

TRANSFORMATIONAL CHAIRWORK

An Introduction to Psychotherapeutic Dialogues

Scott Kellogg, PhD
scott.kellogg@nyu.edu

What is Chairwork?¹ At its most basic, Chairwork is a psychotherapeutic technique that involves the use of two chairs that are typically set facing each other. In the “Empty Chair” model, the patient sits in one chair and speaks to an imagined other in the one opposite; in the “Two-Chair” model, the patient shuttles back and forth between the two chairs giving voice to different perspectives on a problem.

The history of the technique and how it was introduced to the wider field of psychotherapy is not completely clear, but the rough outline appears to be as follows. Chairwork, in both the Empty Chair and Two-Chair versions, was originally created by Dr. Jacob Moreno, the creator of Psychodrama. Within the psychodramatic tradition, it was known as monodrama (Perls, 1973). According to some sources, the empty chair technique was developed for a patient who was speaking to a deceased father; that is why the chair was “empty” (Zerka Moreno, Personal Communication, June 4, 2009). The two-chair version seems to have been developed as a variant of role-reversal. In 1958, the first paper on the use of Chairwork was published by Rosemary Lippitt, who used it with children. In her

¹ This chapter is based, in part on Kellogg, S. H. (2004). Dialogical encounters: Contemporary perspectives on “chairwork” in psychotherapy. *Psychotherapy: Research, Theory, Practice, Training*, 41, 310-320, and material from the Transformational Chairwork Training Program (www.transformationalchairwork.com). It was originally published in German as: Kellogg, S. H. (2010). Veränderungen durch stühlearbeit (transformational chairwork): Eine einföhrung in psychotherapeutische dialoge. In E. Roediger & G. Jacob (Eds.). *Fortschritte der Schematherapie* (pp. 74-85). Goettingen, Germany: Hogrefe.

work, she set up chairs in various patterns that were relevant to social situations that were having difficulty with. They would then speak to and empathize with the different figures that were suggested by the chairs.

In terms of psychotherapy in general, and schema therapy in particular, the use of Chairwork is rooted not only in the work of Moreno, but also in the work of Dr. Frederick “Fritz” Perls. Fritz Perls is one of the most extraordinary and controversial figures in the history of psychotherapy. Originally a German psychoanalyst who worked with both Karen Horney and Wilhelm Reich, he would go on a personal odyssey that would lead him to South Africa, New York, Japan, Israel, and the Esalen Institute in Big Sur, California – where he would become world famous (Gaines, 1975).

It appears that Perls began to train with Moreno in New York City in the late 40’s or 50’s and continued to do so until the early 1960’s when he moved to California (Leveton, 2001; Zerka Moreno, Personal Communication, June 4, 2009).

During the Esalen years, Perls became known for his use of the Chairwork or “hot seat” technique (Perls, 1969). Using a combination of his deep knowledge of the human psyche, an almost incomprehensible intuitive sense, and a charismatic and sometimes confrontational personality, Perls was able to use Chairwork, imagery, and awareness techniques to enable people to have powerful

and, at times, life-changing experiences. The work, done during those years, attained the status of legend.

What Perls did with Chairwork was built on the foundation provided by Moreno; he did, however, move beyond it. His decision to have the patient play all of the roles, rather than having another patient stand in led to a fundamental shift in the psychotherapeutic experience; it also expanded the possibilities for using psychodramatic work in individual therapy. Perls was a complex man (Gaines, 1975), and after his death there was a gradual rejection of his Esalen-style work, including the chair technique, in gestalt circles.

In contrast to the ambivalence of the Gestalt world, a number of integrative psychotherapists were quite attracted to the work that Perls and his colleagues were doing during his last phase of development (Kellogg, 2009). These innovative individuals included Robert and Mary Goulding and their redecision therapy (1997), Leslie Greenberg and his emotion-focused therapy (Greenberg, Rice, & Elliott, 1993), Marvin Goldfried (1988) and his application of Chairwork within a cognitive-behavioral framework, and Jeffrey Young and his use of the technique in schema therapy (Young, Weishaar, & Klosko, 2003).

Core structures and processes

As noted above, the classic typologies for the technique were “Empty Chair” or “Two-Chair”. Perhaps a more useful typology would be to see the dialogues as

being either *internal*, in which patients speak with parts of themselves, or *external*, in which their issues with other people are the focus of the dialogue.

In terms of what actually happens in a Chairwork session, outcomes typically fall somewhere between the diagnostic and the transformational. The transformational dialogues, in which patients make dramatic breakthroughs in a single session, are frequently found in case examples. These stories demonstrate the power and the drama of the technique and are frequently impressive to both the patient and the therapist. In these scenarios, the patient (1) often confronts a figure from the past and moves to a greater level of resolution; and/or (2) successfully rebalances their inner energies.

At the other end of the continuum are those dialogues that might best be described as diagnostic. Quieter and less dramatic, these encounters allow both the patient and the therapist to gain a deeper appreciation of the events, schemas, and other complexities that may be involved in a given situation. While the first may be more intense, both ways of working have their place in the healing process.

Clinical applications

Chairwork can be applied to the full range of psychiatric disorders – including addictions. This chapter will focus on: (1) providing a basic understanding of the external and internal dialogues; (2) presenting some

techniques for making the dialogues more effective; and (3) addressing the issue of resistance.

External dialogues: “Unfinished business” was a central focus of Perls’ work (Perls, 1969; Perls, Hefferline, & Goodman, 1965). For Perls, when events or relationships from the past are not resolved, when the gestalt is not closed, patients can still have emotional energy tied up in these situations. This connection can serve to stifle their growth and prevent them from developing themselves and/or living more fully in the present.

For example, patients may need to say goodbye to former romantic partners as well as to those they have lost through death. In addition, they may also need to say goodbye to geographical locations, to career dreams that did not materialize, and even to body parts that were damaged and hurt, if these are interfering with living a full life (Goulding & Goulding, 1997).

A woman had a baby who had been born with heart problems, and she and her husband agreed to her having a surgical procedure in an attempt to remedy this. The surgery, however, was unsuccessful and the baby died. Sixteen years later, the mother was still blaming herself for the death. The therapist had her imagine the baby in the opposite chair and invited her to speak with him/her. After doing this, the therapist invited the mother to switch chairs and speak from the perspective of the baby. Strikingly, the “baby” said that she had also wanted a full life and that

she would have chosen the surgery as well. After this affirmation that she had done the right thing, the mother was finally able to “let go and say goodbye” (Stevens, 1970, p. 72). It is quite interesting to note that when the patient plays another person, messages emerge that could not have been predicted.

Experiences of sexual, physical, and emotional abuse are frequently encountered in psychotherapeutic practice. In schema therapy, there is a central emphasis on the use of imagery for these kinds of issues. Imagery and Chairwork are probably best understood as two sides of the same coin, and strategies that can be useful with one can often be used with the other.

When working with abuse and trauma, there are a variety of chair dialogues that can be used – the abused child can be spoken with directly, the abuser or abusers can be confronted, and those who knew about the abuse and did not protect the child can be challenged as well. Both the patient and the therapist can engage in dialogue with all of the participants involved. In this way, that which could not be said at the time can now be spoken and the emotions of grief, anger, and sorrow can be expressed and resolved as well.

Goulding and Goulding (1997) have outlined an approach that can be helpful in structuring these dialogues. Patients confront the abuser in the chair and outline what they did and how it hurt them; they then described how they lived their life because of it. The therapeutic moment is when they make a conscious decision

and commitment to live their life in a new way, in a way that is in defiance of the trauma and the damage. This “redecision” is a way of challenging the pathogenic internalization of the trauma. As one patient put it, “From now on, I am going to find trustworthy people, and I will trust them. Everyone is not like you” (p. 248).

A man, in dialogue, confronted the clergyman who had sexually abused him. He described what had happened and expressed his anger that the priest had taken advantage of his need for a father figure and his growing interest in and curiosity about sex. He then spoke to and comforted the young boy that he had been. A memory that he had carried for decades, he felt deeply relieved after that session.

A woman had a dialogue with her grandmother, a woman who had been emotionally abusive to her. “I resent the times you called me a tramp. ...I resent you for not trusting me, for not letting me be a young person. I resent you for dragging me to cemeteries to see dead graves.... I *resent* that... (Engle, Beutler, & Dalup, 1991, pp. 180-182). In both of these cases, the patients were finally able to say things that they had been unable to say when the mistreatment was occurring.

Assertiveness training comes from the Behavioral tradition in psychotherapy; it was, in fact, originally called *behavioristic psychodrama* (Wolpe, 1982). Wolpe has described assertiveness as a form of interpersonal communication in which the patient speaks using any emotional state other than

anxiety, i.e., anger, love, excitement, or grief. He has particularly emphasized the importance of making requests and saying “no” or setting limits with other people.

A patient’s boyfriend had strong opinions and beliefs; a consequence of this was that he could sometimes be critical of others’ opinions and behaviors. She was particularly upset that he criticized the music that she enjoyed, but felt herself to be unable to tell him to stop. In our work, we developed a script and she put him in the empty chair and practiced confronting him. Using “I” statements and speaking forcefully and directly, she affirmed her right to listen to the music that she wanted to and directly requested that he stop criticizing her. She then went on to confront him in real life. To her delight, he agreed to stop the behavior. She reported a general shift for the better in their relationship, and she felt that this experience of empowerment was a major therapeutic accomplishment.

Internal dialogues: The usefulness of envisioning the self as made up of different aspects has been championed by a wide range of psychologists and psychotherapists. Freud (1965) envisioned the personality in terms of Id, Ego, and Superego, and Perls (1969) believed that most patients suffered from a divided or split self and that Chairwork could help in fostering a process of integration. Schema therapy, especially with the mode model, has also divided the patient into a variety of modes. In each case, these parts can be labeled and given a voice.

One thing that each of these models shares is a belief that in states of dysfunction or psychopathology, these parts are not sufficiently working in harmony. That is, parts are in direct conflict, voices seeking expression are being blocked or repressed, and/or some vital aspects of self are either insufficiently developed or are overly-developed and overly relied on.

One common clinical manifestation of the divided self occurs when a patient has to make a difficult decision. Decisions about choosing one path over another or staying in or leaving a relationship or job are not uncommon. Patients who have these problems often find that they keep flipping back and forth between the two sides. Not only may there be no clear right or wrong answer, but also the indecision may reflect an underlying value conflict (Fabry, 1988).

A useful way to prepare the patient for the dialogue is to do a *decisional balance* with them first (Marlatt & Gordon, 1985). Engaging with the issue of whether or not to stay in a relationship, the therapist would ask the patient to first identify the positives and negatives of the relationship and then the positives and negatives of leaving the relationship. The material that emerges can then be used to anchor the dialogue and to facilitate problem-solving for solutions.

In terms of Chairwork, one chair can embody the positives of staying in the relationship *and* the negatives of leaving it, while the other can be where the patient gives voice to the negatives of staying in the relationship and the positives

of leaving it. As the patient goes back and forth, it is compelling to watch as some arguments gain in power and others start to fade. In addition, new arguments may emerge that were not covered in the decisional balance. Again, it is often quite striking to witness the changes in tone, energy, affect, and body language that emerge during the process.

A man had run a successful business for a number of years. At one point, the business had failed, and he had started working for a law firm. At the time he entered therapy, he was very unhappy with this situation. He did not respect some of the managers, the commute was too long, he did not like being in a subordinate position, and the money was adequate but not abundant. Despite this unhappiness, he resisted suggestions that perhaps he should re-engage with some kind of entrepreneurial situation. It turned out that he was very worried about money and financial security. He was blocked because he kept flipping between the two polarities.

After clarifying the issues with the decisional balance, he engaged in a dialogue in which he made the case for leaving the firm in one chair and for staying in the other. He was encouraged to speak as forcefully and as emotionally as he could from each perspective. At the end, he came to the decision that he was going to stay in the current job. He felt much more resolved about being there and was still there a year or so after therapy ended.

As noted above, Perls (1969) stressed the important potential of Chairwork as a technique for fostering integration of the different parts of the self. In a compelling case, Dr. Richard Abell (1976) used Chairwork to help a patient overcome a state of traumatic dissociation. A Jewish woman had, as a small child, been raised in hiding as a Catholic during World War II. Over twenty years later, she was still deeply divided between her Jewish self and her Catholic self. She engaged in a Chairwork dialogue between these two parts. They began the dialogue by identifying who the parts were and how they had served her; she then went on to resolve the split and develop a more authentic sense of self.

A number of psychotherapists have written about the destructive aspects of what is called the *inner critic* (Elliott & Elliott, 2000; Greenberg et al., 1993). In fact, some believe that the experience of harsh, critical, and hurtful internal voices are at the heart of all psychopathology (Elliott & Elliott, 2000). When asked, many patients will rapidly acknowledge that they live these voices on a daily basis. In schema therapy, this phenomenon is typically referred to as the Punitive or Demanding Parent; some have also maintained that the voice of the inner critic overlaps with the voice of the schema (Stinckens, Lietaer, & Leijssen, 2002).

Broadly speaking, there are two ways of using Chairwork in the treatment of inner critic issues: the emotion-focused and the cognitive-restructuring or corrective approaches. Greenberg is the creator of the emotion-focused approach

(Greenberg et al., 1993), and in his work, the patient sits in one chair and speaks from the perspective of the critic, when in the other chair, the patient responds by telling what it feels like to be criticized and attacked; they will later also tell the critic what they want and need from him or her. As they go back and forth between the two chairs, a “softening” often starts taking place. In a sense, Greenberg is encouraging a kind of emotional rebellion or revolt on the part of the patient.

Clearly, this is a very useful way to start. One helpful aspect is that it is not necessary for the therapist to understand all of the concerns of the critic and for a counter-script to be created; instead, the patient can just begin. Often the issues driving the critic will become clear during the dialogue, and the cognitive work can be done later.

Greenberg reported a case in which a writer came to therapy suffering from depression and procrastination. It became apparent that as she began the writing process, the critical voice became activated and she abandoned the process as a form of avoidant coping. He was eventually enabled her to have a dialogue between the critical and the creative parts – both of whom feared and distrusted the other. Through the dialogue process, she was able to develop a more balanced relationship that would permit her to work more constructively.

The use of corrective dialogues developed out of the cognitive-behavioral therapy tradition, and it is relevant to the treatment of inner critic issues, especially to the degree that they embody dysfunctional schemas or modes. At its most basic, the patient will express the dysfunctional thought or schema in one chair and he or she will then counter it in the other. This can be done several ways. The patient can do the negative schema – “You will fail the exam” – and the therapist can take the other side – “There is no evidence that I’ll fail the exam”; they can then reverse roles and the therapist can argue the negative and the patient for the positive (Leahy & Holland, 2000, p. 308). After that, the patient can give voice to both sides.

Typically, this kind of work will involve the patient working with the therapist to create a script that counters the dysfunctional beliefs (Young et al., 2003). It is also frequently necessary for the therapist to coach the patient through the initial rounds as the healthy side often feels strange and not believable.

Goldfried, a cognitive-behavioral therapist who uses Chairwork to good purpose, has argued for the usefulness of the technique within a cognitive perspective. He believes that cognitions are much more malleable during states of emotional arousal and that Chairwork is an excellent vehicle for this kind of inner activation (Samoilove & Goldfried, 2000), a view that has also been endorsed by Arnkoff (1981).

In the *Schema Therapy* book, Young works with a patient named Ivy. Ivy suffers from a Self-Sacrifice schema, and it is a significant problem in her relationship with her friend Adam. The healthy part of her is unhappy because the relationship lacks reciprocity – he tells her his problems but does not listen to hers. While this part of her wants to bring it up with him, the Self-Sacrifice schema tells her that she should not as it would be selfish. She does a dialogue between the parts and is able to get angry at the schema for the way that it has hurt her. Using the full schema model, she does imagery work and confronts her mother, who was the original source of the schema. She further challenges the schema by telling her mother, “It cost me too much to take care of you. It cost me my sense of self” (Young et al., 2003, p. 148).

Integrated models

The dichotomizing of Chairwork into internal and external dialogues is heuristically useful and helpful as a training method. In reality, dysfunctional schemas may be rooted in problematic relations in the past, and present interpersonal difficulties may occur because of connections to schemas and modes. With more experience and practice, therapists find that they can dance between the internal and the external, using two or more chairs in complex ways.

A psychotherapist in a training workshop played a patient who was wrestling with the issue of whether to stay in her marriage or end it. We began the work

with a decisional balance and clarified the forces on both sides of the question. She then did a two-chair dialogue in which she was encouraged to clearly and purposefully state the arguments. After a few rounds of dialogue, I invited her to speak directly to her (imagined) husband in the opposite chair. Here, she really expressed her unhappiness about her life with him. She then switched seats and spoke about the marriage and their relationship from his perspective. We then did a debriefing to see where she was with the issue. This is the kind of flow that often occurs as therapists grow more confident in using Chairwork.

Strengthening the voices

A core theme in the various Chairwork paradigms is to enable the patient to speak clearly and forcefully from each vantage point. To this end, there are a number of techniques that can be used to facilitate this (Passons, 1975; Perls, 1969).

When they first begin to do the work, it is not uncommon to see patients speak from one mode or schema and then switch to another while sitting in the same chair. In a way, this probably parallels what is going on inside of them; it may also be a reflection of the anxiety that is being generated. It is important that the therapist step in and block this. He or she can tell the patient that they would like them to stay with the initial voice while they are in their present chair and that they will be given the opportunity to embody the intruding voice in another chair

later. Alternatively, the patient can be invited to switch chairs at that moment and give voice to that which is most salient to them.

Another not infrequent occurrence with internal dialogues is the emergence of a lecturing voice. When voicing this, patients will often couch their remarks to the other chair with “You should...” It is best to let them do this once. After they finish, they can be encouraged to repeat everything only substituting “I want...” for “You should...” This implies existential ownership of the ideas. It may also happen that the relative weight of what they said may change along with this change of voice.

Another clarifying intervention is to vary the intensity with which things are said (Perls, 1969). In general, the patient is encouraged to increase the intensity of their expression – although a softer approach may be useful in some cases. A common way to do this is to encourage to repeat the meaningful things they said and to say them louder and/or faster. The intensity can also be increased by asking them to stand up, use their arms, or hit a pillow as they speak (Mastro, 2004).

Early on, the patients may also demonstrate difficulty in knowing what to say. Therapists can “feed them a line”; that is, they can suggest something while adding “if it seems like it would fit.” It is important that the patient actually say the words or something like it rather than just agreeing with the therapist. The

provision of words and dialogue is a way of demonstrating an empathic connection with the patient.

In a similar vein, the therapist can also speak to figures from the past. This may involve defending the patient and confronting hurtful persons for what they did or did not do. In turn, they can also challenge the schemas and do battle with punitive or critical modes (Young et al., 2003). Again, this is a way of demonstrating compassion for and connection to the patient. It is also a form of reparenting as the patient hears what the therapist is saying on their behalf while simultaneously seeing an example of the Healthy Adult Mode, an assertive and confident way of being in the world.

Resistance

Because of the challenging nature of the dialogues, resistance may emerge as an issue with some patients. It seems that people who are very reluctant to engage in chair dialogues are often motivated by a sense of self-consciousness or a fear of what will emerge.

One action that therapists can take in response is to do the Chairwork for the patient. This means that they will go back and forth between the two chairs embodying the different parts or re-working the conflicting modes or schemas. The patients can provide them with the lines and/or correct them when they are off. This is an act of generosity and caring, and some patients will appreciate the fact

that the therapist exposed him- or herself on their behalf. I believe that a kind of vicarious healing can take place in this way; hopefully, the modeling of the dialogues will help reduce the anxiety enough to permit them to engage in them.

If that does not work, perhaps the patient will do the same kind of work through imagery. If they reject all of the experiential techniques, then it may just be that they are not a good fit for schema therapy and they should be referred elsewhere.

Conclusion

Chairwork is a simple yet profound tool for psychotherapeutic healing. It is extremely flexible and it can be applied to a wide range of clinical situations. Centered in psychodrama and further developed in gestalt therapy, Chairwork has been re-envisioned by a variety of integrative psychotherapies – including schema therapy. It is to be hoped that many psychotherapists will make psychotherapeutic dialogues an essential part of their practice.

References

- Arknoff, D. B. (1981). Flexibility in practicing cognitive therapy. In G. Emery, S.D. Hollon, & R. C. Bedrosian (Eds.), *New directions in cognitive therapy: A casebook* (pp. 203-223). New York: Guilford.
- Abell, R. (1976). *Own your own life*. New York: David McKay.
- Elliott, J., & Elliott, K. (2000). *Disarming your inner critic*. Lafayette, LA: Anthetics Institute Press.
- Engle, D., Beutler, L. E. & Daldrup, R. J. (1991). Focused expressive psychotherapy: Treating blocked emotions. In J. D. Safran & L. Greenberg (Eds.), *Emotion, psychotherapy, and change* (pp. 169-196). New York: Guilford.
- Fabry, J. (1988). *Guideposts to meaning: Discovering what really matters*. Oakland, CA: New Harbinger Publications.
- Freud, S. (1965). *New introductory lectures on psychoanalysis*. New York: Norton.
- Gaines, J. (1979). *Fritz Perls: Here and now*. Millbrae, CA: Celestial Arts.
- Goldfried, M. R. (1988). Application of rational restructuring to anxiety disorders. *The Counseling Psychologist, 16*, 50-68.
- Goulding, M. M., & Goulding, R. (1997). *Changing lives through Redecision Therapy*. New York: Grove Press.
- Greenberg, L. S., Rice, L. N., & Elliott, R. (1993). *Facilitating emotional change: The moment-by-moment process*. New York: The Guildford Press.
- Kellogg, S. H. (2004). Dialogical encounters: Contemporary perspectives on “chairwork” in psychotherapy. *Psychotherapy: Research, Theory, Practice,*

- Training, 41*, 310-320.
- Kellogg, S. H. (2009). Schema therapy: A Gestalt-oriented overview. *Gestalt!*, *10*:
<http://www.g-gej.org/10-1/schematherapy.html>
- Leahy, R. L., & Holland, S. J. (2000). *Treatment plans and interventions for depression and anxiety disorders*. New York: The Guilford Press.
- Leveton, E. (2001). *A clinician's guide to psychodrama* (3rd ed.). New York: Springer Publishing Company.
- Lippitt, R. (1958). The auxiliary chair technique. *Group Psychotherapy, 11*, 8-23.
- Marlatt, G. A., & Gordon, J. R. (1985). *Relapse prevention*. New York: Guilford Press.
- Mastro, J. (Winter, 2004). *Gestalt-Experiential Seminar*. New York, NY. Faculty member, Gestalt Associates for Psychotherapy:
<http://www.gestaltassociates.org/faculty.shtml>
- Passons, W. R. (1975). *Gestalt approaches in counseling*. New York: Holt, Rinehart, and Winston.
- Perls, F. S. (1969a). *Gestalt therapy verbatim*. Lafayette, California: Real People Press.
- Perls, F. S. (1973). *The Gestalt approach & eye witness to therapy*. Palo Alto, CA: Science and Behavior Books.
- Perls, F., Hefferline, R. F., & Goodman, P. (1965). *Gestalt therapy: Excitement and growth in the human personality*. New York: Dell Publishing.
- Samoilove, A., & Goldfried, M. R. (2000). Role of emotion in cognitive behavior therapy. *Clinical Psychology: Science and Practice, 7*, 373-385.
- Stevens, B. (1970). *Don't push the river*. Moab, UT: Real People Press.
- Stinckens, N., Lietaer, G., & Leijssen, M. (2002). The inner critic on the move: Analysis

of the change process in a case of short-term client-centered/experiential therapy.

Counseling and Psychotherapy Research, 2, 40-54.

Wolpe, J. (1982). *The practice of behavior therapy* (3rd ed.). New York: Pergamon Press.

Young, J. E., Klosko, J. S., Weishaar, M. E. (2003). *Schema Therapy: A practitioner's guide*. New York: The Guilford Press.

Scott Kellogg, PhD, is the author of *Transformational Chairwork: Using Psychotherapeutic Dialogues in Clinical Practice* (Rowman & Littlefield, 2014).

He is also the President of the Division on Addictions of the New York State Psychological Association, a Gestalt Chairwork Practitioner, a Certified Schema Therapist, and a Clinical Assistant Professor in the New York University Department of Psychology. He is in private practice at The Transformational Chairwork Psychotherapy Project in New York City. His website is: <http://transformationalchairwork.com/> His email is scott.kellogg@nyu.edu.