Using Chairwork Psychotherapy to Combat the Psychological Impact of Oppression

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Chairwork Psychotherapy is a dynamic experiential modality that entails: (a) inviting a patient to sit in one chair in order to have an imaginal encounter with someone from the past, the present, or the future in the chair opposite; and/or (b) using several chairs to create dialogues between different parts of the self (Kellogg & Garcia Torres, in review). Chairwork was initially created as a method by Dr. Jacob Moreno, founder of psychodrama, who taught it to Dr. Frederick “Fritz” Perls, the creator of gestalt therapy. Perls went on to further develop Chairwork and turn it into a “psychotherapeutic art form” (Kellogg,

2015, p. 9). Building on the work of a wide range of integrative therapists, (Goulding & Goulding, 1979; Greenberg & Clark, 1979; & Stone, 1989; Young & Klosko, 1993), it was advanced from a method into a freestanding psychotherapy modality with the transformational chairwork psychotherapy project (Kellogg, 2015).

The Four Dialogues

The Four Dialogues of Chairwork are structures that hold all psychotherapeutic dialogue work, and they may be used independently or in combination. The four dialogues are Giving Voice, Telling the Story, Internal Dialogues, and Relationships and Encounters (Kellogg, 2019).

Giving Voice

This dialogue structure, which draws on the insights of gestalt therapy (Perls, 1969) and voice dialogue (Stone & Stone, 1989) involves the expression and amplification of a feeling, a dialogue interview with a mode, or the claiming of personal authority and affirming personal decisions. The therapist does not seek to challenge or change the parts (Kellogg, 2019).

Telling the Story

This structure centers on encouraging patients to express difficult or traumatic narratives in order to reach emotional integration. This can be done in two ways. The first requires repetition; patients are asked to tell the story multiple times during a single session (Kellogg, 2019). The second involves the use of

imagery rescripting; the patient changes the narrative so there is a new and more empowering ending (Goulding & Goulding, 1979; Rafaeli, Bernstein, & Young, 2011).

Internal Dialogues

This dialogue structure requires the engagement of various modes so they may interact in a dialogue. These parts may be suffering or may be focused on healing. The central goal is to strengthen the patient's inner healthy adult mode or inner leader. (Kellogg & Garcia Torres, in review).

Relationships and Encounters

This structure looks at the patient's interpersonal world, and they engage with others from the past, present, or the future. Patients are encouraged to speak from the cycle of emotions, understood as expressions of love, fear, anger, and/or grief (Kellogg, 2019).

The overarching goal of Chairwork Psychotherapy is to build up and support the development of the inner leader or the healthy adult mode. This part holds the strengths of assertiveness, patience, wisdom, and courage and also facilitates respectful, meaningful, and effective action (Kellogg & Tatarsky, 2012). The inner leader may need help with tasks such as healing the pain of suffering parts, creating socially acceptable emotional expression, decreasing the harm of the inner critic mode and potentially rehabilitating it into an ally, and/or decreasing dependence on problematic coping modes (Kellogg & Tatarsky, 2012).

Chairwork Psychotherapy is uniquely suited to addressing the impact of oppression-based traumatization. The ultimate goal of the work is to support patients so they might shift their internal balance away from harmful forces and towards their inner leader. The heart of trauma is the condition of helplessness or loss of self-ownership (Van der Kolk, 2014). Reducing inner helplessness via inner leader development may, to a degree, provide some emotional protection from future traumatization.

This work also allows patients to safely and directly engage with external and/or internalized oppressive powers, while also helping patients access internal energy to challenge and block these harmful forces. Patients may become more empowered, and can improve self-esteem, self-love, and self-compassion. This is a therapeutic way of supporting movements of resistance and becoming active practitioners of Zimbardo's "psychology of liberation," where therapists might step up in their work to oppose the internal and external forces that prevent full realization of human potential (2011, p. 406).

The Five Core Problems of Oppression

There are many ways that oppression-based trauma manifests within an individual, however, the impacts might be simplified into Five Core Problems: socially induced trauma, internalized oppression, identity conflict or confusion, connection to voice, and oppression-rooted coping.

Socially Induced Trauma

When traumatization occurs due to identity-based mistreatment this may be considered socially induced trauma. Such psychological, emotional, or mental injury may happen in the context of a public or private situational event, within close or distant interpersonal encounters, and can involve any action ranging from intimidation to assault (Carter, 2007). Historical trauma and vicarious traumatization also fall under this category.

Such traumas can be addressed using the Telling the Story dialogue structure. For example, a Black man who experienced a hate crime in childhood may tell the story of his victimization many times in order to process and integrate the experience. Using a Relationships and Encounters dialogue, this patient can also confront the perpetrators and comfort and validate his child self.

Internalized Oppression

When “the oppressor is ‘housed’ within the people,” a person’s mind and heart can become sites for further subjugation (Freire, 1972; Garcia Torres, 2020). Individuals impacted by oppression are at-risk for internalizing negative messages and repeating and affirming this negativity to themselves and their own groups, a phenomenon called internalized oppression. This can manifest as many things such as colorism, internalized homophobia, internalized sexism, negative beliefs about intellectual capacity, or harsh judgment about behavior and appearance (hooks, 2003). Internalized oppression may also look like anxiety, self-hatred, or a very harsh inner critic mode (Kellogg, 2015). Loneliness and isolation may arise from feelings of internalized undesirability

or inferiority, especially if one is considered to belong to an “out-group” (Carter, 2007; Estrada, 2009; Young & Klosko, 1993).

These difficulties can be addressed with the Internal Dialogues or Giving Voice dialogue structures. Using Internal Dialogues, a female patient can challenge an inner critic’s patriarchal value system. Alternatively, a patient struggling with shame about their skin color and appearance may channel the ashamed part and then give voice to a part that holds self-love and appreciation. In a Giving Voice stance, a queer young adult may voice his anxieties about potential social rejection.

Identity Conflict

Identity conflict or confusion can occur when an individual is multiracial, multicultural, or holds any historically-oppressed identity that is unaccepted by the surrounding predominant culture. This can result in internal disconnection to, or an overidentification with one or more identities. Oftentimes, internal identities are connected to such differing degrees of privilege or oppression that this also contributes to internal conflict, confusion, and identity imbalance (Crenshaw, 1989).

There is a “destructive and fragmenting” impact of “denying other parts of self” when choosing one part or mode to present to society (Lorde, 1984, p. 113). While some repression may be necessary for personal survival, the loss of the strengths and knowledge of these parts contributes to individual suffering and increases comorbidity of various health issues (Brave Heart, Chase, Elkins, & Altschul, 2011). Through a Giving Voice dialogue, a patient can channel

repressed parts of themself, reestablish a connection, or work towards balance.

Connection to Voice

Individuals living in oppressive systems must constantly assess for safety when deciding to speak or be silent as the risks of retribution, rejection, or vulnerability to exploitation or other harm are a constant presence. This can impact connection to voice, and patterns of submissiveness or verbal aggression may develop.

Using a Relationships and Encounters approach, a patient can practice assertiveness and create a healthier connection to voice. The further development of the inner leader via the Giving Voice dialogue practice is also useful, as this part holds the strengths of strategy, courage, and wisdom needed for successful conflict management. For example, an Asian man experiencing workplace harassment may use assertiveness to advocate for his right to a safe and fair work environment. In another case, a young woman experiencing street harassment may go to a nearby corner store to call for help instead of directly confronting aggressors.

Oppression-rooted coping

Just as with any other form of trauma, oppression can also lead to the development of difficult symptoms and harmful coping patterns. Oppression-rooted coping can be understood as maladaptive coping behaviors enacted by suffering modes directly linked to the experience of historical or present

oppression. These modes may attempt to alleviate suffering through self-soothing, pleasure-seeking, numbing, or behaviors aimed at reclaiming dignity via projections of success and well-being (hooks, 2003). These behaviors are also often encouraged and enabled by institutional power structures with things such as restricted access to health care, targeted marketing of alcohol and cigarettes, repression of community cultures, and capitalist value systems (Estrada, 2009). Oppression-rooted coping is an understandable consequence of oppression-based traumatization and loss.

Using a Giving Voice dialogue structure, a patient can channel a part involved with substance use so that this part might share its motivations and emotional anguish. This gained understanding can help the patient care for this suffering part which creates the potential to decrease dependence on harmful coping behaviors.

Addressing the Core Problems of Oppression in Clinical Practice

A Mexican American patient, Ana, experienced socially induced trauma when she was verbally harassed at a coffee shop by a man who shouted racial slurs and told her she did not belong in the United States. Working within the Relationships and Encounters approach, Ana sat in one chair and imagined the perpetrator in the chair opposite. The patient then expressed her feelings of anger and said: “How dare you hurt me! You coward!” As the patient continued to speak, she began to express sorrow: “The world isn’t safe for people like me.” Ana’s energy shifted toward courage, and she stated, “This is my city, too. I won’t disappear.” She was then encouraged to switch into a

Giving Voice/Existential Intentionality stance where she claimed her authority by saying, “I have a right to take up space in the world. I am proud of who I am.” Afterwards, the patient reported a dramatic reduction in distress, and an increase in self-esteem and courage. Ana also kept visiting the coffee shop (Garcia Torres, 2020).

A young man was struggling with identity conflict. The patient, James, was a half-Cambodian, half-white adult who experienced social judgment and inner conflict regarding his identities. Using two chairs and the Giving Voice approach, James sat in one chair and channeled “Cambodian James.” As this self, he expressed feelings of isolation and rejection: “James doesn’t understand me. People ignore me. I’m never enough.” This part also shared a wish for a closer connection to the patient. James shifted to the second chair and channeled “White James.” He shared feelings of sadness, saying “James doesn’t like me and he wishes I would disappear.” He also tapped into guilt: “I don’t mean to stand out so much.” After working with these identities via Chairwork, James shared a reduction in his internal conflict and an increase in courage to claim his biracial experience. He also reported improved acceptance towards his white identity and increased motivation to embrace his Cambodian culture.

Conclusion

As Lorde (1984) says, people must work to push away “[...] that thin persistent voice that says our efforts are useless […]” (p.137). People cannot effectively work towards justice and wellness when traumatized and

exhausted. While psychoeducation about oppression is important, it is not enough to merely teach patients the clinical language to name it. We must also address psychological despair in order to support lasting change (Lorde, 1984).

Hooks (2003) stated that it is possible to “maintain healthy self-esteem” despite the presence of oppression (p.54). By using Chairwork Psychotherapy, it is entirely feasible to hold harmful forces accountable and get distance from them, while also improving self-esteem through reclaiming power, agency, and identity. This is a matter of survival. It is also an act of love.

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