighting the need for additional investigation into the dynamics between self-control and the authenticity of individual responses.

The concept of self-control involves an internal governance mechanism,

where individuals exert discipline over their actions amidst conflicting desires or external pressures. This suggests that self-control can manifest in dichotomous qualities—active or reactive, adaptive or maladaptive, reflecting either benevolent self-control or hostile control. Similarly, Whelton and Henkelman (2002) discriminated between the positive and negative facets of self-critical processes, recognising their dual nature—both adaptive and maladaptive. Similar to their establishment of a link between the constructive aspects of adaptive self-criticism and the nuanced process of self-regulation, it is suggested that a comparable duality prevails in self-control, encompassing both advantageous and detrimental manifestations. To gain deeper insights into self-control in its positive and negative forms, it is essential to consider it within the broader context of the self-relationship. In navigating the complexities of self-control within self-relating, individuals may benefit from cultivating mindful awareness of their internal processes, acknowledging the need for control without succumbing to over-regulation. This perspective can shed light on how individuals navigate their internal landscape, make choices, and foster a sense of agency and autonomy. Striving for a balanced and compassionate approach to self-control promotes a healthier and more harmonious connection with oneself.

Persistent Self-Doubt and Cultivating Greater Self-Awareness

Observed following the NTS end-of-therapy study, a notable outcome of this investigation bearing implications for theory and future research was the prevalent stability or increase in *self-doubt or indecisiveness* of the *hostile control* domain. Emphasising the persistent nature of self-doubt, especially regarding comprehension, experiencing, and ability (see Table 42), the findings revealed that clients often struggle with uncertainty when trying to make sense of their lived experiences. This unexpected observation in the later stages of the therapeutic process underscored the importance of addressing self-doubt in psychotherapy. It became evident that participants grappled with self-doubt, a factor that could

profoundly affect their therapeutic journey and overall well-being, potentially shaping their emotional experiences, authenticity, and self-knowledge.

Table 42: Extract from Supplemental Table 7 – Self-Doubt or Indecisiveness: Categories and Frequencies

Domains, Subdomains, Categories & Subcategories		*Tx* Beg.	*Tx* End	*Tx* Total	*f* End
C.	**Self-Damaging Activities - Activating Self-Damaging Modes (What I Do That Is Bad For Me)**				
C.2.	***Hostile Control***				
C.2.4.	Self-Doubt or Indecisiveness:				
C.2.4.1.	I'm Unsure How To Comprehend or Make Sense of It	12	12	24	*T*
C.2.4.2.	I'm Unsure What I'm Experiencing	4	26	30	*T*
C.2.4.3.	I'm Unsure If I Can Do It	1	1	2	*U*
		17	39	56	

Note: T = Typical, U = Unique.

This prevalence of self-doubt and uncertainty, indicative of a lack of self-awareness and self-knowledge, was not only discernible in the findings of the second and third studies of this thesis, but is also a common observation in my clinical practice. These phenomena pose challenges to effectively capturing and measuring the self-relationship as all of the concepts under the umbrella of self involve the ability to self-reflect, thus residing '*at the heart of what it means to have a self*' (Leary & Tangney, 2012, p.1). According to Shahar (2015), these wavering and indecisive experiences are often mistakenly viewed as being in direct contrast to authentic and congruent functioning, warranting further investigation and debate. Challenging conventional definitions and interpretations of authentic and congruent functioning, Shahar (2015) proposed a connection between self-authenticity and susceptibility to self-criticism. Conversely, Stephen (2023) likened the frustration and self-doubt of the therapist to '*an expression of painful self-awareness*' (p. 16), indicative of profound introspection that could impact their self-acceptance and, thereby, their genuineness. Regardless of how we conceptualise the construct, results indicated that client self-doubt and ambivalence leading to

indecision could be stubborn, hindering their ability to understand and make sense of their cognition, experiences, emotions, or abilities. Although therapy provided a safe and supportive environment for clients to explore their experiences, identify patterns, and gain insight into their thoughts and feelings, this process of self-discovery, evidenced by positive outcomes at the end of therapy, did not appear to mitigate participants' frequencies of self-doubt or indecisiveness.

Influenced by the fear of judgment or rejection when expressing one's congruent self, research suggests that authenticity is closely linked to self-esteem and psychological well-being (Wood et al., 2008). Frequently intertwined with low self-esteem (McKay & Fanning, 2016), addressing the roots of self-doubt and working towards building self-esteem allows clients to challenge negative self-beliefs, cultivate a more positive self-image, and experience increased self-confidence and self-assuredness. While one might argue that attending to self-doubt in therapy promotes greater authenticity, it is anticipated that these are overlapping yet distinct aspects of the human experience. Although addressing self-doubt may involve creating a non-judgmental and accepting space where clients feel safe to be genuine and authentic, it is argued that a person can be authentic and congruent in their self-doubt and indecisiveness. While a lack of authenticity may impact a client's willingness to display confidence, certainty, and conviction in their discourse, it is anticipated that self-doubt and indecisiveness reach far beyond authentic and congruent functioning. In fact, if congruence is understood as being genuine in one's experiencing at any given moment, one might view self-doubt and indecisiveness as a congruent processes.

Drawing on Rogers' (1961) perspective on the experiencing self, where aspects of a person's experience may sharply contradict their self-concept, it becomes easier to comprehend self-doubt. According to Rogers, individuals may encounter feelings and experiences that do not align with their self-concept, resulting in a sense of detachment from a portion of their own experiencing. This dissonance may cause individuals to see themselves as embodying several distinct selves filled with many contradictions. Rogers' theory provides a convincing

explanation for persistent self-doubt, proposing that recognising one's incongruence may lead to the realisation, '*I was sure that I could not be my experience – it was too contradictory*' (p. 77). This insight supports the potential for acknowledging, accepting, and integrating all aspects of the self, suggesting the possibility of a transformative shift from fragmentation and uncertainty to a state of wholeness and acceptance. Moreover, the conceptual frameworks of multiplicity (Elliott et al., 2004; Greenberg et al., 1993) and configurations of self (Mearns & Thorne, 2000) further highlight the dynamic and multifaceted nature of the self-relationship. These frameworks suggest that individuals harbour multiple self-representations varying across different contexts and relationships. This notion supports the idea that self-doubt may arise when these configurations clash or struggle to integrate seamlessly, leading to uncertainty about one's identity or sense of self. Whilst these interpretations may position self-doubt as a consequence of incongruence or the misalignment between different aspects of self, the enduring presence of self-doubt and its escalation at the conclusion of successful therapy suggests that, although it may be rooted in incongruence, it is also intricately linked to the process of developing self-awareness. Despite these insights, and notwithstanding the continued prevalence of self-doubt at the conclusion of therapy, its persistence or escalation did not appear to undermine the positive outcomes of the therapeutic process or the development of the client's self-awareness. Hence, it is suggested that self-doubt may manifest in both adaptive and maladaptive forms, implying a nuanced comprehension of its psychological implications. Future research exploring the intricacies of self-doubt and the cultivation of self-awareness in psychotherapy has the potential to enrich our understanding of the construct, its evolution, and its influence on the therapeutic process, while also contributing to the development of self-knowledge.

Navigating Self-Neglect: Strategies for Awareness and Prevention

Capaldi and Elliott (2023) delineated self-neglect within the framework of hostile neglect, characterising it as a psychological and behavioural phenomenon

wherein an individual consistently exhibits a pattern of downplaying, negating, or evading their own emotional and physical needs, often resulting in a profound sense of self-abandonment. This type of neglect entails a persistent disregard for personal well-being, a proclivity to acquiesce to or validate negative reactions from both oneself and others, and a tendency to perceive oneself as unworthy of positive responses from the external environment. Furthermore, self-neglect may arise as a response to feelings of abandonment and unworthiness, leading to a state of emotional overwhelm where intense emotions make it increasingly difficult for the individual to effectively address their own needs.

The results from the second and third studies of this thesis emphasised the crucial importance of identifying and addressing disparities within one's self-relationship, particularly in the context of self-neglect—an issue that has often been overlooked in existing literature (Capaldi & Elliott, 2023). Detecting, measuring, and intervening in self-neglect presents significant challenges due to its implicit, undifferentiated, or insufficiently symbolised aspects of the self (Elliott et al., 2004). Furthermore, in contemplating my extensive clinical experience, I have consistently noticed that individuals seeking therapy tend to avoid delving into or demonstrating awareness of the facets of themselves and their lives that they neglect. Conversations about personal needs and desires are often met with a vacant expression of bewilderment or uncertainty, frequently culminating in the ubiquitous response of '*I don't know*'. Highlighting the complexities inherent in self-knowledge, this pattern underscores the pervasive difficulty individuals face in recognising and articulating overlooked facets of their well-being, accentuating the elusive nature of self-neglect within the therapeutic context. Consequently, there is a pressing need for further research and the refinement of humanistic-experiential theory concerning self-neglect, as it holds the potential to provide valuable insights and strategies for addressing this complex issue.

Similar to earlier discussions on persistent self-doubt, individuals navigating the internal turbulence of negative self-treatment often find themselves entangled in a paradoxical interplay—simultaneously employing strategies of NTS and

grappling with the ensuing impact and subsequent suffering. Remarkably, this dynamic tends to unfold without individuals being fully conscious of it, primarily due to the discrepant and conflicting dimensions of their self-relationship. Acting as a gateway to the overlooked facets of the self, the resulting gap in self-awareness gives rise to conflicts between the more abstract, externally influenced self-concept and immediate, in-the-moment feelings and experiences. This void in self-awareness, echoing the challenges previously explored regarding self-knowledge and uncertainty, is proposed as a pivotal factor. It is suggested that the key to addressing not only self-neglect but also uncovering other suppressed elements of one's identity may reside within the chasm between these conflicting aspects of the self (Capaldi & Elliott, 2023). By skilfully navigating this complex terrain of internal contradictions, individuals have the potential to unearth profound insights into their self-relationship, thereby paving the way toward a more integrated and harmonious sense of self. This exploration may lead to a deeper understanding of the self, fostering personal growth and resilience in the face of internal conflicts.

While many forms of hostile neglect dissipated by the end of therapy, several persisted, particularly in challenges such as identifying one's emotions or their origins, articulating or expressing these emotions, engaging in negative self-evaluations of one's feelings, adopting avoidance or minimising strategies, placing excessive importance on others' opinions, withdrawing from life, and feeling uncertain about personal desires and needs. Understanding the complexities of self-neglect and its roots is vital, as it involves inadvertently disregarding one's emotions, desires, and needs. Recognising the multifaceted nature of self-neglect is essential for crafting effective strategies that bolster individual well-being and contribute to broader mental health initiatives. This heightened awareness can be pivotal in addressing and alleviating individuals' struggles with meeting fundamental needs, such as maintaining personal hygiene and health (Dong, 2017). Consequently, this issue emerges as a significant public health concern, particularly within vulnerable populations like the elderly and those contending with mental health challenges. Lauder et al. (2005) underscored the frequent co-occurrence of

self-neglect with mental health issues such as depression, anxiety, and cognitive impairment—a correlation supported by this research. This emphasises the imperative for future research to thoroughly examine the interplay between mental health challenges and self-neglect, prioritising the development of interventions that tackle both aspects while acknowledging the significance of culturally sensitive detection methods (Dong, 2017). The research agenda should involve improving methods for assessing self-neglect, actively engaging individuals in the recognition and treatment process, and ensuring their overall safety. Beyond the individual, self-neglect places a significant burden on caregivers, family members, and healthcare providers. Research plays a crucial role in shedding light on the ethical challenges inherent in intervening in cases of self-neglect, particularly when individuals lack awareness or resist receiving assistance. Given these complexities, there is an urgent call for researchers, clinicians, and public health officials to investigate the prevalence, risk factors, and consequences of self-neglect. This knowledge is indispensable for crafting targeted interventions aimed at addressing and mitigating its associated challenges (Dong, 2017). A comprehensive grasp of its multifaceted nature empowers stakeholders to effectively collaborate in enhancing the well-being and mental health support for affected individuals. Collaboration plays a pivotal role in bridging gaps in understanding and prevention, highlighting the necessity for interdisciplinary efforts.

Antidote to NTS: Self-Affiliation and Acceptance

The decline in instances of NTS observed across each domain at the end of therapy appeared to align with Rogers' (1959) theory, which posited that a reduction in self-discrepancy acts as a catalyst for change, signalling greater self-acceptance. This concept harmonises with Neff's (2016) exploration of self-compassion, characterised as a delicate equilibrium between affirmative and adverse self-responses in the face of personal adversity. Neff encapsulated the idea of self-acceptance by emphasising the importance of cultivating self-compassion and reducing harsh self-judgment, as evidenced in the end of therapy discourse.

Aligning with the conceptualisation of self-attack and self-affiliation as a bipolar construct, the findings illustrated a decrease in NTS, accompanied by a concurrent rise in self-affiliating narratives. This alignment substantiates the notion of self-acceptance as a pivotal catalyst in the therapeutic process.

In his emotional processing model, Pascual-Leone (2018) delineated a developmental shift from overall distress to acceptance and agency. This transformative process involved addressing maladaptive emotions in a manner that facilitated the expression of negative self-evaluations and unmet needs, thereby fostering the recognition of these needs and a progression towards resolution. Highlighting the crucial role of self-acceptance as a central element in alleviating negative self-treatment within the therapeutic process not only aligns with person-centred theory but also resonates with the principles of emotion-focused therapy. Furthermore, this emphasis converges with broader research domains such as self-compassion (Neff, 2003; MacBeth & Gumley, 2012) and emotional transformation (Pascual-Leone, 2018; Pascual-Leone et al., 2016; Greenberg & Pascual-Leone, 2006), underscoring the interconnectedness of these approaches in promoting emotional well-being and growth.

An Integrative Summary: Definition of Negative Treatment of Self

Having previously delineated the definition of NTS as part of the preliminary rational-empirical study (Capaldi & Elliott, 2023), which was summarised in Chapter 1.2, this section presents a more refined definition that integrates recent empirical elaborations to the model.

Negative Treatment of Self (NTS): Understood as a synergistic activity encompassing the dimensions of the objects and directness of NTS, modes or inimical self-actions, and their preceding or reactional emotional effects. These domains, identified through analysis, operate as a cyclical and interconnected system, creating challenges and hindering personal goals. Each variable within this system contained a self-sabotaging aspect that directly influenced and perpetuated the others.

Objects and Directness of NTS: Manifesting in various forms and intensities, individuals perceived aspects of themselves as flawed in terms of identity, actions, or possessions. This perception led to a preoccupation with how others might perceive or judge these perceived flaws and how one could attain an acceptable or worthy sense of self. Expressions of self-dislike or self-criticism manifested through inflated demands and idealistic expectations, coupled with a tendency toward belligerent self-derogation, abasement, or rejection when these standards were unmet. Strategies for enacting self-dislike or self-criticism included direct (through oneself) or indirect (through others) actions, impacting both behaviour and emotional states. These strategies often led to the adoption of seemingly protective avoidance strategies that, while intended to shield, proved ultimately detrimental.

Modes of NTS: Appearing as either self-critical process or inimical self-actions, modes of NTS functioned as observable behavioural reactions or enactments stemming from NTS. Exhibiting varying forms and intensities, these actions—whether conscious or unconscious—were obstructive or harmful to oneself, manifesting as self-attacking, distancing, controlling, or neglectful behaviours. These behavioural reactions had adverse effects on emotional experiencing, perpetuating the self-critical process. Strategies for implementing these behavioural reactions included direct actions through oneself or indirect actions through others.

Emotional Effects of NTS: Invoking bodily feelings and sensations activated by the impact or enactment of NTS actions, emotional effects negatively influenced an individual's homeostasis or experiencing. This, in turn, sustained pessimistic thinking and detrimental behaviours, causing various forms of emotional pain.

Adapted from Capaldi and Elliott (2023, p.116).

In summary, NTS constitutes a complex and interrelated process involving objects or *what I dislike about myself*, directness or *how I dislike myself*, inimical self-actions or *what I do that is bad for me*, and emotional effects or *what I feel*

preceding or in reaction to my self-dislike and inimical self-actions. Recognising the cyclical nature of these dimensions is crucial for understanding how they collectively contribute to personal challenges and hinder progress toward individual goals. This comprehensive perspective underscores the importance of addressing and interrupting this self-sabotaging cycle for improved psychological well-being and personal growth. Considering the cyclical and interconnected patterns of NTS, future research directions might consider what triggers or initiates the NTS cycle, such as specific events, thoughts, or situations, and how it intensifies and is maintained over time. Additionally, it feels important to further identify strategies or interventions that can break the cycle or reduce the intensity of negative self-treatment alongside examining its consequences on overall well-being, relationships, and functioning.

Relevance of Pluralism in Psychotherapy Research

Incorporating multiple and occasionally conflicting observations and interpretations, this series of studies underscored the significance of methodological pluralism in psychotherapy research (Klein & Elliott, 2006; Smith et al., 2021). The findings aligned with Levitt et al. (2020), who asserted that diverse perspectives from various sources can support a dialectical process, leading to greater differentiation or synthesis. Similarly, Smith et al. (2021) proposed that both convergent and divergent findings should be considered equally valuable, arguing that having multiple answers to a research question enhances the relevance of the findings. The nuanced and contradictory relationship observed among self-criticism, anger, and shame emphasised the importance of methodological diversity. While quantitative findings revealed decreased self-criticism and anger but increased shame, qualitative results showed increased assertive anger and decreased shame. Highlighting the complexity of varied observations, examining self-relationship and NTS research across diverse paradigms validated insights from multiple perspectives. As highlighted by Smith et al. (2021), the acknowledgment of '*multiple truths is not only a core philosophical assumption of pluralism*' (p.5), but is

also a commonplace element of psychotherapy practice, wherein a significant portion of the therapeutic process revolves around the dialectic between the perspectives of client and therapist. Leveraging varied observations from client quantitative self-report instruments and in-session qualitative narratives, enriched the knowledge base of self-relating and NTS, enabling exploration of different facets including their mechanisms and outcomes. The findings indicated a correlation between the reductions in self-attack and the heightened self-affiliation reported by participants' SRQ scores across the duration of therapy (see Appendix E - Outcome Case Summaries). This alignment mirrored the evident decrease in NTS discourse observed in the qualitative findings of the final study of this thesis. Moreover, the medium effect sizes derived from McNemar's quantitative test of significance largely corroborated the qualitative observations and clients' self-reports.

Research guided by pluralism directly benefits clinical practice by promoting the exploration of diverse therapeutic options, fostering personalised and effective treatment plans for clients (Norcross & Lambert, 2018), while recognising the strengths and limitations of various research methods and therapeutic approaches. For example, the psychometric study's three-factor solution for the SRQ validated the hypothesis that self-attack and self-affiliation operates on a continuum, functioning as inversely related measures. Participant SRQ scores supported this association, alongside the observed decrease in end of therapy NTS discourse descriptors. Nonetheless, it remained pertinent to maintain separate items and scoring systems for self-affiliation and self-attack. Despite their conceptual intertwining, subsequent studies indicated that these components represent qualitatively distinct concepts. Embracing multiple approaches and techniques offered a broader toolkit, leading to more effective and responsive strategies (Lebow, 2014). Pluralism in research fosters innovation through the exploration of new techniques and theories, potentially leading to the discovery of more effective treatments (Norcross & Goldfried, 2005). It also counters dogmatism in psychotherapy by promoting receptivity to new ideas and empirical evidence, facilitating on-going critical evaluation of approaches (Hubble et al., 1999).

Contributing to the evolution of theories and practices, pluralism recognises the importance of cultural and contextual factors, enhancing therapists' cultural competence and the relevance of interventions (Smith et al., 2011).

The incorporation of pluralism in this series of studies has played a crucial role in advancing our comprehension of the self-relationship and NTS. Insights garnered from these findings have reinforced its capacity to enhance clinical practice and improve client outcomes. By embracing diversity in theoretical orientations, methodologies, and cultural considerations, researchers and practitioners can jointly strive to cultivate a more holistic understanding of psychotherapy. This collaborative effort supports the provision of mental health services that are not only more effective but also inclusive.

Constraints, Consequences, and Future Directions

This research established a robust foundation for on-going exploration and advancement in the realm of self-relationship and negative self-treatment, highlighting challenges and promising future avenues. Despite significant contributions to measuring and understanding the self-relationship, particularly NTS, the projects were not without limitations. Positioned between the initial psychometric and subsequent qualitative studies, several constraints surfaced, offering valuable insights for future research on the measurement of the self-relationship and the field of NTS. It is important to acknowledge that the researchers conducting data collection and analysis for each study in this thesis were deeply committed to emotion-focused therapy, potentially influencing the outcomes. If different researchers had approached the data from alternative perspectives, diverse conclusions might have been influenced by theoretical orientations, methodologies, and contextual factors, contributing to potential variations in data interpretation. Moreover, therapy sessions in this study, conducted by EFT-trained therapists in a research clinic setting, may have shaped the therapeutic discourse and content. Factors like fear of failure or the research environment could have affected both therapy effectiveness and topics related to

the self-relationship. These studies relied on archival data from the research clinic, presenting inherent limitations such as missing data. The availability of complete datasets varied amongst clients, impacting the analyses conducted in the studies. This highlighted the challenges of gathering data for secondary use, particularly when the immediate needs of vulnerable clients take precedence over data collection. The findings of these studies may have limited generalisability due to the specific context in which the research was conducted. As the data came from UK-based clients, accessing counselling at a university research clinic with free service at the point of delivery, various cultural and socioeconomic factors may influence the applicability of the findings to other populations or settings. The qualitative approach utilised in the second and third studies prioritised transferability over generalisability, whereby purposeful sampling selected participants based on high pre-therapy SRQ self-attack scores and significant improvement post-therapy. While this approach enriched depth, it may have limited applicability beyond the sample. Despite this limitation, the qualitative studies provided insights into NTS processes and mechanisms, enriching the preliminary theoretical framework. Although findings may not universally apply, they offer value in specific contexts or groups, capturing the intricacies of human experiences.

Testing and Validating the SRQ - Limitations and Future Directions

One of the primary challenges encountered during the testing and validation of the SRQ was related to the collection of participant nonclinical data. The study faced issues with participant attrition, partly attributed to response fatigue, likely stemming from the initial extensive 247-item survey. Necessitating strategies to boost participant commitment to follow-up assessments, the attrition observed in the first phase seemed to influence motivation for the second retest phase, potentially contributing to the low uptake rates. Future research should consider utilising a shorter questionnaire to mitigate dropout rates and ensure increased participant engagement. Another concern pertained to the significant sample size disparity between the nonclinical test and retest datasets, as well as between the nonclinical and clinical samples. While the study's sample sizes were adequate for

robust analyses, additional confirmatory factor and reliability studies are essential to validate the revised 26-item version of the SRQ. Continuing efforts to rigorously test the SRQ instrument will fortify its generalisability and robustness across diverse contexts and client populations, necessitating validation of the newly crafted instrument with freshly collected data. Furthermore, assessing convergent validity by comparing the revised SRQ domains with analogous measures will enrich comprehension of the multifaceted constructs shaping the self-relationship.

The reliability and validity analyses of the SRQ did not account for the influence of cross-cultural and gender differences. Variations in self-understanding arise from societal norms, cultural values, and personal experiences, impacting perceptions and relationships (Markus & Kitayama, 1991). Gender roles influence self-expression, revealing gender-specific variations in self-doubt and self-affiliation (Eagly & Wood, 2012). Ethnicity shapes self-perception through cultural norms such as collectivism, impacting self-construal and interactions (Oyserman et al., 2002). Cultural background, encompassing language and religion, interacts with ethnicity to shape self-identity and behaviours (Berry, 2003). As a result, research outcomes on the self vary across cultural contexts (Markus & Kitayama, 1991). Considering such distinctions in self-relationship constructs, future research should delve deeper into these disparities to explore how gender, ethnicity, and cultural background may impact self-relationship patterns. This is crucial for enhancing the instrument's cross-cultural validity and applicability, encompassing diverse demographic factors to address potential variations in self-relationship constructs. Further considering cultural differences and aligning with Benjamin's (1996) SASB circumplex model, a potential avenue for further inquiry involves developing a self-relationship instrument that distinguishes between self-to-self and self in relation to other interpersonal dynamics.

The clinical sample consisted exclusively of individuals with social phobia undergoing emotion-focused therapy for social anxiety, potentially limiting the generalisability of results to other clinical populations. While earlier discussions on the self-relationship of individuals with SA highlighted shared characteristics with

depression and eating disorders, such as negative self-perceptions and avoidance behaviours, distinctive features of social phobia presentations include an intense fear of social evaluation and avoidance of social situations, particularly those involving unfamiliar people or performance. Understanding such disparities between clinical presentations and their impact on the self-relationship and its measurement is crucial for developing more refined instruments and interventions. For example, although the data indicated a significant overlap between social anxiety and depression, it is possible that depressed individuals do not exhibit the same level of self-monitoring and control as those with SA or eating difficulties. Subsequent studies should therefore explore SRQ scores among diverse client groups to refine cut-off values applicable across various clinical settings. The SRQ's applicability has primarily been explored within EFT. Future research should compare different therapeutic modalities to assess the instrument's transferability and effectiveness. Expanding SRQ application across various therapies can determine if results hold within a broader framework of self-relating. Examining NTS in modalities with distinct experiential processing approaches could yield valuable insights. Broader research involving extreme populations, such as those struggling with severe substance abuse problems or active psychotic conditions, can shed light on how NTS functions in challenging therapeutic contexts. Lastly, the study used classical test theory (CTT) for reliability and validity analyses. While this approach provided preliminary data and suggestions for improving the instrument's reliability, further testing in relevant populations is recommended. Future studies should consider using Rasch analysis on both nonclinical and clinical data to examine item fit, scale structure, and rating functioning, thereby enhancing the instrument's validity. Addressing these limitations through future research will enhance the instrument's utility and expand its clinical applicability.

Developing the Empirical Model of NTS - Limitations and Future Directions

This thesis enhances our understanding of negative treatment of self by developing a detailed taxonomy that encapsulates its cognitive, behavioural, and affective dimensions. By capturing the complexity of negative self-treatment, the

empirical model proved relevant across both the initial and final stages of therapy data, with NTS appearing less prevalent in the latter stages of the therapeutic process. The framework offers a comprehensive classification of NTS, highlighting its interconnectedness and cyclical nature, providing a model that practitioners and researchers can use to better understand, assess, and intervene in cases of negative self-treatment.

Challenges in Developing the NTS Empirical Model: The development of the taxonomy posed significant challenges due to the subjective nature of identifying, interpreting, and categorising NTS phenomena. Despite efforts to adhere closely to participant narratives, distinguishing between NTS objects and behavioural modes often proved difficult, potentially leading to evolving labels and categories in future analyses.

Furthermore, the model, which was derived from data on socially anxious clients, may not fully capture other clinical presentations. While overlaps with constructs such as the inner critic, depression, and eating disorders were noted, further research is necessary to explore its applicability to diverse client populations and therapeutic modalities.

Although saturation was suggested by the emergence of few new categories in the latter stages of therapy, additional research could refine and expand the model. The current NTS taxonomy is therefore tentative and likely to evolve with further investigation.

Methodological and Sampling Considerations: The sampling strategy utilised in Studies 2 and 3 introduced certain limitations, which may have influenced the outcomes and the generalisability of the findings. Data collection focused on two distinct points in therapy—the beginning and end—thereby overlooking the evolution of NTS within individual sessions. Furthermore, the sampling targeted extreme cases, selecting participants who showed high levels of self-attack at therapy onset and substantial reductions by its conclusion. While this approach aided the refinement of NTS categories, it may limit the applicability of findings to clients with more balanced therapeutic trajectories.

The small sample size—six clients observed at two moments, yielding 12 data points—further constrained the study's generalisability. This limited sample supports a process-outcome correlational approach but does not establish causality between NTS and therapeutic outcomes. The complexity of self-relationship dynamics and change processes during therapy makes establishing causal links particularly challenging.

Future research should address these limitations by examining NTS manifestations on a session-by-session basis, capturing its dynamic evolution. Larger sample sizes could provide deeper insights into individual differences and their interaction with variables such as culture, gender, and age. Additionally, investigating the relationship between therapist interventions and transitions in NTS could illuminate therapeutic strategies that facilitate more productive processing of negative self-treatment.

Directions for Future Research: The initial psychometric study of the Self-Relationship Questionnaire suggested an inverse relationship between self-attack and self-affiliation. Observations in Studies 2 and 3 also supported this bipolar connection, with reductions in NTS often coinciding with the emergence of self-affiliating narratives. Future studies should examine self-affiliation in conjunction with self-dislike and inimical self-actions to provide a richer understanding of NTS. Combining self-report measures with implicit assessments and diversifying methodologies could further elucidate the various presentations of NTS. Additionally, developing a standardised taxonomy of NTS manifestations would enhance objectivity in both research and clinical practice.

Ethical and Methodological Challenges of Dual Roles: As outlined on page 172, serving as both tutor and researcher introduced methodological and ethical complexities. Tutor-to-researcher bias was a key concern, as my research aims could have inadvertently influenced the MSc students' analyses. To mitigate this, I ensured that their analyses were independent, based on distinct client cases, and reflective of each student's unique perspective. Subsequently, I conducted an independent reanalysis of all client cases to strengthen validity and confirm the

originality of my contributions, ensuring they were distinct from the student analyses.

Conversely, researcher-to-tutor bias presented challenges during dissertation grading, as familiarity with the students' work might have compromised assessment objectivity. Adhering to clear marking criteria, implementing second marking practices, and following objective standards minimised this risk. Ethical considerations also included avoiding the exploitation of student work. While their analyses informed initial data familiarisation and reduced transcription workloads, my final research synthesis and cross-case analysis were conducted independently to ensure originality.

Oversight from my research supervisor, a highly experienced academic, further safeguarded the integrity of the studies. Nevertheless, future research would benefit from clearer delineation of tutor and researcher roles to minimise potential conflicts of interest.

Influence of Therapist Expertise: Variations in therapist experience across the studies presented methodological challenges that likely influenced the therapeutic outcomes. As noted on page 173 and detailed in Appendix O, therapist expertise varied significantly, ranging from the co-developer of EFT, with 38 years of clinical experience, to less experienced practitioners, who had completed only Levels I and II training and had 1.5 to 3 years of practice.

This disparity in experience influenced the delivery of therapy, as the co-developer's advanced proficiency likely enabled more nuanced interventions and deeper emotional processing compared to the less experienced therapists. Although the co-developer supervised the less experienced practitioners, this could not fully offset differences in skill or familiarity with EFT principles. These variations, combined with an unequal distribution of client caseloads, may have had a disproportionate impact on outcomes, with the co-developer's clients showing more marked progress.

Despite observed improvements across all clients, the findings may not fully reflect EFT outcomes when delivered by less experienced therapists. Future

research should examine the impact of therapist expertise on client outcomes and investigate how training and experience affect the application of EFT. Such insights could inform the development of standards for therapist training and supervision, ensuring consistent effectiveness across varying levels of experience.

Methodological Challenges in Identifying NTS: As outlined on pages 176-177, the study's reliance on EFT task markers, such as the two-chair dialogue, to identify instances of NTS revealed several limitations. Prioritising high-intensity moments of self-attack risked overlooking subtler, recurrent patterns of negative self-treatment, potentially underrepresenting key aspects of the clients' experiences.

Furthermore, the dependence on structured task markers introduced a degree of selection bias, restricting the applicability of the findings to therapeutic modalities that do not employ such interventions. The segmented approach also risked losing contextual continuity by excluding preceding or subsequent exchanges, which might have been crucial for understanding client progress.

The study's focus on EFT, particularly the two-chair dialogue for conflict splits tasks, may not accurately reflect levels of engagement in other therapeutic approaches, thereby influencing NTS process structures. As a result, the findings are limited to this modality, and their applicability to other therapeutic approaches remains speculative. Additionally, individual differences, such as personality traits or comfort with emotional expression, contributed to variability in responses to these markers.

To mitigate these limitations, future research should adopt broader sampling methods that include both high- and low-intensity moments across therapeutic sessions. Investigating NTS without exclusive reliance on task markers would improve the generalisability of findings and offer a more comprehensive understanding of self-treatment across diverse therapeutic contexts.

Conclusion: This thesis has contributed to the understanding of negative self-treatment through the development of a detailed taxonomy that captures its key dimensions. While the model is a valuable starting point, further refinement

and broader applicability studies are required. The methodological limitations, including the reliance on EFT task markers, small sample size, and the correlational methodology, highlight the need for future research to explore NTS more comprehensively. Future studies should focus on refining sampling methods, exploring therapist expertise, and investigating the dynamics between self-attack and self-affiliation, paving the way for improved research and clinical practices.

Implications for Practice

The revised self-relationship questionnaire and empirical model of negative treatment of self have demonstrated significant potential for research, clinical practice, and therapist training. Delving into how the use of the SRQ and NTS model as practice and training instruments affects therapists' engagement in the therapeutic process presents an intriguing avenue. Gathering feedback from therapists who learn the model, continue to employ the questionnaire, and respond to NTS processes can contribute to their on-going development and refinement.

Revised SRQ: The findings of the study implied that the revised self-relationship questionnaire stands as a valuable tool for evaluating shifts in the self-relationship, showcasing stability in application across both normative and distressed groups while maintaining reliability and validity. The instrument proved its efficacy in assessing the impact of humanistic-experiential therapy, meeting robust psychometric standards and incorporating clinical cut-off and reliable change indices. Its discernment of variations in psychological distress highlighted its potential applicability in both clinical practice and research.

The SRQ provides a snapshot of an individual's present thoughts, feelings, and behaviour towards themselves, fostering self-reflection. This introspection can elevate self-awareness and assist in delineating therapeutic goals, particularly in addressing negative self-treatment. However, individuals might encounter challenges in accurately assessing themselves and their negative emotions due to unconscious behaviours, repression, denial, or distortion. To reduce potential biases in SRQ self-reporting, incorporating a mixed-methods approach that includes

clinical observations and analysis of in-session narratives could improve its effectiveness. Nevertheless, the SRQ stands as a valuable tool to assess an individual's progression from rigidity and external focus to increased internal fluency and self-affiliation, aligning with Rogers' (1961) concept of the individual's movement towards being fully functioning.

Although validated using EFT-SA data, the universal nature of the self-relationship implies that the SRQ is an adaptable instrument, potentially relevant across diverse presenting issues and therapeutic modalities. While further research is needed, it is argued that this measure of self-relating is not confined to emotion-focused therapy or social anxiety, offering potential suitability for broader adoption in clinical settings. The study, whilst emphasising the relevance of the SRQ in the context of social anxiety, identified similarities with research findings for individuals experiencing depression. Both client groups often exhibit high levels of harshly punitive self-attack (Elliott & Shahar, 2019; Elliott et al., 2004), which can be ameliorated through therapeutic interventions. Fluctuations in self-affiliation and self-attack, as measured by the SRQ, may offer insights into the severity and improvement of these difficulties. Furthermore, given the comorbidity of anxiety and depression with various clinical presentations, the SRQ appears to have broad clinical applicability.

Initially conceived as a more accessible alternative to Benjamin's (1996) SASB model, the SRQ has undergone refinement, transforming into a robust tool suitable for wider clinical applications. This study has played a crucial role in refining the instrument, contributing to the understanding and measurement of key aspects of the self-relationship, thereby solidifying its relevance in both clinical practice and research. The findings suggest that therapists and researchers should adopt an informed approach to measurement, acknowledging both its strengths and limitations. Measurement data ought to be perceived as a snapshot of progress, guiding reflective practice and contributing to the enhancement of client outcomes.

Empirical Model of NTS: This research represents a substantial contribution

to our understanding of negative treatment of self, extending beyond the existing literature on self-criticism, perfectionism, and self-efficacy (Whelton et al., 2007; Powers et al., 2011; Shahar, 2015). Taking a broader view of the conventional concept of the inner critic (Stinckens et al., 2002a; 2002b; 2013a; 2013b), self-criticism was identified as part of a broader spectrum of harmful self-actions, offering insights into the complexities and manifestations of inner conflict and struggle. Providing a deeper understanding of NTS dynamics and enhancing our knowledge of problematic self-relationships, this study significantly refined the preliminary rational-empirical model (Capaldi & Elliott, 2023). It illuminated the complex interplay between self-dislike, inimical self-actions, and their emotional effects, thereby carrying practical implications for recognising and measuring problematic self-presentations in both clinical practice and research.

The NTS studies suggest significant potential for improving therapy by integrating the empirical NTS model with client self-reporting, broadening awareness of the various forms and expressions of negative self-treatment. The empirical model of NTS serves as a valuable tool for training clinicians, enhancing their ability to identify and address negative self-treatment processes during psychotherapy. This model provides a refined vocabulary that aids in recognising and focusing on specific NTS processes as they emerge in therapy sessions, thereby assisting practitioners and clients in expressing and navigating these experiences more effectively. Moreover, the model supports empathic awareness of negative self-treatment, enabling therapists to closely monitor clients' NTS experiences as they unfold, and to engage with them productively.

The empirical evidence suggests that the NTS model's relevance extends beyond specific issues or diagnoses, indicating its potential applicability across diverse therapeutic contexts. It may offer valuable insights into a client's pattern of self-relationship, irrespective of their presenting difficulties. Whilst the study focused on negative self-treatment in socially anxious clients and demonstrated overlap with other clinical issues, it underscored the importance of further research across various client presentations. This would not only refine the model but also

bring attention to specific activities or strategies more common in certain clinical contexts. The diverse dynamics of NTS emphasises the need for flexible and adaptable therapeutic approaches that prioritise effective emotional processing. Just as successful therapy requires therapists to engage with the critic in all its manifestations (Stinckens et al., 2013b), the same holds true for addressing all forms of negative self-treatment.

Representing a pioneering effort in exploring the broader self-relationship concept of negative self-treatment, this research delved into the intricate workings of NTS, uncovering a myriad of harmful self-relating strategies, both overt and subtle. Executed internally or externally, these NTS processes were identified as contributors to significant psychological distress. Understanding the nuances of this complexity can help therapists better recognise and address various forms of negative self-treatment, thereby enhancing the effectiveness of therapeutic interventions. This investigation underscored the multifaceted nature of the self, with various problematic voices or self-aspects emerging within clients' lives and narratives (Cooper, 1999; Elliott & Greenberg, 1997).

Examining the intensity of negative self-treatment indicators, particularly when comparing the initial and later stages of therapy, demonstrated the potential to effectively track client change. This not only provided an enhanced ability to monitor client progress but also allowed for the tailoring of interventions based on their NTS narratives, ultimately supporting more effective therapeutic outcomes. The study emphasised the significance of recognising and addressing self-sabotaging patterns as a pathway toward greater self-affiliation, fostering self-awareness and enabling various facets of the self to emerge more freely. In supporting healing and transformation, the empirical model of NTS has the capacity to facilitate self-discovery and liberation from self-imposed oppression.

Conclusion: The SRQ instrument and NTS model hold promise for improving therapeutic outcomes in psychotherapy across practice, research, and training. These studies successfully bridge these domains by offering practical clinical tools, including an effective self-relationship measure and a foundation for therapists to

enhance their skills in recognising and effectively responding to clients' NTS during therapy. These investigations significantly contribute to the understanding of the self-relationship and NTS complexities, providing a comprehensive framework for addressing their manifestations and promoting healing through self-compassionate approaches. They set the stage for further research, stimulating creativity and impact for enhanced therapeutic outcomes.

Reflections On My Journey and Personal Implications

While contributing valuable knowledge to the fields of humanistic-experiential psychotherapy, the self-relationship, and negative treatment of self, this research also played a pivotal role in my personal and professional development as a psychotherapist and researcher. Gaining a deeper understanding of measuring and comprehending the self-relationship and NTS in therapy prompted a process of personal introspection regarding my own self-relationship. Exploring expressions of negative self-treatment not only heightened my awareness of my personal self-relating but also that of my clients and how it manifests in therapy. This project has been a transformative journey, shaping both my role as a researcher and as a therapist, deepening my commitment to addressing NTS in all its forms through transparent communication with my clients regarding our therapeutic collaboration. At its core, the NTS model necessitates an on-going dialogue between practice and inquiry, and it is within this conversation that I have experienced significant growth in both domains, with key transformations emerging from this experience.

The continued development of the SRQ and the construction of the empirical model of NTS have profoundly transformed my understanding of how clients relate to themselves, comprehend, engage with, and communicate their experiences of self. The meticulous process involved in constructing these tools compelled me to think with increased rigour and systematicity, fostering a methodical and critical perspective. This endeavour challenged my initial beliefs, leading to a deeper comprehension of the self-relationship and negative treatment

of self. Developing the empirical model of NTS underscored the significance of bridging the divide between research and practice. This integrative approach not only facilitated the formulation of the NTS model but also offered a systematic framework for therapeutic engagement. It emphasised the proactive role that therapists assume in the research process.

The iterative development of the SRQ and NTS model served as a form of self-training, sharpening my capacity to identify components of the self-relationship and negative self-treatment more discerningly. Observing therapy sessions with a meticulous focus encouraged a nuanced understanding of NTS processes. The juxtaposition of participant SRQ self-report data with my observations of their in-session expressions of NTS heightened my attentiveness and reflection, presenting a nuanced diagnostic map of the therapeutic process. This iterative process underscored the significance of attending to all NTS processes, whether overt or subtle, in fostering improvements in the self-relationship and promoting meaningful client engagement.

The comprehensive and immersive analysis of participant NTS in this research yielded profound insights into the clinical sensitivity required for understanding and working with the self-relationship. These insights have transformed into a valuable asset in my clinical practice. Beyond my initial goal of making a tangible contribution to the field, the process of examining the self-relationship has enriched my personal knowledge as a psychotherapy practitioner and researcher. There is a paradox in pursuing a Ph.D. by delving into the study of negative treatment of self. While this academic journey presented significant personal challenges—some of which I would characterise as NTS—it has nonetheless been immensely beneficial for my professional development, shaping me as both a researcher and psychotherapist. Reflecting on my initial struggle to formulate a research project, I began with a somewhat naive aspiration to accurately explore, measure, and classify the self-relationship, particularly concerning problematic self-relating. Abandoning the notion that the self-relationship could be fully captured and understood marked one of my earliest

experiences of unresolved feelings related to this project. The search for self at times felt elusive and meaningless, adopting a changeable, transient, and often conflicting quality. This resonated with the self-doubt experiences expressed by the participants in the study sample who, during their psychotherapeutic journeys, encountered difficulties in fully knowing and understanding themselves.

A notable revelation arising from this thesis is my newfound enthusiasm for delving further into the development and application of measures in my clinical practice. Before embarking on this research, I regarded measurement instruments simply as tools used by time-limited services to furnish outcome evidence for funders, a perspective shaped by my experience providing psychotherapy services for community projects over the years. While I recognise the inherent constraints of measurement as a methodology, I have gained a fresh understanding of its substantial worth and untapped potential when employed with care. Consequently, I am eager to leverage these newfound insights and contribute innovatively to the field by actively working towards enhancing the practicality and user-friendliness of self-relationship measurement.

In conclusion, this research project has made significant contributions to knowledge in the field of psychotherapy, self-relating, and negative treatment of self. It not only validated the SRQ as an effective measure of therapy outcomes but also deepened understanding of negative self-treatment, presenting a robust model that highlights the importance of how clients engage with and express their self-relationship and NTS experiences during psychotherapy. These studies underscored the crucial need to recognise, understand, and address NTS in therapeutic settings. By emphasising the value of an informed approach to self-relationship measurement in psychotherapeutic practice, it laid a solid foundation for comprehending client self-relationship perspectives and bridging the gap between research and clinical practice. I anticipate that these contributions will serve as inspiration for future research in the field of psychotherapy, further enriching our understanding and practice in this vital domain.

Summary of Original Contributions to Knowledge

1. A solid evidence base confirming the value of the Self-Relationship Questionnaire as a reliable and valid measure of the self-relationship, applicable to both clinical and nonclinical populations, complete with clinical cut-off points and reliable change indices.
2. Introduction of a concise 26-item version of the Self-Relationship Questionnaire.
3. Robust empirical evidence supporting and expanding the comprehension and categorisation of negative treatment of self, resulting in a well-defined model.
4. The conceptualisation of NTS as a cyclical process that integrates objects, directness, modes, and emotional effects within its framework, presenting a paradigm bearing implications for clients, therapists, researchers, and trainers.
5. A comprehensive and refined definition of negative treatment of self, encompassing recent empirical elaborations to the model.
6. Evidence-based insight into self-attack and self-affiliation as bipolar constructs within the realm of self-relating.
7. Evidence-based insight into self-control as a distinct form of self-relating.
8. Evidence-based understanding of self-doubt and indecisiveness as inherent aspects of the human experience, remaining prevalent in the concluding stages of therapy in cases demonstrating positive outcomes.

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Appendix A: Ethical Approval of Research Clinic Generic Framework (Renewed April 2018)

Approval: UEC17/73 Elliot: Generic Framework Application – Practice-Based Psychotherapy Research Clinic Protocol, Phase 2 (RESUBMISSION FROM NOVEMBER 2017)

Ethics
Sent: 10 April 2018 13:25
To: Robert Elliott
Cc: Susan Stephen; Lorna Carrick; Ethics

Dear Robert

ETHICAL AND SPONSORSHIP APPROVAL
UEC17/73 Elliot: Generic Framework Application – Practice-Based Psychotherapy Research Clinic Protocol, Phase 2 (RESUBMISSION FROM NOVEMBER 2017)

I can confirm that the University Ethics Committee (UEC) has approved this protocol and appropriate insurance cover and sponsorship have now also been confirmed.

I would remind you that the UEC must be informed of any changes you plan to make to the research project, so that it has the opportunity to consider them. Any change of staffing within the research team should be reported to UEC.

The UEC would also expect you to report back on the progress and outcome of your project, with an account of anything which may prompt ethical questions for any similar future project and with anything else that you feel the Committee should know.

Any adverse event that occurs during an investigation must be reported as quickly as possible to UEC and, within the required time frame, to any appropriate external agency.

The University agrees to act as sponsor of the above mentioned project subject to the following conditions:

1. That the project obtains/has and continues to have University/Departmental Ethics Committee approval.

2. That the project is carried out according to the project protocol.

3. That the project continues to be covered by the University's insurance cover.

4. That the Director of Research and Knowledge Exchange Services is immediately notified of any change to the project protocol or circumstances which may affect the University's risk assessment of the project.

5. That the project starts within 12 months of the date of this letter.

As sponsor of the project the University has responsibilities under the Scottish Executive's Research Governance Framework for Health and Community Care. You should ensure you are aware of those responsibilities and that the project is carried out according to the Research Governance Framework.

On behalf of the Committee, I wish you success with this project.

Kind regards
Angelique

Angelique Laverty

Appendix B: Consent Form

Name of department: Psychological Sciences & Health, HASS
Title of the study: Developing the Self-Relationship Questionnaire: A Psychometric Study

- I confirm that I have read and understood the Participant Information Sheet for the above project and the researcher has answered any queries to my satisfaction.
- I confirm that I have read and understood the Privacy Notice for Participants in Research Projects and understand how my personal information will be used and what will happen to it (i.e. how it will be stored and for how long).
- I understand that my participation is voluntary and that I am free to withdraw from the project at any time, up to the point of completion, without having to give a reason and without any consequences.
- I understand that I can request the withdrawal from the study of some personal information and that whenever possible researchers will comply with my request.
- I understand that anonymised data (i.e. data that do not identify me personally) cannot be withdrawn once they have been included in the study.
- I understand that any information recorded in the research will remain confidential and no information that identifies me will be made publicly available.
- I consent to being a participant in the project.

(PRINT NAME)	
Signature of Participant:	**Date:**

Strathclyde Counselling Research Clinic
GH506, Level 5 Graham Hills Building
University of Strathclyde Counselling Unit
50 Richmond Street, Glasgow G1 1QE
Email: enquiries@strathclydetherapy.com
Phone: 0844 586 4560

PRACTICE-BASED PSYCHOTHERAPY RESEARCH CLINIC PROTOCOL, PHASE 2
CLIENT CONSENT FORM (v2.0; 10/2017)

		Please initial box
1.	I confirm that I have read and understand the information sheet dated 10/2017 (v2.0) for the above study. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily.	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected.	☐
3.	I understand that relevant data collected during the study may be used by members of the research team at the University of Strathclyde. I understand that I will be asked separately about the use of the recordings of my counselling sessions and research interviews as detailed in the Release of Recordings form dated 10/2017 (v2.0).	☐
4.	I confirm that I am aged 18 or over and that I am aware of what my participation involves and any potential risks.	☐
5.	I agree to take part in this study	☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of researcher/witness	Date	Signature

Appendix C: Release of Recordings Form

Strathclyde Counselling Research Clinic
GH506, Level 5 Graham Hills Building
50 Richmond Street, Glasgow G1 1QE
Email: enquiries@strathclydetherapy.com
Phone: 0844 586 4560

PRACTICE-BASED PSYCHOTHERAPY RESEARCH CLINIC PROTOCOL, PHASE 2
RELEASE OF RECORDINGS CONSENT FORM (v2.0; 10/2017)

Once you have finished your counselling, we would like your permission to use the recordings of your research interviews and therapy sessions to help us understand how therapy works. Below are some of the possible situations in which we would like to use these recordings, if you are willing to give us permission to do so. For each of the situations described below, please indicate whether you agree to this use or not. Please don't agree to anything you feel uncomfortable with. We will ask you to review this form after each ten sessions of counselling and again at the end of counselling so that you can make changes if you wish to. Please feel free to discuss this with your counsellor and to negotiate with your researcher about any of these possible uses.

		Please circle one	Please initial box
1.	After counselling is over, I am willing for my counsellor to read the questionnaires and listen to what I said in the research interviews.	NO YES	☐
2.	I am willing for the audio recordings of my sessions to be used for training other therapists or counsellors in the present project, for a period of at least 5 years.	NO YES	☐
3.	I am willing for the audio recordings of my counselling sessions and research interviews to be used for training other postgraduate level students or other mental health professionals, for a period of at least 5 years or as long as there is a specific use identified by the Chief Investigator or research team.	NO YES	☐
4.	I am willing for the professional members (the	NO	☐

investigators, research associates, postgraduate counselling students, and professional consultants) of the research team to analyse the recordings for the purpose of developing and evaluating Person-Centred and Experiential psychotherapies.

YES ☐

5. I am willing for brief excerpts from my counselling sessions and research interviews to be presented at scientific meetings or in scientific publications in order to better understand what the therapeutic process is like for clients. I am willing for these excerpts to take the form of: (please cross out any which you wish to exclude):
    - anonymous transcripts of counselling sessions
    - audio recordings of counselling sessions
    - anonymous transcripts of research interviews
    - audio recordings of research interviews

NO ☐
YES ☐

6. I am willing for the information that I have given in my research questionnaires and interviews, as well as extracts from therapy sessions, to be analysed and presented as a systematic single case study.

NO ☐
YES ☐

7. I am willing for research teams at other Universities within the European Union to analyse data from my counselling as long as they are monitored by the Chief Investigator and pledge to protect my identity. This permission includes (please cross any which you wish to exclude):
    - questionnaire data
    - anonymous transcripts of counselling sessions
    - audio recordings of counselling sessions
    - anonymous transcripts of research interviews
    - audio recordings of research interviews

NO ☐
YES ☐

8. I am willing for research teams at Universities outside the European Union, which are not covered by the Data Protection Act, to analyse data from my counselling as long as they are monitored by the Chief Investigator and

NO ☐
YES ☐

pledge to protect my identity. This permission includes (please cross any which you wish to exclude):

- questionnaire data
- anonymous transcripts of counselling sessions
- audio recordings of counselling sessions
- anonymous transcripts of research interviews
- audio recordings of research interviews

9. I am willing to be contacted if any additional use of the recordings or other data is requested, including reviewing or commenting on systematic single case study reports.

NO ☐
YES

Please indicate specific identifying information which should be edited from the recordings
(e.g. personal names, place names, places of employment or schools):

Please indicate a permanent address and phone number or email address at which you may be contacted:

I understand that, by responding to the above items and signing below, I have given my permission for the audio recordings and other data from my sessions and interviews to be used in the manner I have specified.

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Name of researcher/witness	Date	Signature

Appendix D: Self-Relationship Questionnaire (Faur & Elliott, 4/2007)

This questionnaire asks about your attitudes and feelings toward yourself and how you treat yourself. Please use your initial reaction to answer these questions based on how you really feel or think. There are no "right" or "wrong" answers. It's important to answer these questions in a way that you think is true for you, not what someone else might think is right.

Please circle the number which best describes your relationship with yourself as you have been in the past month, using this scale:

Not at all true	Slightly true	Usually true	Always true
0	1	2	3

1. Even though I know I have some faults I am happy with myself as I am…….0 1 2 3
2. I am comfortable with listening to my innermost feelings……..0 1 2 3
3. I am content with myself……0 1 2 3
4. I appreciate myself for just being me……0 1 2 3
5. I avoid paying attention to important things……..0 1 2 3
6. I believe that whatever happens, happens, so it's better not to try..0 1 2 3
7. I carefully monitor my behaviour……..0 1 2 3
8. I comfort myself when I am sad or hurt……..0 1 2 3
9. I confidently allow myself to do what feels right……..0 1 2 3
10. I criticize myself harshly when I don't do something perfectly…….0 1 2 3
11. I don't attend to the condition of my personal environment……..0 1 2 3
12. I don't check up on things to make sure they're done correctly……..0 1 2 3
13. I don't feel that I deserve anything good to happen to me……0 1 2 3
14. I don't spend much time planning for the future……..0 1 2 3

15. I don't try to develop good habits or skills.....0 1 2 3

16. I harshly reject myself as worthless.....0 1 2 3

17. I have no internal direction or goals.....0 1 2 3

18. I have physically hurt myself when I felt I deserved it.....0 1 2 3

19. I have thought of hurting myself, although I haven't done it.....0 1 2 3

20. I hurt myself by overburdening myself with work.....0 1 2 3

21. I keep an eye on myself to be sure I am doing what I should.....0 1 2 3

22. I keep tight control over myself.....0 1 2 3

23. I let my needs go unattended.....0 1 2 3

24. I like myself very much.....0 1 2 3

25. I look after my own best interests.....0 1 2 3

26. I only live for the moment.....0 1 2 3

27. I put a great deal of energy into making sure I follow the rules properly.....0 1 2 3

28. I put a lot of effort into everything that I do.....0 1 2 3

29. I respect myself deeply.....0 1 2 3

30. I take my anger out on myself.....0 1 2 3

31. I think of ways to punish myself.....0 1 2 3

32. I treat myself with love.....0 1 2 3

33. I try very hard to become like an ideal image of myself.....0 1 2 3

34. I try very hard to make sure my work is done on time.....0 1 2 3

35. I watch myself closely to make sure I don't do the wrong thing.....0 1 2 3

36. My goal is to be as perfect as possible.....0 1 2 3

Appendix E: SRQ Outcome Case Summaries

Client	Pattern	Assess-ment	SRQAFFm	SRQATTm	SRQNEGm	SRQCONm
C1	Gradual decline	Pre	.90	2.00	1.75	2.00
C1		Mid	1.80	.43	.63	2.50
C1		End	3.00	.00	.88	2.70
C2	Gradual decline	Pre	.40	1.43	1.25	1.80
C2		Mid	.90	.71	1.38	1.30
C2		End	1.40	.00	.38	1.30
C3	Gradual decline	Pre	.90	1.00	1.38	.90
C3		Mid	1.00	.57	.88	1.70
C3		End	1.60	.14	.38	1.00
C4	Worsening to decline	Pre	.40	1.57	1.63	1.80
C4		Mid	1.10	1.86	1.25	2.50
C4		End	1.90	.71	.25	2.50
C5	Worsening to decline	Pre	.30	.57	1.88	1.40
C5		Mid	.10	1.14	1.13	1.50
C5		End	1.20	.14	.75	1.30
C6	Worsening to decline	Pre	1.10	.29	.75	1.60
C6		Mid	1.00	1.00	1.13	1.60
C6		End	1.70	.14	1.00	1.60

Note: As measured by the Self-Relationship Questionnaire, SRQAFF: Self-Affiliation, SRQATT: Self-Attack, SRQNEG: Self-Neglect, SRQCON: Self-Control.

Appendix F: Qualtrics Survey 1 (Test)

Developing the Self-Relationship Questionnaire (SRQ) - A Psychometric Study
Survey Flow

Introduction (PIS & Privacy Notice/GDPR)

Eligibility (3 Questions)

Consent Form (1 Question)

Demographics (5 Questions)

Self-Relationship Questionnaire (36 Questions)

CORE-OM (34 Questions)

Self-Compassion Scale (26 Questions)

Social Desirability Scale (33 Questions)

Rosenberg Self-Esteem Scale (10 Questions)

HEXACO-PI-R (60 Questions)

Depressive Experiences Questionnaire (48 Questions)

Appendix G: Qualtrics Survey 2 (Retest)

Developing the Self-Relationship Questionnaire (SRQ) - A Psychometric Study
Survey Flow

Introduction

Demographics (1 Question)

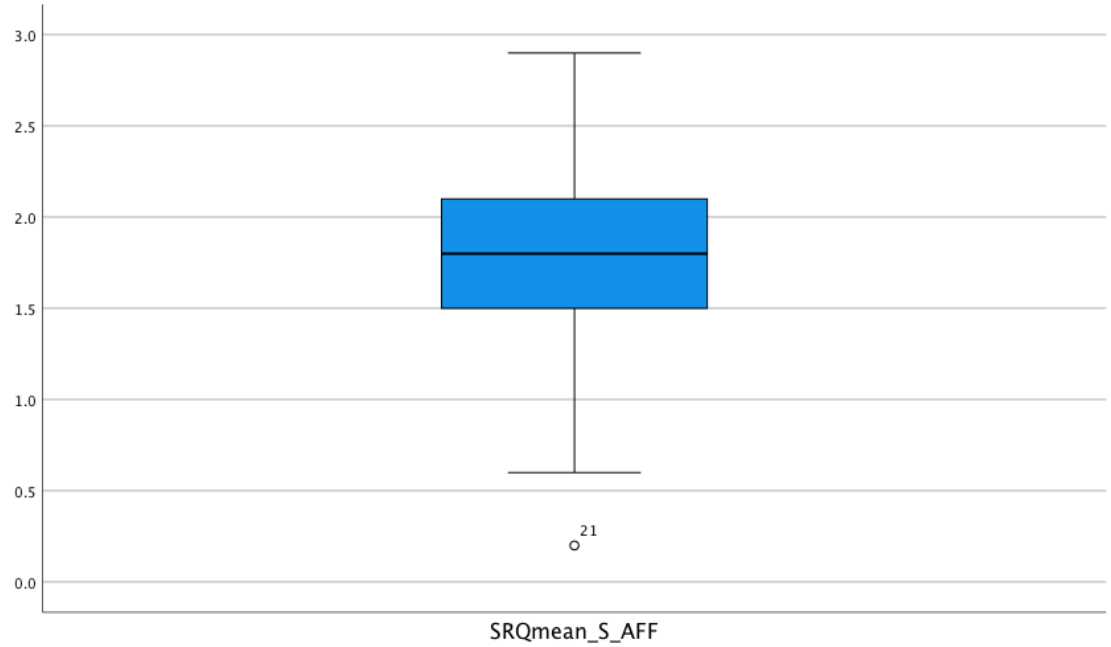
Self-Relationship Questionnaire (36 Questions)

Appendix H: Procedure for Creating the Unique Identifier Code

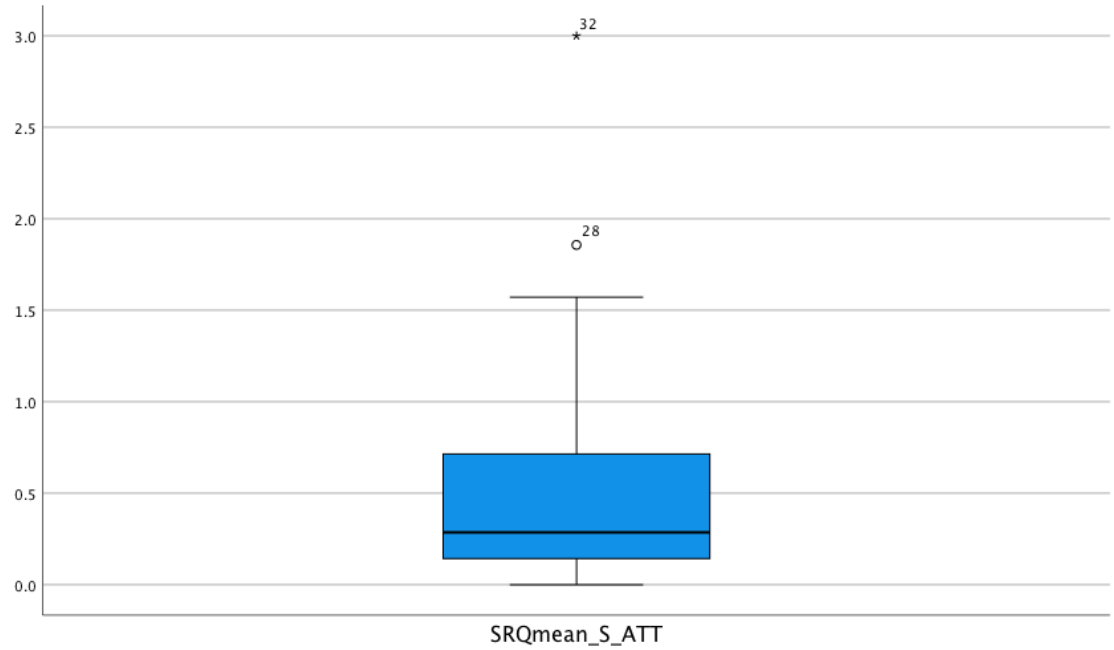
Your answers to the survey are anonymous. You will only be identified by a unique key, which you create yourself. Please create your unique key by writing the first three letters of your mother's maiden name, then the first three letters of your father's first name and then the last two digits of your year of birth. In total your key consists of eight characters. Please use capital letters. For example: if your mother's name is Polly Smith, your father's name is John McRay and you were born in 1976, your private key is SMIJOH76. If you are willing to take part in the second shorter survey in two weeks' time, we will ask you to insert your unique key again at the end of this survey, when we ask for your email address. Please take a note of your unique key.

Appendix I: Statistical Outlier Graphs

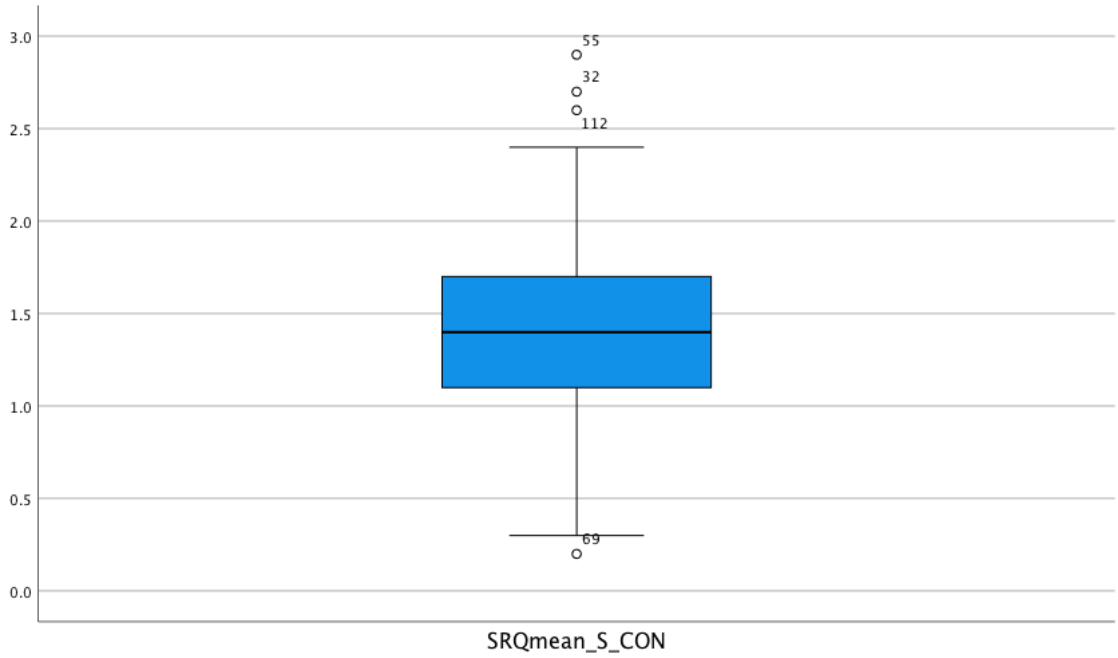
Graph 1: Outliers in SRQ Self-Affiliation (N=150 nonclinical)



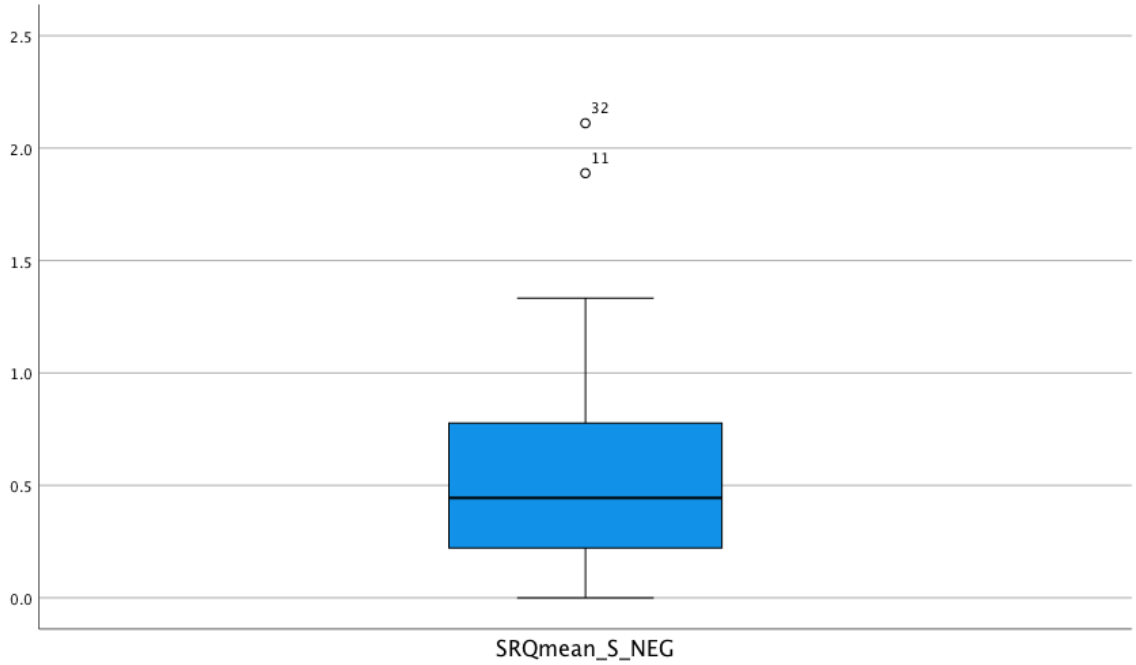
Graph 2: Outliers in SRQ Self-Attack (N=150 nonclinical)



Graph 3: Outliers in SRQ Self-Control (N=150 nonclinical)

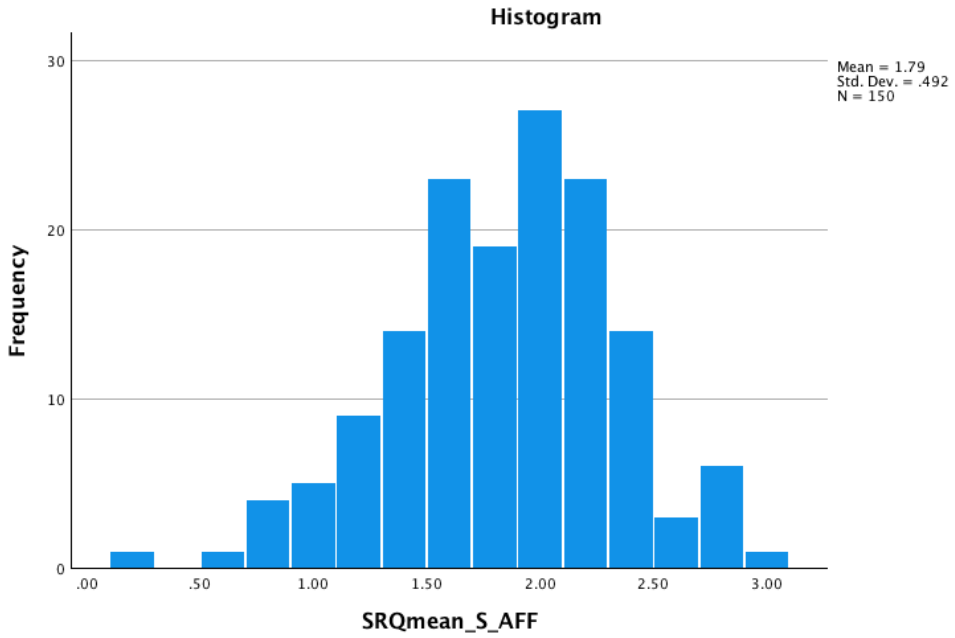


Graph 4: Outliers in SRQ Self-Neglect (N=150 nonclinical)

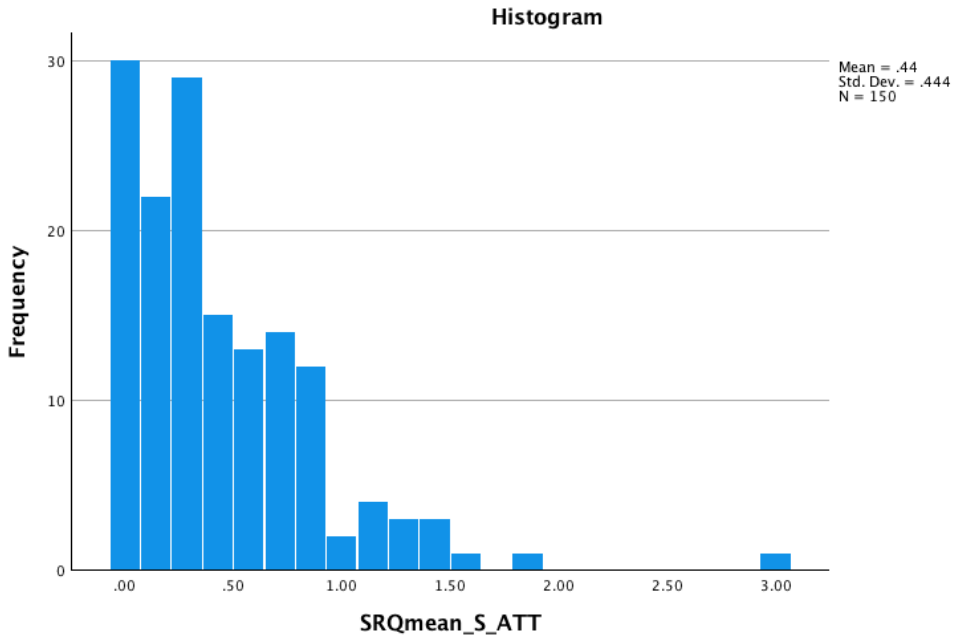


Appendix J: Distribution Graphs

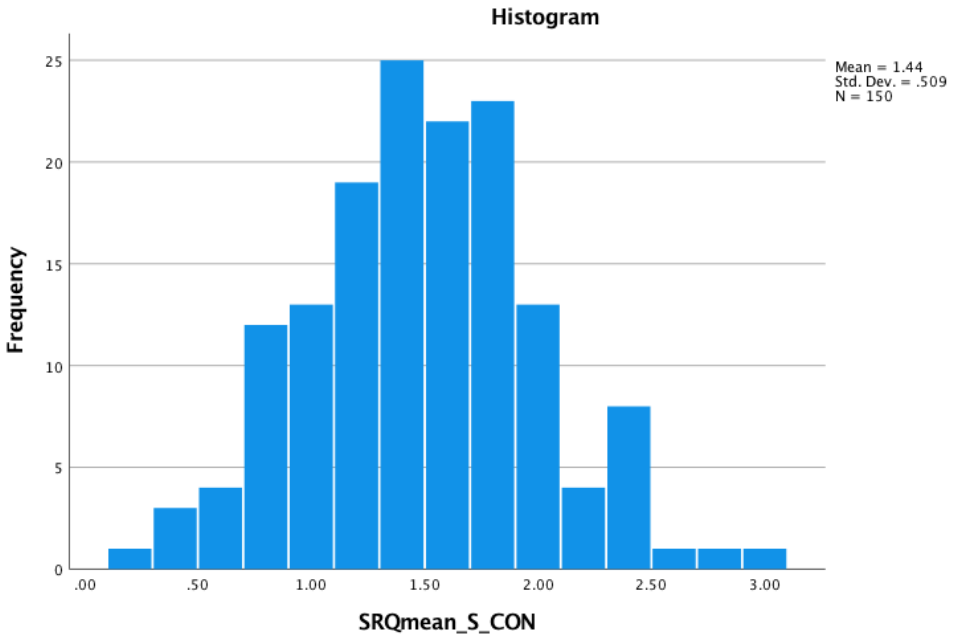
Graph 1: Self-Affiliation Distribution (N=150 nonclinical)



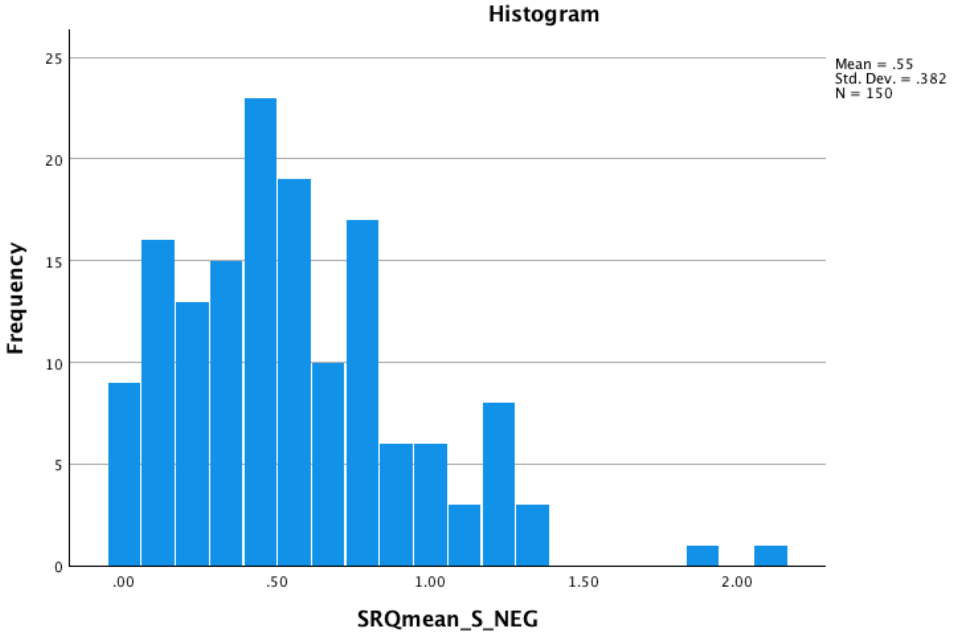
Graph 2: Self-Attack Distribution (N=150 nonclinical)



Graph 3: Self-Control Distribution (N=150 nonclinical)



Graph 4: Self-Neglect Distribution (N=150 nonclinical)



Appendix K: SPSS Syntax (Reliability, Validity, Factor Analyses)

Recoding Values

```
RECODE RSE02 RSE05 RSE06 RSE08 RSE09 (1=4) (2=3) (3=2) (4=1).
EXECUTE.

RECODE HPR01 HPR09 HPR10 HPR12 HPR14 HPR15 HPR19 HPR20 HPR21 HPR24
HPR26 HPR28 HPR30 HPR31 HPR32 HPR35 HPR41 HPR42 HPR44 HPR46 HPR48
HPR49 HPR52 HPR53 HPR55 HPR56 HPR57 HPR59 HPR60 (1=5) (2=4) (3=3) (4=2)
(5=1).
EXECUTE.

RECODE SCS01 SCS02 SCS04 SCS06 SCS08 SCS11 SCS13 SCS16 SCS18 SCS20 SCS21
SCS24 SCS25 (1=5) (2=4) (3=3) (4=2) (5=1).
EXECUTE.

RECODE DEQ09 DEQ12 DEQ18 DEQ27 DEQ42 DEQ57 DEQ05 DEQ21 DEQ61 (1=7)
(2=6) (3=5) (4=4) (5=3) (6=2) (7=1).
EXECUTE.
```

Means

```
COMPUTE SRQmean=MEAN(SRQ01 to SRQ36).
EXECUTE.

COMPUTE COREmean2=MEAN(COR01 to COR34).
EXECUTE.

COMPUTE COREmean2_P=MEAN(COR02, COR05, COR08, COR11, COR13, COR15,
COR18, COR20, COR23, COR27, COR28, COR30).
EXECUTE.

COMPUTE COREmean2_R=MEAN(COR06, COR09, COR16, COR22, COR24, COR34).
EXECUTE.

COMPUTE COREmean2_W=MEAN(COR04, COR14, COR17, COR31).
EXECUTE.

COMPUTE COREmean2_F=MEAN(COR01, COR03, COR07, COR10, COR12, COR19,
COR21, COR25, COR26, COR29, COR32, COR33).
```

```
EXECUTE.

COMPUTE SCSmean2=MEAN(SCS01 to SCS26).
EXECUTE.

COMPUTE SCSmean2_S_K=MEAN(SCS05, SCS12, SCS19, SCS23, SCS26).
EXECUTE.

COMPUTE SCSmean2_S_J=MEAN(SCS01, SCS08, SCS11, SCS16, SCS21).
EXECUTE.

COMPUTE SCSmean2_C_H=MEAN(SCS03, SCS07, SCS10, SCS15).
EXECUTE.

COMPUTE SCSmean2_I=MEAN(SCS04, SCS13, SCS18, SCS25).
EXECUTE.

COMPUTE SCSmean2_M=MEAN(SCS09, SCS14, SCS17, SCS22).
EXECUTE.

COMPUTE SCSmean2_O_I=MEAN(SCS02, SCS06, SCS20, SCS24).
EXECUTE.

COMPUTE SDSmean2=MEAN(SDS01 to SDS33).
EXECUTE.

COMPUTE RSEmean2=MEAN(RSE01 to RSE10).
EXECUTE.

COMPUTE HEXmean2=MEAN(HPR01 to HPR60).
EXECUTE.

COMPUTE HEXmean2_H_H=MEAN(HPR06, HPR12, HPR18, HPR24, HPR30, HPR36,
HPR42, HPR48, HPR54, HPR60).
EXECUTE.

COMPUTE HEXmean2_Emo=MEAN(HPR05, HPR11, HPR17, HPR23, HPR29, HPR35,
HPR41, HPR47, HPR53, HPR59).
EXECUTE.
```

```
COMPUTE HEXmean2_Ext=MEAN(HPR04, HPR10, HPR16, HPR22, HPR28, HPR34,
HPR40, HPR46, HPR52, HPR58).
EXECUTE.

COMPUTE HEXmean2_Agr=MEAN(HPR03, HPR09, HPR15, HPR21, HPR27, HPR33,
HPR39, HPR45, HPR51, HPR57).
EXECUTE.

COMPUTE HEXmean2_Con=MEAN(HPR02, HPR08, HPR14, HPR20, HPR26, HPR32,
HPR38, HPR44, HPR50, HPR56).
EXECUTE.

COMPUTE HEXmean2_O_E=MEAN(HPR01, HPR07, HPR13, HPR19, HPR25, HPR31,
HPR37, HPR43, HPR49, HPR55).
EXECUTE.

COMPUTE
DEQmean2=MEAN(DEQ02,DEQ03,DEQ05,DEQ07,DEQ09,DEQ10,DEQ11,DEQ12,DEQ
13,DEQ14,DEQ16,DEQ17,DEQ18,DEQ19,DEQ20,DEQ21,DEQ22,DEQ23,DEQ26,DEQ2
7,DEQ28,DEQ30,DEQ31,DEQ32,DEQ34,DEQ35,DEQ36,DEQ38,DEQ39,DEQ40,DEQ42,
DEQ43,DEQ44,DEQ45,DEQ46,DEQ49,DEQ50,DEQ52,DEQ53,DEQ55,DEQ56,DEQ57,D
EQ58,DEQ61,DEQ62,DEQ64,DEQ65,DEQ66).
EXECUTE.

COMPUTE
DEQmean2_Dep=MEAN(DEQ02, DEQ19, DEQ22, DEQ23, DEQ28, DEQ34, DEQ40,
DEQ45, DEQ46, DEQ50,DEQ52, DEQ55, DEQ09, DEQ12, DEQ18, DEQ27, DEQ42,
DEQ57).
EXECUTE.

COMPUTE DEQmean2_S_Cri=MEAN(DEQ07, DEQ10, DEQ11, DEQ13, DEQ16,
DEQ17, DEQ30, DEQ36, DEQ39, DEQ43,DEQ53, DEQ56, DEQ58, DEQ64, DEQ66,
DEQ05, DEQ21, DEQ61).
EXECUTE.
```

Reliability

```
RELIABILITY
  /VARIABLES=SRQ01 SRQ02 SRQ03 SRQ04 SRQ05 SRQ06 SRQ07 SRQ08 SRQ09
SRQ10 SRQ11 SRQ12 SRQ13 SRQ14 SRQ15 SRQ16 SRQ17 SRQ18 SRQ19 SRQ20
```

```
SRQ21 SRQ22 SRQ23 SRQ24 SRQ25 SRQ26 SRQ27 SRQ28 SRQ29 SRQ30 SRQ31
SRQ32 SRQ33 SRQ34 SRQ35 SRQ36
  /SCALE('SRQ') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=SRQ13 SRQ16 SRQ18 SRQ19 SRQ20 SRQ30 SRQ31
  /SCALE('SRQ_S_ATT') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=SRQ07 SRQ10 SRQ21 SRQ22 SRQ27 SRQ28 SRQ33 SRQ34 SRQ35
SRQ36
  /SCALE('SRQ_S_CON') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
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  /SCALE('SRQ_S_NEG') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
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SRQ32
  /SCALE('SRQ_S_AFF') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=COR01 COR02 COR03 COR04 COR05 COR06 COR07 COR08 COR09
COR10 COR11 COR12 COR13 COR14 COR15 COR16 COR17 COR18 COR19 COR20
```

```
COR21 COR22 COR23 COR24 COR25 COR26 COR27 COR28 COR29 COR30 COR31
COR32 COR33 COR34
  /SCALE('CORE_OM') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=COR02 COR05 COR08 COR11 COR13 COR15 COR18 COR20 COR23
COR27 COR28 COR30
  /SCALE('CORE_P_mean') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=COR06 COR09 COR16 COR22 COR24 COR34
  /SCALE('CORE_R_mean') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=COR04 COR14 COR17 COR31
  /SCALE('CORE_W_mean') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=COR01 COR03 COR07 COR10 COR12 COR19 COR21 COR25 COR26
COR29 COR32 COR33
  /SCALE('CORE_F_mean') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
```

```
  /VARIABLES=SCS01 SCS02 SCS03 SCS04 SCS05 SCS06 SCS07 SCS08 SCS09 SCS10
SCS11 SCS12 SCS13 SCS14 SCS15 SCS16 SCS17 SCS18 SCS19 SCS20 SCS21 SCS22
SCS23 SCS24 SCS25 SCS26
  /SCALE('SCS') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=SCS05 SCS12 SCS19 SCS23 SCS26
  /SCALE('SCS_S_K') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=SCS01 SCS08 SCS11 SCS16 SCS21
  /SCALE('SCS_S_J') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=SCS03 SCS07 SCS10 SCS15
  /SCALE('SCS_C_H') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=SCS04 SCS13 SCS18 SCS25
  /SCALE('SCS_Iso') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=SCS09 SCS14 SCS17 SCS22
  /SCALE('SCS_Min') ALL
  /MODEL=ALPHA
```

```
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=SCS02 SCS06 SCS20 SCS24
  /SCALE('SCS_O_I') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=SDS01 SDS02 SDS03 SDS04 SDS05 SDS06 SDS07 SDS08 SDS09 SDS10
SDS11 SDS12 SDS13 SDS14 SDS15 SDS16 SDS17 SDS18 SDS19 SDS20 SDS21 SDS22
SDS23 SDS24 SDS25 SDS26 SDS27 SDS28 SDS29 SDS30 SDS31 SDS32 SDS33
  /SCALE('SDS') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=RSE01 RSE02 RSE03 RSE04 RSE05 RSE06 RSE07 RSE08 RSE09 RSE10
  /SCALE('RSE') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=HPR01 HPR02 HPR03 HPR04 HPR05 HPR06 HPR07 HPR08 HPR09
HPR10 HPR11 HPR12 HPR13 HPR14 HPR15 HPR16 HPR17 HPR18 HPR19 HPR20
HPR21 HPR22 HPR23 HPR24 HPR25 HPR26 HPR27 HPR28 HPR29 HPR30 HPR31
HPR32 HPR33 HPR34 HPR35 HPR36 HPR37 HPR38 HPR39 HPR40 HPR41 HPR42
HPR43 HPR44 HPR45 HPR46 HPR47 HPR48 HPR49 HPR50 HPR51 HPR52 HPR53
HPR54 HPR55 HPR56 HPR57 HPR58 HPR59 HPR60
  /SCALE('HEXACO') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
```

```
  /VARIABLES=HPR06 HPR12 HPR18 HPR24 HPR30 HPR36 HPR42 HPR48 HPR54
HPR60
  /SCALE('HEXACO_H_H') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=HPR05 HPR11 HPR17 HPR23 HPR29 HPR35 HPR41 HPR47 HPR53
HPR59
  /SCALE('HEXACO_Emo') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=HPR04 HPR10 HPR16 HPR22 HPR28 HPR34 HPR40 HPR46 HPR52
HPR58
  /SCALE('HEXACO_Ext') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=HPR03 HPR09 HPR15 HPR21 HPR27 HPR33 HPR39 HPR45 HPR51
HPR57
  /SCALE('HEXACO_Agr') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=HPR02 HPR08 HPR14 HPR20 HPR26 HPR32 HPR38 HPR44 HPR50
HPR56
  /SCALE('HEXACO_Con') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
```

```
  /VARIABLES=HPR01 HPR07 HPR13 HPR19 HPR25 HPR31 HPR37 HPR43 HPR49
HPR55
  /SCALE('HEXACO_O_Exp') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=DEQ02 DEQ03 DEQ05 DEQ07 DEQ09 DEQ10 DEQ11 DEQ12 DEQ13
DEQ14 DEQ16 DEQ17 DEQ18 DEQ19 DEQ20 DEQ21 DEQ22 DEQ23 DEQ26 DEQ27
DEQ28 DEQ30 DEQ31 DEQ32 DEQ34 DEQ35 DEQ36 DEQ38 DEQ39 DEQ40 DEQ42
DEQ43 DEQ44 DEQ45 DEQ46 DEQ49 DEQ50 DEQ52 DEQ53 DEQ55 DEQ56 DEQ57
DEQ58 DEQ61 DEQ62 DEQ64 DEQ65 DEQ66
  /SCALE('DEQ_ALL') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=DEQ02 DEQ19 DEQ22 DEQ23 DEQ28 DEQ34 DEQ40 DEQ45 DEQ46
DEQ50 DEQ52 DEQ55 DEQ09 DEQ12 DEQ18 DEQ27 DEQ42 DEQ57
  /SCALE('DEQ_DEP') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.

RELIABILITY
  /VARIABLES=DEQ07 DEQ10 DEQ11 DEQ13 DEQ16 DEQ17 DEQ30 DEQ36 DEQ39
DEQ43 DEQ53 DEQ56 DEQ58 DEQ64 DEQ66 DEQ05 DEQ21 DEQ61
  /SCALE('DEQ_S_CRIT') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL CORR.
```

Correlations

```
CORRELATIONS
  /VARIABLES=SRQmean_S_ATT SRQmean_S_CON SRQmean_S_NEG
SRQmean_S_AFF
  /PRINT=TWOTAIL NOSIG FULL
  /STATISTICS DESCRIPTIVES
```

```
  /MISSING=PAIRWISE.

CORRELATIONS
  /VARIABLES=SRQmean_S_ATT SRQmean_S_CON SRQmean_S_NEG
SRQmean_S_AFF SRQmean COREmean_P COREmean_R COREmean_W
COREmean_F COREmean SCSmean_S_K SCSmean_S_J SCSmean_C_H SCSmean_I
SCSmean_M SCSmean_O_I SCSmean SDSmean RSEmean HEXmean_H_H
HEXmean_Emo HEXmean_Ext HEXmean_Agr HEXmean_Con HEXmean_O_E
HEXmean DEQmean_Dep DEQmean_S_Cri DEQmean
  /PRINT=TWOTAIL NOSIG FULL
  /STATISTICS DESCRIPTIVES
  /MISSING=PAIRWISE.
```

Retest Values

```
COMPUTE SRQmean=MEAN(SRQ01 to SRQ36).
EXECUTE.

COMPUTE SRQ2mean=MEAN(A2SRQ01 to A2SRQ36).
EXECUTE.

CORRELATIONS
  /VARIABLES=SRQmean SRQ2mean
  /PRINT=TWOTAIL NOSIG FULL
  /STATISTICS DESCRIPTIVES
  /MISSING=PAIRWISE.

CORRELATIONS
  /VARIABLES=SRQmean SRQmean_S_ATT SRQmean_S_CON SRQmean_S_NEG
SRQmean_S_AFF with SRQ2mean SRQ2mean_S_ATT SRQ2mean_S_CON
SRQ2mean_S_NEG SRQ2mean_S_AFF
  /PRINT=TWOTAIL NOSIG FULL
  /STATISTICS DESCRIPTIVES
  /MISSING=PAIRWISE.

RELIABILITY
  /VARIABLES=SRQ01 SRQ02 SRQ03 SRQ04 SRQ05 SRQ06 SRQ07 SRQ08 SRQ09
SRQ10 SRQ11 SRQ12 SRQ13 SRQ14 SRQ15 SRQ16 SRQ17 SRQ18 SRQ19 SRQ20
SRQ21 SRQ22 SRQ23 SRQ24 SRQ25 SRQ26 SRQ27 SRQ28 SRQ29 SRQ30 SRQ31
SRQ32 SRQ33 SRQ34 SRQ35 SRQ36
  /SCALE('SRQ1_descriptive statistics') ALL
```

```
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL MEANS CORR.

RELIABILITY
  /VARIABLES=A2SRQ01 A2SRQ02 A2SRQ03 A2SRQ04 A2SRQ05 A2SRQ06 A2SRQ07
A2SRQ08 A2SRQ09 A2SRQ10 A2SRQ11 A2SRQ12 A2SRQ13 A2SRQ14 A2SRQ15
A2SRQ16 A2SRQ17 A2SRQ18 A2SRQ19 A2SRQ20 A2SRQ21 A2SRQ22 A2SRQ23
A2SRQ24 A2SRQ25 A2SRQ26 A2SRQ27 A2SRQ28 A2SRQ29 A2SRQ30 A2SRQ31
A2SRQ32 A2SRQ33 A2SRQ34 A2SRQ35 A2SRQ36
  /SCALE('SRQ2_descriptive statistics') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL MEANS CORR.

RELIABILITY
  /VARIABLES=A2SRQ13 A2SRQ16 A2SRQ18 A2SRQ19 A2SRQ20 A2SRQ30 A2SRQ31
  /SCALE('SRQ2_Att_descriptive statistics') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL MEANS CORR.

RELIABILITY
  /VARIABLES=A2SRQ07 A2SRQ10 A2SRQ21 A2SRQ22 A2SRQ27 A2SRQ28 A2SRQ33
A2SRQ34 A2SRQ35 A2SRQ36
  /SCALE('SRQ2_Con_descriptive statistics') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL MEANS CORR.

RELIABILITY
  /VARIABLES=A2SRQ05 A2SRQ06 A2SRQ11 A2SRQ12 A2SRQ14 A2SRQ15 A2SRQ17
A2SRQ23 A2SRQ26
  /SCALE('SRQ2_Neg_descriptive statistics') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL MEANS CORR.

RELIABILITY
```

```
  /VARIABLES=A2SRQ01 A2SRQ02 A2SRQ03 A2SRQ04 A2SRQ08 A2SRQ09 A2SRQ24
A2SRQ25 A2SRQ29 A2SRQ32
  /SCALE('SRQ2_Aff_descriptive statistics') ALL
  /MODEL=ALPHA
  /STATISTICS=DESCRIPTIVE SCALE CORR
  /SUMMARY=TOTAL MEANS CORR.
```

Outliers

```
EXAMINE VARIABLES=SRQmean_S_AFF SRQmean_S_ATT SRQmean_S_CON
SRQmean_S_NEG
  /PLOT BOXPLOT STEMLEAF HISTOGRAM
  /COMPARE GROUPS
  /MESTIMATORS HUBER(1.339) ANDREW(1.34) HAMPEL(1.7,3.4,8.5) TUKEY(4.685)
  /STATISTICS DESCRIPTIVES
  /CINTERVAL 95
  /MISSING PAIRWISE
  /NOTOTAL.
```

Factor Analysis

```
FACTOR
  /VARIABLES SRQ01 SRQ02 SRQ03 SRQ04 SRQ05 SRQ06 SRQ07 SRQ08 SRQ09
SRQ10 SRQ11 SRQ12 SRQ13 SRQ14 SRQ15 SRQ16 SRQ17 SRQ18 SRQ19 SRQ20
SRQ21 SRQ22 SRQ23 SRQ24 SRQ25 SRQ26 SRQ27 SRQ28 SRQ29 SRQ30 SRQ31
SRQ32 SRQ33 SRQ34 SRQ35 SRQ36
  /MISSING PAIRWISE
  /ANALYSIS SRQ01 SRQ02 SRQ03 SRQ04 SRQ05 SRQ06 SRQ07 SRQ08 SRQ09 SRQ10
SRQ11 SRQ12 SRQ13 SRQ14 SRQ15 SRQ16 SRQ17 SRQ18 SRQ19 SRQ20 SRQ21
SRQ22 SRQ23 SRQ24 SRQ25 SRQ26 SRQ27 SRQ28 SRQ29 SRQ30 SRQ31 SRQ32
SRQ33 SRQ34 SRQ35 SRQ36
  /PRINT UNIVARIATE INITIAL CORRELATION KMO EXTRACTION ROTATION
  /FORMAT SORT
  /PLOT EIGEN
  /CRITERIA FACTORS(3) ITERATE(25)
  /EXTRACTION PAF
  /CRITERIA ITERATE(25)
  /ROTATION VARIMAX
  /METHOD=CORRELATION.
```

Appendix L: SRQ Inter-Item Correlation Matrix

	Q 01	Q 02	Q 03	Q 04	Q 05	Q 06	Q 07	Q 08	Q 09	Q 10	Q 11	Q 12	Q 13	Q 14	Q 15	Q 16	Q 17	Q 18	Q 19	Q 20	Q 21	Q 22	Q 23	Q 24	Q 25	Q 26	Q 27	Q 28	Q 29	Q 30	Q 31	Q 32	Q 33	Q 34	Q 35	Q 36
Q 01		.5	.76	.51	-.07	-.06	.11	.13	.30	-.35	-.26	-.03	-.41	-.03	-.05	-.49	-.28	-.37	-.26	-.18	.11	.09	-.32	.53	.33	.11	-.03	.18	.48	-.39	-.44	.49	.11	.01	.02	-.06
Q 02	.5		.46	.42	-.03	-.02	.16	.11	.29	-.24	-.16	.02	-.25	-.12	.04	-.25	-.09	-.15	-.12	.02	.11	.10	-.29	.38	.31	.11	.00	.14	.53	-.29	-.22	.43	.23	.11	.05	.14
Q 03	* .76	.46		.58	-.11	-.04	-.01	.10	.29	-.31	-.20	-.10	-.36	-.06	-.09	-.46	-.25	-.35	-.31	-.13	.08	.05	-.34	.57	.35	.05	-.11	.21	.50	-.39	-.45	.50	.15	.04	-.01	-.05
Q 04	* .51	.42	* .58		-.05	-.06	-.01	.08	.22	-.28	-.12	-.02	-.38	-.09	-.06	-.43	-.23	-.19	-.24	-.13	.09	-.03	-.39	.53	.31	.10	.12	.02	.54	-.25	-.45	.37	.13	.01	.06	-.07
Q 05	-.07	-.03	-.11	-.05		.26	-.09	.14	-.03	.03	.33	.40	.09	.25	.31	.10	.18	.12	.06	.13	-.11	-.14	.21	.13	-.11	.12	.04	-.18	-.08	.06	.15	-.04	-.08	-.20	-.11	-.18
Q 06	-.06	-.02	-.04	-.06	.26		-.10	.09	-.03	.03	.12	.15	.07	.08	.16	.19	.13	.03	.03	.09	.07	-.09	.10	.10	-.06	.11	.02	-.05	-.08	.04	.05	-.03	.05	-.11	-.08	-.09
Q 07	.11	.16	-.01	-.01	-.09	-.10		.12	.16	.15	-.13	-.20	-.08	-.23	-.08	.08	-.06	.05	.07	.19	.33	.42	-.05	-.02	.13	.04	.20	.25	.08	.01	.03	.14	.21	.17	.48	.30
Q 08	* .13	* .11	* .10	* .08	.14	.09	.12		.19	-.15	-.11	.12	-.09	.00	-.01	.03	-.01	.13	-.01	.16	.05	-.07	-.01	.21	.20	.11	-.08	.08	.11	-.21	.02	.26	.24	.06	.10	-.18
Q 09	.30	.29	.29	.22	-.03	-.03	.16	* .19		-.23	-.14	-.02	-.13	.04	-.09	-.01	-.06	.01	-.06	.08	-.02	.04	-.07	.27	.24	.21	-.02	.21	.30	-.15	-.18	.23	.10	.05	.09	.04
Q 10	-.35	-.24	-.31	-.28	.03	.03	* .15	-.15	-.23		.10	-.23	.38	-.02	.00	.30	.06	.14	.17	.14	.18	.27	.31	-.32	-.29	-.19	.23	.18	-.28	.30	.35	-.28	.10	-.03	.29	.25
Q 11	-.26	-.16	-.20	-.12	.33	* .12	-.13	-.11	-.14	.10		.40	.33	.33	.27	19	.32	.16	.23	.21	-.16	-.10	.35	-.17	-.20	.27	.03	-.11	-.19	.29	.27	-.25	-.02	-.17	-.10	-.03
Q 12	-.03	.02	-.10	-.02	.40	* .15	-.20	.12	-.02	-.23	.40		.02	.34	.28	.02	.14	.07	.13	.08	-.25	-.29	.16	.03	-.07	.33	-.08	-.29	-.06	-.00	.14	.02	-.06	-.18	-.24	-.15
Q 13	-.41	-.25	-.36	-.38	.09	.07	-.08	-.09	-.13	.38	.33	.02		.20	.18	.48	.36	.32	.29	.20	-.08	.09	.49	-.44	-.37	-.14	.07	-.10	-.40	.40	.56	-.42	-.07	-.11	.10	.08
Q	-	-	-	-	.25	*	-	.00	.04	-	.33	.34	.20		.26	.04	.29	.07	.17	.07	-	-	.21	.01	-	.27	-	-	-	.18	.07	-	-	-	-	-

14	.03	.12	.06	.09		.08	.23			.02											.33	.24			.19		.07	.11	.12			.15	.15	.19	.09	.13
Q 15	-.05	.04	-.09	-.06	.31	*.16	-.08	-.01	-.09	.00	.27	.28	.18	.26		-.00	.33	.08	.09	.14	-.16	-.12	.07	.02	-.12	.19	-.11	-.15	-.04	.10	.13	-.12	-.13	-.23	-.11	-.12
Q 16	-.49	-.25	-.46	-.43	.10	.19	.08	.03	-.01	.30	.19	.02	.48	.04	-.00		.24	.39	.33	.27	-.03	.07	.40	-.36	-.29	-.10	.03	-.05	-.38	.31	.48	-.40	.02	.12	.13	.14
Q 17	-.28	-.09	-.25	-.23	*.18	*.13	-.06	-.01	-.06	.06	.32	*.14	.36	.29	.33	.24		.31	.31	.06	-.06	.06	.30	-.15	-.32	.14	-.02	-.22	-.34	.23	.36	-.35	-.06	-.07	.05	-.01
Q 18	-.37	-.15	-.35	-.19	.12	.03	.05	.13	.01	.14	.16	.07	.32	.07	.08	.39	.31		.43	.24	-.04	.02	.16	-.23	-.28	.04	.06	-.06	-.17	.20	.50	-.21	.10	-.05	.13	.09
Q 19	-.26	-.12	-.31	-.24	.06	.03	.07	-.01	-.06	.17	.23	.13	.29	.17	.09	.33	.31	.43		.24	-.03	.17	.23	-.18	-.24	.15	.05	-.09	-.30	.22	.41	-.29	-.02	.08	.25	.11
Q 20	-.18	.02	-.13	-.13	.13	.09	.19	.16	.08	.14	.21	.08	.20	.07	.14	.27	.06	.24	.24		.07	.05	.27	-.14	-.10	-.05	-.10	.14	-.08	.22	.33	-.21	.17	.05	.18	.24
	Q 01	Q 02	Q 03	Q 04	Q 05	Q 06	Q 07	Q 08	Q 09	Q 10	Q 11	Q 12	Q 13	Q 14	Q 15	Q 16	Q 17	Q 18	Q 19	Q 20	Q 21	Q 22	Q 23	Q 24	Q 25	Q 26	Q 27	Q 28	Q 29	Q 30	Q 31	Q 32	Q 33	Q 34	Q 35	Q 36
Q 21	.11	.11	.08	.09	-.11	.07	.33	.47	-.02	*.18	-.16	-.25	-.08	-.33	-.16	-.03	-.06	-.04	-.03	.07		.55	-.17	.08	.24	-.23	.17	.21	.17	-.04	-.07	.17	.30	.15	.38	.22
Q 22	.09	.1	.05	-.03	-.14	-.09	.42	-.07	.04	.27	-.10	-.29	.09	-.24	-.12	.07	.06	.02	.17	.05	*.55		-.04	.06	.13	-.26	.25	.24	.10	.07	.12	-.01	.20	.20	.56	.35
Q 23	-.32	-.29	-.34	-.40	.21	*.10	-.05	-.01	-.07	.31	.35	*.16	.49	.21	*.07	.40	.30	.16	.23	.27	-.17	-.04		-.33	-.35	-.13	.09	.01	-.39	.30	.48	-.40	-.08	-.02	.05	.23
Q 24	*.53	.38	*.57	*.53	.13	.10	.02	.21	.27	-.32	-.17	.03	-.44	.01	.02	-.36	-.15	-.23	-.18	-.14	.08	.06	-.33		.37	.15	-.01	.08	.56	-.29	-.39	.48	.15	.03	-.07	-.06
Q 25	.33	.31	.35	.31	-.11	-.06	.13	.20	.24	-.29	-.20	-.07	-.37	-.19	-.12	-.29	-.32	-.28	-.24	-.10	.24	.13	-.35	.37		.08	.00	.25	.49	-.29	-.31	.51	.31	.08	.04	.10
Q 26	.11	.11	.05	.10	*.12	*.11	.04	.11	.21	-.19	.27	.33	-.14	.27	*.19	-.10	*.14	.04	.15	-.05	-.23	-.26	*-.13	.15	.08		-.08	-.06	.08	-.06	-.15	.20	-.06	-.13	-.15	-.25
Q 27	-.03	.0	-.11	.12	.04	.02	.20	-.08	-.02	.23	.03	-.08	.07	-.07	-.11	.03	-.02	.06	.05	-.10	*.17	.25	.09	-.01	.00	-.08		.16	.03	.01	.08	-.01	.10	.38	.43	.30
Q 28	.18	.14	.21	.02	-.18	-.05	.25	.08	.21	*.18	-.11	-.29	-.10	-.11	-.15	-.05	-.22	-.06	-.09	.14	.21	.24	.01	.08	.25	-.06	*.16		.24	-.11	-.13	.13	.25	.36	.22	.37
Q 29	.48	*.53	.5	*.54	-.08	-.08	.08	*.11	.30	-.28	-.19	-.06	-.40	-.12	-.04	-.38	-.34	-.17	-.30	-.08	.17	.10	-.39	*.56	.49	.08	.03	.24		-.24	-.38	.60	.26	.09	.05	.08

Q 30	-.39	-.29	-.39	-.25	.06	.04	.01	-.21	-.15	.30	.29	.00	.40	.18	.10	.31	.23	.20	.22	.22	-.04	.07	.30	-.29	-.29	-.06	.01	-.11	-.24		.47	-.41	-.04	-.05	.12	.13
Q 31	-.44	-.22	-.45	-.45	.15	.05	.03	.02	-.18	.35	.27	.14	*.56	.07	.13	.48	.36	.50	.41	.33	-.07	.12	.48	-.39	-.31	-.15	.08	-.13	-.38	.47		-.39	.07	.03	.11	.22
Q 32	.49	.43	.5	.37	-.04	-.03	.14	.26	.23	-.28	-.25	.02	-.42	-.15	-.12	-.39	-.35	-.21	-.29	-.21	.17	-.05	-.40	.48	*.51	.20	-.01	.13	*.60	-.41	-.39		.22	.05	-.09	-.01
Q 33	.11	.23	.15	.13	-.08	.05	.21	.24	.10	*.10	-.02	-.06	-.07	-.15	-.13	.02	-.06	.10	.02	.17	.30	.20	-.08	.15	.31	-.06	*.10	.25	.26	-.04	.07	.22		.26	.35	.42
Q 34	.01	.11	.04	.01	-.20	-.11	*.17	.06	.05	*-.03	-.17	-.18	-.11	-.19	-.23	.12	-.07	-.05	.08	.05	*.15	.20	-.02	.03	.08	-.13	.38	.36	.09	-.05	.03	.05	.26		.41	.35
Q 35	.02	.05	.01	.06	-.11	-.08	.48	.10	.09	.29	-.10	-.24	.10	-.09	-.11	.13	.05	.13	.25	.18	.38	*.56	.05	-.07	.04	-.15	.43	.22	.05	.12	.11	-.09	.35	.41		.48
Q 36	-.06	.12	-.05	-.07	-.18	-.09	.30	-.02	.04	.25	-.03	-.15	.08	-.13	-.12	.14	-.01	.09	.11	.24	.22	.35	.23	.06	.10	-.25	.30	.37	.08	.13	.22	-.01	.42	.35	.48	

Note: For each question, green cells indicate other items within the same domain, red cells indicate items in a different domain. Self-attack and self-affiliation question numbers are indicated in pink and blue respectively with shaded red cells indicating their correlations. Self-neglect question numbers are indicated in yellow and self-control in white. ≥.60 very high, .50 strong, .30 medium, .20 weak correlation.

*very high correlations >0.6

*strong correlations >0.5

*weak within domain correlations <0.2

*negative scores <0

Appendix M: Supplemental Tables

Table 1: Recommendations for the Revision of the 36-Item SRQ

Item No.	Question	Justification
Retain for Clinical Usefulness:		
18	I have physically hurt myself when I felt I deserved it	Clinically relevant irrespective of factor loadings below absolute value and low extraction communalities across all populations.
Remove:		
8	I comfort myself when I am sad or hurt	Originally intended as a self-affiliation item. Corrected item-total correlation .22, increasing alpha if removed from .86 to .87 (nonclinical). Multiple weak correlations were found involving this variable. Interwoven aspects of self-soothing and sadness/pain confounding item.
20	I hurt myself by overburdening myself with work	Lacks consistency. Originally intended as a self-attack item, loading below absolute value for this domain in the nonclinical sample (-.19). Weighted toward self-neglect in the nonclinical (.33) and self-control in the combined (.37) samples. Loaded as a self-control variable in the clinical sample (.41).
26	I only live for the moment	Lacks consistency. Originally intended as a self-neglect item however it just met minimum absolute value in the nonclinical sample (.40). Did not meet loading criteria for the clinical and combined populations. Multiple weak correlations were found

		involving this variable in both the nonclinical and clinical populations.

Review:

1 3	Even though I know I have some faults I am happy with myself as I am I am content with myself	Conceptual overlap. Squared multiple correlations r=.62 (nonclinical), r=.76 (clinical), and r=.65 (nonclinical), r=.75 (clinical) respectively. High inter-item correlation r=.76 (nonclinical), r=.81 (clinical). Combine items: 'Even though I know I have some faults I am happy and content with myself'.
4 24	I appreciate myself for just being me I like myself very much	Conceptual overlap. High inter-item correlation r=.53 (nonclinical), r=.70 (clinical). Combine items: 'I like and appreciate myself for just being me'.
29 32	I respect myself deeply I treat myself with love	Conceptual overlap. High inter-item correlation r=.60 (nonclinical) r=.74 (clinical). Combine items: 'I treat myself with love and respect'.
13 31	I don't feel that I deserve anything good to happen to me I think of ways to punish myself	Conceptual overlap. High inter-item correlation r=.56 (nonclinical). Combine items: 'I think of ways to punish myself and don't feel that I deserve anything good'.
22 35	I keep tight control over myself I watch myself closely to make sure I don't do the wrong thing	Conceptual overlap. High inter-item correlation r=.56 (nonclinical). Combine items: 'I keep tight control over myself to make sure I don't do the wrong thing'.
33 36	I try very hard to become like an ideal image of myself My goal is to be as perfect as possible	Conceptual overlap. High inter-item correlation r=.64 (clinical). Combine items: 'My goal is to be as perfect as possible, like an ideal image of myself'.

6 12 23 26	I believe that whatever happens, happens, so it's better not to try I don't check up on things to make sure they're done correctly I let my needs go unattended I only live for the moment	Corrected item-total correlations α =.23 (nonclinical), α =.27 (clinical), α =.27 (nonclinical) and α =.28/.11 (nonclinical/clinical) respectively. No improvement in alpha if items removed, however evidence of poor fit within the subscale. Multiple weak correlations were found involving these variables. Negative value inter-item correlations between items 23. 'I let my needs go unattended', and 26. 'I only live for the moment', (r=-0.13, nonclinical), and 12. 'I don't check up on things to make sure they're done correctly' and 26. 'I only live for the moment' (r=-.03, clinical). It is anticipated that removing item 26. may resolve these issues, along with item 12. as this was flagged as problematic multiple times in the clinical sample, i.e. it appears to imply a controlling aspect, and is similar to item 5. 'I avoid paying attention to important things'.
10	I criticize myself harshly when I don't do something perfectly	Originally intended as a self-control item but loaded in the nonclinical sample as self-attack. Corrected item-total correlation .30. Multiple weak correlations were found involving this variable. Negative value inter-item correlation with item 34. 'I try very hard to make sure my work is done on time' (r=-.03, nonclinical). Interwoven aspects of self-criticism and the expectation of perfection appear to be confounding the item. Perfection aspect is included in item 36. 'My goal is to be as perfect as possible' which can be combined with item 33. 'like an ideal image of myself'. Suggested revision: 10. 'I tend to be highly critical of myself' (self-attack domain).

Table 2: Revision of the 36-Item SRQ

Item No.	Question	Domain
1	~~Even though I know I have some faults I am happy with myself as I am~~ **Even though I know I have some faults I am happy and content with myself**	Self-Affiliation
2	I am comfortable with listening to my innermost feelings	Self-Affiliation
~~3~~	~~I am content with myself~~	~~Self-Affiliation~~
4	~~I appreciate myself for just being me~~ **I like and appreciate myself for just being me**	Self-Affiliation
5	I avoid paying attention to important things	Self-Neglect
6	I believe that whatever happens, happens, so it's better not to try	Self-Neglect
7	I carefully monitor my behaviour	Self-Control
~~8~~	~~I comfort myself when I am sad or hurt~~	~~Self-Affiliation~~
9	I confidently allow myself to do what feels right	Self-Affiliation
10	~~I criticize myself harshly when I don't do something perfectly~~ **I tend to be highly critical of myself**	~~Self-Control~~ Self-Attack
11	I don't attend to the condition of my personal environment	Self-Neglect
~~12~~	~~I don't check up on things to make sure they're done correctly~~	~~Self-Neglect~~
~~13~~	~~I don't feel that I deserve anything good to happen to me~~	~~Self-Attack~~
14	I don't spend much time planning for the future	Self-Neglect
15	I don't try to develop good habits or skills	Self-Neglect
16	I harshly reject myself as worthless	Self-Attack
17	I have no internal direction or goals	Self-Neglect
18	I have physically hurt myself when I felt I deserved it	Self-Attack
19	I have thought of hurting myself, although I haven't done it	Self-Attack
~~20~~	~~I hurt myself by overburdening myself with work~~	~~Self-Attack~~
21	I keep an eye on myself to be sure I am doing what I should	Self-Control

22	~~I keep tight control over myself~~ **I keep tight control over myself to make sure I don't do the wrong thing**	Self-Control
23	I let my needs go unattended	Self-Neglect
~~24~~	~~I like myself very much~~	~~Self-Affiliation~~
25	I look after my own best interests	Self-Affiliation
~~26~~	~~I only live for the moment~~	~~Self-Neglect~~
27	I put a great deal of energy into making sure I follow the rules properly	Self-Control
28	I put a lot of effort into everything that I do	Self-Control
~~29~~	~~I respect myself deeply~~	~~Self-Affiliation~~
30	I take my anger out on myself	Self-Attack
31	~~I think of ways to punish myself~~ **I think of ways to punish myself and don't feel that I deserve anything good**	Self-Attack
32	~~I treat myself with love~~ **I treat myself with love and respect**	Self-Affiliation
~~33~~	~~I try very hard to become like an ideal image of myself~~	~~Self-Control~~
34	I try very hard to make sure my work is done on time	Self-Control
~~35~~	~~I watch myself closely to make sure I don't do the wrong thing~~	~~Self-Control~~
36	~~My goal is to be as perfect as possible~~ **My goal is to be as perfect as possible, like an ideal image of myself**	Self-Control

Table 3: Revised 26-Item SRQ

Item No.	Question	Domain
1	Even though I know I have some faults I am happy and content with myself	Self-Affiliation
2	I am comfortable with listening to my innermost feelings	Self-Affiliation
3	I like and appreciate myself for just being me	Self-Affiliation

4	I avoid paying attention to important things	Self-Neglect
5	I believe that whatever happens, happens, so it's better not to try	Self-Neglect
6	I carefully monitor my behaviour	Self-Control
7	I confidently allow myself to do what feels right	Self-Affiliation
8	I tend to be highly critical of myself	Self-Attack
9	I don't attend to the condition of my personal environment	Self-Neglect
10	I don't spend much time planning for the future	Self-Neglect
11	I don't try to develop good habits or skills	Self-Neglect
12	I harshly reject myself as worthless	Self-Attack
13	I have no internal direction or goals	Self-Neglect
14	I have physically hurt myself when I felt I deserved it	Self-Attack
15	I have thought of hurting myself, although I haven't done it	Self-Attack
16	I keep an eye on myself to be sure I am doing what I should	Self-Control
17	I keep tight control over myself to make sure I don't do the wrong thing	Self-Control
18	I let my needs go unattended	Self-Neglect
19	I look after my own best interests	Self-Affiliation
20	I put a great deal of energy into making sure I follow the rules properly	Self-Control
21	I put a lot of effort into everything that I do	Self-Control
22	I take my anger out on myself	Self-Attack
23	I think of ways to punish myself and don't feel that I deserve anything good	Self-Attack
24	I treat myself with love and respect	Self-Affiliation
25	I try very hard to make sure my work is done on time	Self-Control
26	My goal is to be as perfect as possible, like an ideal image of myself	Self-Control

Table 4: Domain Structures of the Revised 26-Item SRQ

Item No.	Question
Self-Affiliation (6 items):	
1	Even though I know I have some faults I am happy and content with myself
2	I am comfortable with listening to my innermost feelings
3	I like and appreciate myself for just being me
7	I confidently allow myself to do what feels right
19	I look after my own best interests
24	I treat myself with love and respect
Self-Attack (6 items):	
8	I tend to be highly critical of myself
12	I harshly reject myself as worthless
14	I have physically hurt myself when I felt I deserved it
15	I have thought of hurting myself, although I haven't done it
22	I take my anger out on myself
23	I think of ways to punish myself and don't feel that I deserve anything good
Self-Neglect (7 items):	
4	I avoid paying attention to important things
5	I believe that whatever happens, happens, so it's better not to try
9	I don't attend to the condition of my personal environment
10	I don't spend much time planning for the future
11	I don't try to develop good habits or skills
13	I have no internal direction or goals
18	I let my needs go unattended
Self-Control (7 items):	

6	I carefully monitor my behaviour
16	I keep an eye on myself to be sure I am doing what I should
17	I keep tight control over myself to make sure I don't do the wrong thing
20	I put a great deal of energy into making sure I follow the rules properly
21	I put a lot of effort into everything that I do
25	I try very hard to make sure my work is done on time
26	My goal is to be as perfect as possible, like an ideal image of myself

Table 5: Preliminary Rational-Empirical Model of Negative Treatment of Self: Categories and Frequencies

Domains, Subdomains, Categories & Subcategories		Category
A.	**Objects of Negative Treatment of Self - Being, Doing & Having (What I Dislike About Myself)**	
A.1.	***Who I am (Being)***	
A.1.1.	Core-Self or Personality	*General*
A.1.2.	Self-Esteem or Self-Worth	*Unique*
A.1.3.	Body or Self-Image	*Unique*
A.2.	***What I do (Doing)***	
A.2.1.	Self-Expression	*General*
A.2.2.	Self-Efficacy, Performance, Action or Inaction:	
A.2.2.1.	Being Held Back by Limiting Emotion	*General*
A.2.2.2.	Falling Short of One's Own Expectation of Self	*General*
A.2.2.3.	Falling Short of the Perceived Expectation of Others	*Typical*
A.2.2.4.	Inability or Incapacity to Act	*Typical*
A.2.2.5.	Incompetence/Non-Proficiency in Attempted Action	*Typical*
A.2.2.6.	Lack of Success or Progress	*Typical*
A.3.	***What I have (Having)***	
A.3.1.	Life Situation	*Unique*
B.	**Directness of Negative Treatment of Self - Direct vs Indirect (How I Dislike Myself)**	
B.1.	***Direct Self-Critical Process via Self***	
B.1.1.	Self-Reproach or Censure	*General*
B.1.2.	Minimising or Negating Self-Affiliative Action	*Unique*
B.2.	***Indirect Self-Critical Process via Others***	
B.2.1.	Seeking External Validation	*General*
B.2.2.	Minimising or Negating Positive Reaction or Observation from Others	*Unique*
C.	**Modes of Negative Treatment of Self - Behaviour (What I Do That Is Bad For Me)**	
C.1.	***Self-Attack***	

C.1.1.	Negative Comparison of Self to Others	*General*
C.1.2.	Self-Derogation, Loathing or Rejection	*Unique*
C.1.3.	Self-Punitive or Hostile	*Unique*
C.2.	***Hostile Control***	
C.2.1.	Pressurising, Stressing or Overburdening Self:	
C.2.1.1.	Expecting Attack, Threat or Danger	*General*
C.2.1.2.	Expecting Judgement, Criticism or Rejection	*General*
C.2.1.3.	Meeting One's Own High Expectations	*General*
C.2.1.4.	Meeting the Perceived Expectations of Others	*General*
C.2.1.5.	Expecting Failure	*Typical*
C.2.1.6.	Expecting to be Ignored, Neglected or Overlooked	*Unique*
C.2.2.	Monitoring or Controlling Self – Restraining, Complying or Intruding	*General*
C.2.3.	Monitoring or Controlling Others – Enforced Propriety or Conformity	*Typical*
C.2.4.	Self-Doubt or Indecisiveness	*Typical*
C.3.	***Hostile Neglect***	
C.3.1.	Minimising, Negating or Avoiding One's Feelings	*General*
C.3.2.	Self-Neglect or Abandonment	*Typical*
C.3.3.	Acquiescing or Affirming Negative Reactions from Others	*Typical*
C.3.4.	Undeserving of Positive Reactions from Others	*Unique*
C.3.5.	Reacting in a Flooded or Overwhelmed Emotional State	*Unique*
C.4.	***Hostile Freedom or Separation from Others***	
C.4.1.	Isolating or Distancing Self from Others	*Typical*
C.4.2.	Self-Entitlement or Grandiosity	*Typical*
C.4.3.	Relinquishing Personal Responsibility	*Unique*
D.	**Emotional Effects of Negative Treatment of Self (What I Feel in Reaction to my Self-Dislike & Inimical Self-Actions)**	
D.1.	***Fear or Anxiety***	*General*
D.2.	***Sadness, Grief or Emotional Pain***	*General*
D.3.	***Anger or Frustration with Self or Others***	*General*
D.4.	***Guilt or Shame***	*General*

Note: Themes (n=39) include both client self-report (acknowledging) and observational (expressing) data. *General* means that this phenomenon applied to all four participants (n=17); *Typical* means that this phenomenon applied to two or three of the participants (n=11); *Unique* means that this phenomenon applied to one participant (n=11).

Table 6: Revised Rational-Empirical Model of Negative Treatment of Self as it Presents at the Beginning Phase of Therapy: Categories and Frequencies

Domains, Subdomains, Categories & Subcategories		Frequency (n=MU's)
A.	**Objects of Negative Treatment of Self - Being, Doing & Having (What I Dislike About Myself)**	
A.1.	***Who I am (Being)***	
A.1.1.	Core-Self or Personality:	
A.1.1.1.	Abhorrent, Contemptible or Deplorable Self	*Typical (12)*
A.1.1.2.	Broken, Flawed or Defective Self	*Typical (8)*

A.1.2.	Self-Esteem or Self-Worth	*Typical (4)*
A.1.3.	Body or Self-Image	*N/a*
A.2.	***What I do (Doing)***	
A.2.1.	Self-Expression:	
A.2.1.1.	Saying the Wrong Thing (Boring, Hurtful, Stupid)	*Typical (2)*
A.2.1.2.	Not Knowing What to Say or Having Nothing to Talk About	*Unique (5)*
A.2.1.3.	Failing at Conversation, Making it Awkward or Difficult	*Typical (6)*
A.2.2.	Self-Efficacy, Performance, Action or Inaction:	
A.2.2.1.	Being Held Back or Affected by Impeding Emotions/ Feelings/ Old Stuck Patterns:	
A.2.2.1.1.	Emotion Limiting or Affecting Behaviour	*Typical (12)*
A.2.2.1.2.	Emotion Affecting Perception or Decision Making	*Unique (1)*
A.2.2.1.3.	Emotion Perpetuating Old Stuck Patterns	*Unique (3)*
A.2.2.1.4.	Criticising, Resenting or Rejecting Self Parts That Impede And Create Difficulties	*Typical 11)*
A.2.2.2.	Falling Short of One's Own Expectation of Self:	
A.2.2.2.1.	Oughts and Shoulds	*Typical (7)*
A.2.2.2.2.	Lack of Focus or Direction	*Unique (1)*
A.2.2.2.3.	Lack of Energy or Motivation	*Unique (1)*
A.2.2.2.4.	Self-Disappointment/ Expecting More From Self	*Typical (6)*
A.2.2.3.	Falling Short of the Perceived Expectation of Others:	
A.2.2.3.1.	They Are Ashamed Of Me	*Unique (3)*
A.2.2.3.2.	They Are Annoyed By Me	*Unique (2)*
A.2.2.3.3.	They Are Disappointed With Me	*Unique (1)*
A.2.2.4.	Inability or Incapacity to Act/ Receive Criticism/ Defend Self:	
A.2.2.4.1.	I Can't Do The Things I'd Like To Do or Feel I Ought To Be Able To Do	*Typical (7)*
A.2.2.4.2.	I Can't Do What's Expected Of Me	*Typical (3)*
A.2.2.4.3.	I Can't Take Criticism	*Unique (2)*
A.2.2.4.4.	I Can't Respond Effectively To Assert or Defend Myself	*Unique (7)*
A.2.2.5.	Incompetence/Non-Proficiency in Attempted Action:	
A.2.2.5.1.	I'm Hopeless, Inadequate, Useless or Incompetent	*Typical (7)*
A.2.2.5.2.	I'm Not Logical or Clever (Stupidity, Confusion or Lack of Understanding)	*Typical (13)*
A.2.2.5.3.	I Don't React or Respond Well, I Get Things Wrong and Make Mistakes	*Typical (13)*
A.2.2.5.4.	I Can't Win, No Matter What I Do or How Much I Try	*Typical (3)*
A.2.2.6.	Lack of Success or Progress/ Failure:	
A.2.2.6.1.	I Try But I Fail or I Expect to Fail	*Typical (3)*
A.2.2.6.2.	I Don't Find Solutions	*Unique (3)*
A.2.2.7.	Avoidance Strategies:	
A.2.2.7.1.	Avoidance Through Fantasy, Pretence or Dishonesty	*Typical (7)*
A.2.2.7.2.	Avoidance Through Submission and Passivity	*Unique (2)*
A.2.2.7.3.	Avoidance Through Blocking Uncomfortable Feelings	*Unique (1)*
A.3.	***What I have (Having)***	
A.3.1.	Life Situation	*Typical (2)*
A.3.2.	My Relationships	*Unique (3)*
B.	**Directness of Negative Treatment of Self - Direct vs Indirect (How I Dislike Myself)**	
B.1.	***Direct Self-Critical Process via Self***	
B.1.1.	Self-Reproach or Censure	*Typical (3)*
B.1.2.	Minimising or Negating Self-Affiliative Action	*N/a*
B.2.	***Indirect Self-Critical Process via Others***	

B.2.1.	Seeking External Validation	*Typical (2)*
B.2.2.	Minimising or Negating Positive Reaction or Observation from Others	*N/a*
C.	**Modes of Negative Treatment of Self - Behaviour (What I Do That Is Bad For Me)**	
C.1.	***Self-Attack***	
C.1.1.	Negative Comparison of Self to Others:	
C.1.1.1.	Other People Perform Better Than Me	*Typical (6)*
C.1.1.2.	Other People Are Nicer, More Normal or More Open Than Me	*Typical (4)*
C.1.1.3.	Other People Know Better Than Me	*Unique (2)*
C.1.2.	Self-Derogation, Loathing or Rejection:	
C.1.2.1.	I Insult Myself	*Typical (2)*
C.1.2.2.	I Dislike, Hate or Reject Myself	*Unique (8)*
C.1.2.3.	I'm Ashamed of Myself	*Unique (2)*
C.1.3.	Self-Punitive or Hostile:	
C.1.3.1.	I Take My Anger and Frustration Out On Myself	*Typical (11)*
C.1.3.2.	I Attack or Punish Myself	*Typical (9)*
C.1.3.3.	I Injure Myself	*Unique (7)*
C.1.4.	Self-Reproach, Blame or Judgement	*Typical (8)*
C.2.	***Hostile Control***	
C.2.1.	Pressurising, Stressing or Overburdening Self:	
C.2.1.1.	Expecting Attack, Threat, Danger or Repercussion:	
C.2.1.1.1.	I Will Be Hurt or Bullied	*Typical (6)*
C.2.1.1.2.	I Feel Unsafe, Vulnerable or Uneasy	*Typical (8)*
C.2.1.1.3.	Anything Could Happen or Go Wrong	*Typical (3)*
C.2.1.2.	Expecting Judgement, Criticism, Rejection or Ridicule:	
C.2.1.2.1.	I Will Be Judged, Criticised or Rejected	*Typical (11)*
C.2.1.2.2.	I Will Be Belittled, Mocked or Picked On	*Typical (8)*
C.2.1.2.3.	I Am Disliked, People Are Not Interested In Me or I Don't Fit In	*Typical (8)*
C.2.1.2.4.	People Get Annoyed With Me, They Find Me Unbearable or Push Me Away	*Typical (5)*
C.2.1.2.5.	People See Me As An Easy Target	*Typical (3)*
C.2.1.3.	Meeting One's Own High Expectations:	
C.2.1.3.1.	I Expect Myself To Be Capable	*Unique (2)*
C.2.1.3.2.	I Should Do Better	*Unique (2)*
C.2.1.3.3.	I Shouldn't Make Mistakes	*Unique (1)*
C.2.1.4.	Meeting the Perceived Expectations of Others:	
C.2.1.4.1.	I'm Expected To Converse	*Unique (6)*
C.2.1.4.2.	I'm Expected To Be Capable	*Typical (3)*
C.2.1.4.3.	I'm Expected To Respond The Way Others Want	*Typical (3)*
C.2.1.5.	Expecting Failure, Getting Things Wrong or Worst Case Scenario	*Typical (3)*
C.2.1.6.	Expecting to be Ignored, Neglected or Overlooked	*Typical (3)*
C.2.1.7.	Expecting to be Undermined or Taken Advantage Of	*Unique (1)*
C.2.2.	Monitoring or Controlling Self – Restraining, Complying or Intruding:	
C.2.2.1.	Stopping, Restraining or Limiting Self	*Typical (3)*
C.2.2.2.	Being Agreeable, Pushing Self To Comply or Intrude	*Typical (3)*
C.2.2.3.	Avoiding or Restricting Communication With Others	*Typical (12)*
C.2.2.4.	Guarding or Hiding Parts of Self	*Unique (6)*
C.2.2.5.	Avoiding Social Interactions With Others	*Unique (2)*
C.2.3.	Monitoring or Controlling Others – Enforced Propriety or Conformity	*N/a*
C.2.4.	Self-Doubt or Indecisiveness:	

C.2.4.1.	I'm Unsure How To Comprehend or Make Sense of It	*Typical (12)*
C.2.4.2.	I'm Unsure What I'm Experiencing	*Typical (4)*
C.2.4.3.	I'm Unsure If I Can Do It	*Unique (1)*
C.3.	***Hostile Neglect***	
C.3.1.	Minimising, Negating or Avoiding One's Feelings:	
C.3.1.1.	I Don't Know What I'm Feeling	*Unique (1)*
C.3.1.2.	I Don't Want Others To Know What I'm Feeling	*Typical (2)*
C.3.1.3.	It's Difficult to Arrive At The Feeling	*Unique (1)*
C.3.1.4.	I'm Negatively Judging What I'm Feeling	*Unique (2)*
C.3.1.5.	I Don't Know What To Do With The Feeling	*Unique (1)*
C.3.1.6.	I'm Avoiding, Blocking, Masking or Minimising The Feeling	*Typical (8)*
C.3.2.	Self-Neglect or Abandonment/ Not Attending to Important Things:	
C.3.2.1.	Other People's Opinions Carry More Weight Than Mine	*Unique (3)*
C.3.2.2.	I Have No Direction or Motivation	*Unique (3)*
C.3.2.3.	I Hide Myself Away From Life	*Unique (1)*
C.3.2.4.	I Don't Attend to My Basic Needs	*Unique (1)*
C.3.3.	Acquiescing or Affirming Negative Reactions From Others:	
C.3.3.1.	Taking On Board Negative or Hostile Reactions From Others	*Unique (4)*
C.3.3.2.	Submitting To or Appeasing Hostile Demands or Reactions of Others	*Typical (5)*
C.3.3.3.	Assuaging or Mitigating Negative or Hostile Reactions From Others	*Typical (6)*
C.3.4.	Undeserving of Positive Reactions From Others	*N/a*
C.3.5.	Reacting in a Flooded or Overwhelmed Emotional State:	
C.3.5.1.	Quick To Anger	*Typical (4)*
C.3.5.2.	Emotionally Triggered	*Unique (1)*
C.3.5.3.	Compounding Emotion	*Unique (2)*
C.4.	***Hostile Freedom or Separation from Others***	
C.4.1.	Isolating or Distancing Self from Others:	
C.4.1.1.	I Avoid Social Interaction As I Worry About Conversing, I Don't Know What To Say	*Typical (6)*
C.4.1.2.	I Am Guarded With Others Because I Don't Trust People	*Typical (4)*
C.4.1.3.	I Am Guarded With Others To Hide Parts of Myself	*Unique (6)*
C.4.1.4.	I Feel Uncomfortable Around Others, I Isolate or Distance To Protect Myself	*Unique (4)*
C.4.1.5.	I Feel Uncomfortable Going Into Public Places On My Own	*Unique (2)*
C.4.1.6.	I Instrumentally Distance Myself From Others	*Unique (1)*
C.4.2.	Self-Entitlement or Grandiosity	*N/a*
C.4.3.	Relinquishing Personal Responsibility or Agency	*Typical (3)*
D.	**Emotional Effects of Negative Treatment of Self (What I Feel Preceding or in Reaction to my Self-Dislike & Inimical Self-Actions)**	
D.1.	***Fear, Anxiety, Panic, Worry or Tension***	*General (25)*
D.2.	***Sadness, Grief or Emotional Pain***	*General (30)*
D.3.	***Anger or Frustration with Self or Others***	*Typical (21)*
D.4.	***Shame, Humiliation or Embarrassment***	*Typical (5)*
D.5.	***Guilt, Regret or Remorse***	*Typical (5)*

Note: Themes (n=103) include both client self-report (acknowledging) and observational (expressing) data. *General* means that this phenomenon applied to all six participants (n=2); *Typical* means that this phenomenon applied to two to five of the participants (n=54); *Unique* means that this phenomenon applied to only one participant (n=41); *N/a* means that this phenomenon applied to none of the participants (n=6). Red indicates the elaborations to the preliminary rational model (depicted in Black) following the beginning phase analysis.

Table 7: Empirical Model of Negative Treatment of Self Incorporating the Ending Phase of Therapy: Categories and Frequencies

	Domains, Subdomains, Categories & Subcategories	*Tx* Beg.	*Tx* End	*Tx* Total	*f* End
A.	**Objects of Negative Treatment of Self - Being, Doing & Having (What I Dislike About Myself)**				
A.1.	***Who I am (Being)***				
A.1.1.	Core-Self or Personality:				
A.1.1.1.	Abhorrent, Contemptible or Deplorable Self	12	5	17	*Typical*
A.1.1.2.	Broken, Flawed or Defective Self	8	5	13	*Typical*
A.1.2.	Self-Esteem or Self-Worth	4	1	5	*Unique*
A.1.3.	Body or Self-Image	0	5	5	*Typical*
A.2.	***What I do (Doing)***				
A.2.1.	Self-Expression:				
A.2.1.1.	Saying the Wrong Thing (Boring, Hurtful, Stupid)	2	3	5	*Unique*
A.2.1.2.	Not Knowing What to Say or Having Nothing to Talk About	5	6	11	*Unique*
A.2.1.3.	Failing at Conversation, Making it Awkward or Difficult	6	0	6	*N/a*
A.2.2.	Self-Efficacy, Performance, Action or Inaction:				
A.2.2.1.	Being Held Back or Affected by Impeding Emotions/Feelings/ Old Stuck Patterns:				
A.2.2.1.1.	Emotion Limiting or Affecting Behaviour	12	5	17	*Typical*
A.2.2.1.2.	Emotion Affecting Perception or Decision Making	1	1	2	*Unique*
A.2.2.1.3.	Emotion Perpetuating Old Stuck Patterns	3	6	9	*Typical*
A.2.2.1.4.	Criticising, Resenting or Rejecting Self Parts That Impede And Create Difficulties	11	5	16	*Typical*
A.2.2.2.	Falling Short of One's Own Expectations of Self:				
A.2.2.2.1.	Oughts and Shoulds	7	2	9	*Typical*
A.2.2.2.2.	Lack of Focus or Direction	1	0	1	*N/a*
A.2.2.2.3.	Lack of Energy or Motivation	1	0	1	*N/a*
A.2.2.2.4.	Self-Disappointment/ Expecting More From Self	6	6	12	*Typical*
A.2.2.3.	Falling Short of the Perceived Expectations of Others:				
A.2.2.3.1.	They Are Ashamed Of Me	3	0	3	*N/a*
A.2.2.3.2.	They Are Annoyed By Me	2	0	2	*N/a*
A.2.2.3.3.	They Are Disappointed With Me	1	0	1	*N/a*
A.2.2.3.4.	They Are Bored With Me or Disinterested	0	5	5	*Unique*
A.2.2.4.	Inability or Incapacity to Act/ Receive Criticism/ Defend Self:				
A.2.2.4.1.	I Can't Do The Things I'd Like To Do or Feel I Ought To Be Able To Do	7	12	19	*Typical*
A.2.2.4.2.	I Can't Do What's Expected Of Me	3	1	4	*Unique*
A.2.2.4.3.	I Can't Take Criticism	2	0	2	*N/a*
A.2.2.4.4.	I Can't Respond Effectively To Assert or Defend Myself	7	2	9	*Typical*
A.2.2.5.	Incompetence/Non-Proficiency in Attempted Action:				
A.2.2.5.1.	I'm Hopeless, Inadequate, Useless, Incompetent or Talentless	7	2	9	*Unique*
A.2.2.5.2.	I'm Not Logical or Clever (Stupidity, Confusion, Lack of Understanding, I Don't Know How)	13	3	16	*Typical*
A.2.2.5.3.	I Don't React or Respond Well, I Get Things Wrong and Make Mistakes	13	8	21	*Typical*

A.2.2.5.4.	I Get Stuck, I Can't Win, No Matter What I Do or How Much I Try	3	13	16	*Typical*
A.2.2.6.	Lack of Success or Progress/ Failure:				
A.2.2.6.1.	I Try But I Fail or I Expect to Fail	3	2	5	*Unique*
A.2.2.6.2.	I Don't Find Solutions	3	0	3	*N/a*
A.2.2.7.	Avoidance Strategies:				
A.2.2.7.1.	Avoidance Through Fantasy, Pretence or Dishonesty	7	10	17	*Unique*
A.2.2.7.2.	Avoidance Through Submission and Passivity	2	0	2	*N/a*
A.2.2.7.3.	Avoidance Through Blocking Uncomfortable Feelings	1	0	1	*N/a*
A.3.	***What I have (Having)***				
A.3.1.	Life Situation	2	4	6	*Unique*
A.3.2.	My Relationships	3	0	3	*N/a*
B.	**Directness of Negative Treatment of Self – Direct vs Indirect (How I Dislike Myself)**				
B.1.	***Direct Self-Critical Process via Self***				
B.1.1.	Self-Reproach or Censure	3	11	14	*Unique*
B.1.2.	Minimising or Negating Self-Affiliative Action	0	0	0	*N/a*
B.2.	***Indirect Self-Critical Process via Others***				
B.2.1.	Seeking External Validation	2	14	16	*General*
B.2.2.	Minimising or Negating Positive Reaction or Observation from Others	0	0	0	*N/a*
C.	**Modes of Negative Treatment of Self – Behaviour (What I Do That Is Bad For Me)**				
C.1.	***Self-Attack***				
C.1.1.	Negative Comparison of Self to Others:				
C.1.1.1.	Other People Perform Better Than Me	6	1	7	*Unique*
C.1.1.2.	Other People Are Nicer, More Normal, More Tolerant or More Open Than Me	4	2	6	*Unique*
C.1.1.3.	Other People Are Better or Know Better Than Me	2	5	7	*Typical*
C.1.2.	Self-Derogation, Loathing or Rejection:				
C.1.2.1.	I Insult Myself	2	4	6	*Typical*
C.1.2.2.	I Dislike, Hate or Reject Myself	8	4	12	*Unique*
C.1.2.3.	I'm Ashamed of Myself	2	1	3	*Unique*
C.1.3.	Self-Punitive or Hostile:				
C.1.3.1.	I Take My Anger and Frustration Out On Myself	11	2	13	*Unique*
C.1.3.2.	I Attack or Punish Myself	9	0	9	*N/a*
C.1.3.3.	I Injure Myself	7	0	7	*N/a*
C.1.4.	Self-Reproach, Blame or Judgement	8	12	20	*Typical*
C.2.	***Hostile Control***				
C.2.1.	Pressurising, Stressing or Overburdening Self:				
C.2.1.1.	Expecting Attack, Threat, Danger or Repercussion:				
C.2.1.1.1.	I Will Be Hurt or Bullied	6	3	9	*Typical*
C.2.1.1.2.	I Feel Unsafe, Vulnerable or Uneasy	8	26	34	*Typical*
C.2.1.1.3.	Anything Could Happen or Go Wrong	3	0	3	*N/a*
C.2.1.1.4.	There Will Be Consequences	0	2	2	*Typical*
C.2.1.2.	Expecting Judgement, Criticism, Rejection or Ridicule:				
C.2.1.2.1.	I Will Be Judged, Criticised or Rejected	11	21	32	*Typical*
C.2.1.2.2.	I Will Be Belittled, Mocked or Picked On	8	3	11	*Typical*
C.2.1.2.3.	I Am Disliked, People Are Not Interested In Me or I Don't Fit In	8	12	20	*Typical*

C.2.1.2.4.	People Get Annoyed With Me, They Find Me Unbearable or Push Me Away	5	3	8	*Unique*
C.2.1.2.5.	People See Me As An Easy Target	3	0	3	*N/a*
C.2.1.3.	Meeting One's Own High Expectations:				
C.2.1.3.1.	I Expect Myself To Be Capable	2	2	4	*Unique*
C.2.1.3.2.	I Should Do or Be Better	2	2	4	*Typical*
C.2.1.3.3.	I Shouldn't Make Mistakes	1	0	1	*N/a*
C.2.1.4.	Meeting the Perceived Expectations of Others:				
C.2.1.4.1.	I'm Expected To Converse	6	2	8	*Unique*
C.2.1.4.2.	I'm Expected To Be Capable	3	0	3	*N/a*
C.2.1.4.3.	I'm Expected To Respond The Way Others Want	3	3	6	*Unique*
C.2.1.4.4.	I Try To Be Nice To Be Accepted	0	1	1	*Unique*
C.2.1.5.	Expecting Failure, Getting Things Wrong or Worst Case Scenario	3	0	3	*N/a*
C.2.1.6.	Expecting to be Ignored, Neglected or Overlooked	3	0	3	*N/a*
C.2.1.7.	Expecting to be Undermined or Taken Advantage Of	1	0	1	*N/a*
C.2.2.	Monitoring or Controlling Self – Restraining, Complying or Intruding:				
C.2.2.1.	Stopping, Restraining or Limiting Self	3	3	6	*Typical*
C.2.2.2.	Being Agreeable, Pushing Self To Comply or Intrude	3	0	3	*N/a*
C.2.2.3.	Avoiding or Restricting Communication With Others	12	2	14	*Typical*
C.2.2.4.	Guarding or Hiding Parts of Self	6	0	6	*N/a*
C.2.2.5.	Avoiding Social Interactions With Others	2	0	2	*N/a*
C.2.3.	Monitoring or Controlling Others – Enforced Propriety or Conformity	0	2	2	*Unique*
C.2.4.	Self-Doubt or Indecisiveness:				
C.2.4.1.	I'm Unsure How To Comprehend or Make Sense of It	12	12	24	*Typical*
C.2.4.2.	I'm Unsure What I'm Experiencing	4	26	30	*Typical*
C.2.4.3.	I'm Unsure If I Can Do It	1	1	2	*Unique*
C.3.	***Hostile Neglect***				
C.3.1.	Minimising, Negating or Avoiding One's Feelings:				
C.3.1.1.	I Don't Know What I'm Feeling or Why	1	1	2	*Unique*
C.3.1.2.	I Don't Want Others To Know What I'm Feeling	2	0	2	*N/a*
C.3.1.3.	It's Difficult to Arrive At or Express The Feeling	1	1	2	*Unique*
C.3.1.4.	I'm Negatively Judging What I'm Feeling	2	5	7	*Unique*
C.3.1.5.	I Don't Know What To Do With The Feeling	1	0	1	*N/a*
C.3.1.6.	I'm Avoiding, Blocking, Masking or Minimising The Feeling	8	3	11	*Unique*
C.3.2.	Self-Neglect or Abandonment/ Not Attending to Important Things:				
C.3.2.1.	Other People's Opinions Carry More Weight Than Mine	3	1	4	*Unique*
C.3.2.2.	I Have No Direction or Motivation	3	0	3	*N/a*
C.3.2.3.	I Hide Myself Away From Life	1	1	2	*Unique*
C.3.2.4.	I Don't Attend to My Basic Needs	1	0	1	*N/a*
C.3.2.5.	I Don't Know What I Want or Need	0	1	1	*Unique*
C.3.3.	Acquiescing or Affirming Negative Reactions From Others:				
C.3.3.1.	Taking On Board Negative or Hostile Reactions From Others	4	0	4	*N/a*
C.3.3.2.	Submitting To or Appeasing Hostile Demands or Reactions of Others	5	0	5	*N/a*
C.3.3.3.	Assuaging or Mitigating Negative or Hostile Reactions From Others	6	0	6	*N/a*

C.3.4.	Undeserving of Positive Reactions From Others	0	0	0	*N/a*
C.3.5.	Reacting in a Flooded or Overwhelmed Emotional State:				
C.3.5.1.	Quick To Anger	4	0	4	*N/a*
C.3.5.2.	Emotionally Triggered	1	0	1	*N/a*
C.3.5.3.	Compounding Emotion	2	0	2	*N/a*
C.4.	***Hostile Freedom or Separation from Others***				
C.4.1.	Isolating or Distancing Self from Others:				
C.4.1.1.	I Avoid Social Interaction As I Worry About Conversing, I Don't Know What To Say	6	1	7	*Unique*
C.4.1.2.	I Am Guarded With Others Because I Don't Trust People	4	2	6	*Unique*
C.4.1.3.	I Am Guarded With Others To Hide Parts of Myself	6	6	12	*Unique*
C.4.1.4.	I Feel Uncomfortable In Relationships or Around Others, I Isolate or Distance To Protect Myself	4	11	15	*Typical*
C.4.1.5.	I Feel Uncomfortable Going Into Public Places On My Own	2	0	2	*N/a*
C.4.1.6.	I Instrumentally Distance Myself From Others	1	1	2	*Unique*
C.4.2.	Self-Entitlement or Grandiosity	0	2	2	*Unique*
C.4.3.	Relinquishing Personal Responsibility or Agency	3	0	3	*N/a*
D.	**Emotional Effects of Negative Treatment of Self (What I Feel Preceding or in Reaction to my Self-Dislike & Inimical Self-Actions)**				
D.1.	***Fear, Anxiety, Panic, Worry or Tension***	25	21	46	*Typical*
D.2.	***Sadness, Grief or Emotional Pain***	30	8	38	*Typical*
D.3.	***Anger or Frustration with Self or Others***	21	6	27	*Typical*
D.4.	***Shame, Humiliation or Embarrassment***	5	6	11	*Typical*
D.5.	***Guilt, Regret or Remorse***	5	3	8	*Typical*
D.6.	***Despair, Hopelessness or Defeat***	0	5	5	*Unique*

Note: Themes (n=108) include both client self-report (acknowledging) and observational (expressing) data. Red indicates the elaborations to the preliminary rational model (depicted in Black) following the beginning phase analysis, and Blue indicates the elaborations following the ending phase analysis. Tx Beg. and Tx End indicates the total occurrences of expressed themes across all six participants. *General* means that this phenomenon applied to all six participants; *Typical* means that this phenomenon applied to two to five of the participants; *Unique* means that this phenomenon applied to only one participant.

Table 8: Structural Identification for the Cross-Case Analysis

Level of Category	Description	Identification	Total for Level of Category
Domains	Main themes of the analysis	A.	4
Sub-Domains	Specific themes of the analysis	A.1.	15
Categories	Main categories of the analysis	A.1.1.	27

Sub-Categories	Specific categories of the analysis	A.1.1.1.	59
Lower-Level Sub-Categories	Differentiated lower-level categories of the analysis	A.1.1.1.1.	41

Appendix N: Participant Profiles

This appendix provides detailed profiles of participants from the EFT-SA research protocol, included in Studies 2 and 3, combining clinical assessments with self-reported data. The diagnostic tools employed include the EFT-SA project's 2007 edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) (American Psychiatric Association, 2000) and the Personality Diagnostic Questionnaire-4+ (PDQ-4+) (Hyler, 1994). Additionally, each participant completed a Personal Questionnaire (PQ) to assess levels of distress and prioritise presenting issues (Elliott, 2001).

Client 1: A 57-year-old unemployed British man, living with his partner, self-referred after seeing an Oxfam poster about the EFT-SA research protocol. His complex mental health history, which included 30 years of intermittent support, began after a two-month hospitalisation. At the time of assessment, he was prescribed 300 mg of Venlafaxine for depression and anxiety.

The clinical assessment indicated recurrent major depression, generalised anxiety disorder (GAD), post-traumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), panic disorder, and social anxiety (SA). His SA, present since the age of five, was linked to PTSD from childhood emotional abuse, causing intrusive thoughts, flashbacks, and nightmares. He also exhibited OCD behaviours, such as compulsive door-checking.

Personality assessments (PDQ-4+) revealed traits associated with paranoid, borderline, avoidant, dependent, obsessive-compulsive, and depressive personality types, reflecting entrenched dependence, avoidance, and sensitivity to criticism. His PQ highlighted key issues, such as severe self-consciousness, especially when eating in public, leading to isolation. He reported persistent feelings of worthlessness, tearfulness, fatigue, and difficulty concentrating, alongside heightened anxiety about

death and social criticism. Panic attacks with palpitations and fears of losing control, as well as insomnia, were recent concerns.

Client 2: A 49-year-old British man, living alone and working full-time, sought therapy for severe social anxiety and low self-esteem. He self-referred after seeing a poster for the EFT-SA research protocol and supplemented prescribed psychological medication with herbal remedies.

The clinical assessment identified major depressive disorder, SA, and specific phobias. His SA, which began at 16, manifested as intense fear of criticism, leading to avoidance of speaking, eating, or writing in public. This avoidance negatively impacted his self-esteem and reinforced feelings of isolation. He also developed a specific phobia of flying at 24 following a single flight experience.

PDQ-4+ results indicated avoidant and depressive personality traits. His PQ highlighted complete social avoidance, difficulty initiating conversations, and forming friendships. He struggled with expressing himself openly, fearing judgement and rejection. His deep vulnerability and pessimism included doubts about his capacity for change and concerns that it might be ‘too late’ for personal growth.

Client 3: A 29-year-old British woman and full-time mother, living with her partner and children, self-referred to the EFT-SA protocol. She had no previous history of mental health support or medication.

The clinical assessment confirmed GAD, SA, and PTSD. Her GAD, present since childhood, included constant worry about the safety of loved ones, muscle tension, fatigue, and irritability. SA, which began at 14, caused distress in social interactions and led to withdrawal to avoid potential judgement. Traumatic experiences, including sexual assault and a parent's depression, contributed to persistent PTSD symptoms, such as flashbacks and nightmares, alongside a specific phobia of birds.

PDQ-4+ assessments identified avoidant and depressive traits. Her PQ revealed intense anxiety around meeting new people, fears of criticism, and self-criticism, leading to social withdrawal and low self-worth. She described punishing herself for perceived mistakes, difficulty trusting her abilities, and being on edge in social situations.

Client 4: A 37-year-old Scottish woman, referred by an Employee Assistance Programme (EAP) counsellor, sought therapy for anxiety and depressive symptoms affecting her work and social life. She lived with her partner and was employed full-time.

The clinical assessment identified GAD, SA, and specific phobias, including fears of spiders and flying. Her mental health challenges, including recurrent panic attacks and depression, intensified after her father's stroke four years earlier. SA caused her to avoid social situations, refrain from speaking up at work, and decline promotions.

PDQ-4+ results indicated avoidant, dependent, obsessive-compulsive, and depressive personality traits. Her PQ highlighted low self-esteem, fear of embarrassment, and difficulties with self-expression. She avoided situations involving criticism and overthought interactions, affecting both professional and personal relationships.

Client 5: A 57-year-old Scottish woman, living alone and unemployed, self-referred following longstanding mental health difficulties that had necessitated the long-term use of antidepressants. Despite previous therapeutic interventions, including inpatient treatment after her father's death in 1999, her challenges remained unresolved.

The clinical assessment identified GAD, SA, major depressive disorder, and specific phobias. Her social anxiety, present since childhood, severely restricted her ability to engage in public activities. GAD was characterised by pervasive worry and

tension, while recent depressive episodes included chronic fatigue, insomnia, and feelings of worthlessness. Although she had overcome alcohol dependence, recent panic attacks and a fear of heights had emerged.

PDQ-4+ assessments revealed traits associated with schizoid, histrionic, borderline, avoidant, obsessive-compulsive, passive-aggressive, and depressive tendencies. Her PQ highlighted pervasive feelings of inadequacy, shame, and fear of judgement, which deepened her loneliness. Despite a longing for connection, her avoidant behaviour and distrust of others perpetuated her isolation.

Client 6: A 40-year-old British woman of Scottish origin, living alone, self-referred to the EFT-SA research protocol. She attributed deep-seated self-esteem and trust issues to childhood trauma and challenging family dynamics.

The clinical assessment identified GAD, SA, panic disorder, PTSD, and major depression. Recurrent depressive episodes had been present since childhood, alongside low-level dysthymia. SA had restricted her participation in group activities since the age of seven. Social interactions frequently triggered panic attacks, with symptoms including palpitations, sweating, and derealisation. Her early life was marked by financial struggles, parental conflict, and bullying, which contributed to PTSD.

PDQ-4+ results indicated histrionic, borderline, avoidant, obsessive-compulsive, and depressive traits. Her PQ highlighted displaced anger related to childhood bullying, persistent feelings of inadequacy, and unresolved anger. She managed emotional flashbacks by intellectualising her struggles, which inhibited trauma processing. Her self-perception was dominated by a sense of unworthiness, further perpetuating her isolation.

Appendix O: Therapist Profiles

Client	Assessment Date	Therapist	Gender	Age	Counselling Qualifications	EFT Qualifications	Post-Qualifying Experience
C1 & C2	07.11.08 & 13.01.09	T1	Male	61	Post-graduate Diploma in Person-Centred Therapy	EFT Levels I & II (2007-2008)	10 years as therapist, 1.5 years in EFT
C3 & C5	19.11.07 & 29.01.16	T2	Male	Avg. 61 (57 & 65)	PhD in Clinical Psychology (1978)	EFT co-developer since late 1980s, EFT therapist since 1986, EFT trainer since 1987	Avg. 38.5 years as therapist (1973-2007 & 2016), and Avg. 25.5 years in EFT
C4	29.07.13	T3	Male	29	BSc Psychology (2006), Post-graduate Diploma in Person-Centred Therapy (2010)	EFT Levels I, II, & III (2011-2013)	7 years as therapist (3 years post-qualification), 3 years in EFT
C6	06.08.10	T4	Female	35	PhD in Psychology & Counselling (1999), Diploma in Gestalt Psychotherapy (2000-2004), Certificate in Supervision (2006)	No formal EFT training but specialised in Gestalt (forms part of EFT chair-work)	10 years as therapist, 6 years in Gestalt

Appendix P: McNemar's Test

```
CROSSTABS
  /TABLES=P1B BY P1E
  /FORMAT=AVALUE TABLES
  /STATISTICS=PHI MCNEMAR
  /CELLS=COUNT ROW COLUMN
  /COUNT ROUND CELL.

* Encoding: UTF-8.
* MACRO definition (it also computes a 95%CI -Newcombe's method- for the
difference in percentages, nice extra!) *.
DEFINE MYMCNEMAR(!POSITIONAL !TOKENS(1) /!POSITIONAL
!TOKENS(1)/!POSITIONAL !TOKENS(1)/!POSITIONAL !TOKENS(1)).
DATASET NAME Datos.
DATASET DECLARE Results1 WINDOW=HIDDEN.
DATASET DECLARE Results2 WINDOW=HIDDEN.
PRESERVE.
SET ERRORS=NONE RESULTS=NONE.
MATRIX.
COMPUTE nanb=!1 .
COMPUTE napb=!2 .
COMPUTE panb=!3 .
COMPUTE papb=!4 .
COMPUTE a=nanb.
COMPUTE b=napb.
COMPUTE c=panb.
COMPUTE d=papb.
COMPUTE perc={(c+d)/(a+b+c+d);(b+d)/(a+b+c+d)}.
COMPUTE chi2=((b-c)**2)&/(b+c).
COMPUTE chi2sig=1-CHICDF(chi2,1).
COMPUTE chi2cor=(ABS(b-c)-1)**2&/(b+c).
COMPUTE chi2sigc=1-CHICDF(chi2cor,1).
COMPUTE z = 1.959964.
COMPUTE zsq = 1.959964*1.959964.
COMPUTE x5=papb+panb.
COMPUTE x6=napb+nanb.
```

```
COMPUTE x7=papb+napb.
COMPUTE x8=panb+nanb.
COMPUTE x9=x7+x8.
COMPUTE x10=(panb-napb)/x9.
COMPUTE x11=2*x5+zsq.
COMPUTE x12=z&*(zsq+4*x5&*x6/x9)&**0.5.
COMPUTE x13=2*(x9+zsq).
COMPUTE x14=(x11+x12)/x13.
COMPUTE x15=(x11-x12)/x13.
COMPUTE x16=x5/x9-x15.
COMPUTE x17=x14-x5/x9.
COMPUTE x21=2*x7+zsq.
COMPUTE x22=z&*(zsq+4*x7&*x8/x9)&**0.5.
COMPUTE x24=(x21+x22)/x13.
COMPUTE x25=(x21-x22)/x13.
COMPUTE x26=x7/x9-x25.
COMPUTE x27=x24-x7/x9.
COMPUTE x29=x5&*x6&*x7&*x8.
COMPUTE x30=1.
DO IF x29 EQ 0.
- COMPUTE x30=0.
END IF.
COMPUTE x31=papb&*nanb-panb&*napb.
COMPUTE x32=0.
DO IF (x31 GT 0).
- COMPUTE x32=1.
END IF.
COMPUTE x33=x31-x9/2.
COMPUTE x35=0.
DO IF (x33 GT 0).
- COMPUTE x35=x33.
END IF.
COMPUTE x36=x32&*x35+(1-x32)&*x31.
COMPUTE x37=x30&*x36.
COMPUTE x38=x30&*x29&**0.5+(1-x30).
COMPUTE x39=x37/x38. /* phi hat.
COMPUTE x40=x16&*x16-2*x39&*x16&*x27+x27&*x27.
COMPUTE x41=x17&*x17-2*x39&*x17&*x26+x26&*x26.
COMPUTE x42=x10-SQRT(x40).
COMPUTE x43=x10+SQRT(x41).
```

```
COMPUTE vnames={'P1','P2','Puntual','Lower.CI','Upper.CI'}.
SAVE {100*T(perc),100*x10,100*x42,100*x43} /OUTFILE=Results1
/NAMES=vnames.
COMPUTE vnames={'Chi2','Sig'}.
SAVE {chi2,chi2sig;chi2cor,chi2sigc} /OUTFILE=Results2 /NAMES=vnames.
END MATRIX.
RESTORE.
DATASET ACTIVATE Results1.
FORMAT P1 TO Upper.CI (PCT4.2).
VAR LABEL P1 'Percent A'/P2 'Percent B'/ Puntual 'Difference'.
OMS /SELECT TABLES
 /IF COMMANDS='Summarize' SUBTYPES='Case Processing Summary'
 /DESTINATION VIEWER=NO.
SUMMARIZE
 /TABLES=ALL
 /FORMAT=LIST NOCASENUM NOTOTAL
 /TITLE='95%CI for difference in proportions (paired) (*)'
 /CELLS=NONE.
OMSEND.
ECHO '(*) Exact (As per Newcombe, 1998)'.
DATASET ACTIVATE Results2.
DATASET CLOSE Results1.
FORMAT chi2(F8.3) Sig (F8.4).
VAR LABEL chi2 'Chi-Square'/ Sig 'Sig.'.
STRING Test (A12).
IF ($casenum EQ 1) Test = 'Uncorrected' .
IF ($casenum EQ 2) Test = 'Corrected*' .
OMS /SELECT TABLES
 /IF COMMANDS='Summarize' SUBTYPES='Case Processing Summary'
 /DESTINATION VIEWER=NO.
SUMMARIZE
 /TABLES=Test chi2 Sig
 /FORMAT=LIST NOCASENUM NOTOTAL
 /TITLE='McNemar Chi-square statistics'
 /CELLS=NONE.
OMSEND.
DATASET ACTIVATE Datos.
DATASET CLOSE Results2.
ECHO '(*) Corrected for continuity; this correction is too conservative in most cases.'
!ENDDEFINE.
```

Appendix Q: Cross-Case Analyses (Beginning and Ending)

Link to Data Repositories on PURE:

https://doi.org/10.15129/e2ad5f92-a674-438c-bf1b-fbeb57f347ae