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I WANT TO SORT THIS OUT MYSELF: USING CHAIRWORK AS A PERSONAL PRACTICE

As a part of his Gestalt Therapy workshops in the 1960s, Dr. Friedrich "Fritz" Perls recommended that the participants become their own therapists and have their own self-therapy sessions (Perls, 1970); in turn, Farrell and Shaw (2018) also affirmed that schema therapists could benefit from ongoing self-practice/self-reflection work. In this paper, I have presented several Chairwork dialogue structures that therapists can use to work through difficult relationships or challenges within themselves.

In as much as Schema Therapy is centered on working with people who have personality disorders and/or who may have problematic interpersonal styles (Rafaeli, Bernstein, & Young, 2011; Young, Klosko, and Weishaar, 2003), these are certainly grounds for countertransferential or negative reactions to the patient. *Relationships and Encounters* dialogues focus on the interpersonal world (Kellogg & Garcia Torres, 2021), and clinicians can use Chairwork to work through the complex emotions that they might be feeling toward these "difficult" patients or other problematic people in their lives. In Figure 1, there is a two-chair model with the different parts labeled, respectively, *Self* and *Other*. The therapist begins by sitting in the *Self* chair. They then imagine the difficult or troubling person in the *Other* chair, and they work to become aware of whatever feelings that they are having toward that person. The next step is to use the *Cycle of Emotions* – which means they are encouraged to express the feelings of love, anger, fear, and/or sorrow that they may have toward the other person. As a self-practice, the therapist will want to consciously go through the four core emotions to see if any of them resonate. It is important that the therapist be able to speak with all the force and intensity that they can muster and say things like: "I really hate working with you. You are so difficult, and you do not let me do my work. I am frustrated and I am so unhappy with the way I feel during and after our sessions." To be clear, this is a self-practice – which means that it is not a rehearsal for a real conversation with the patient.

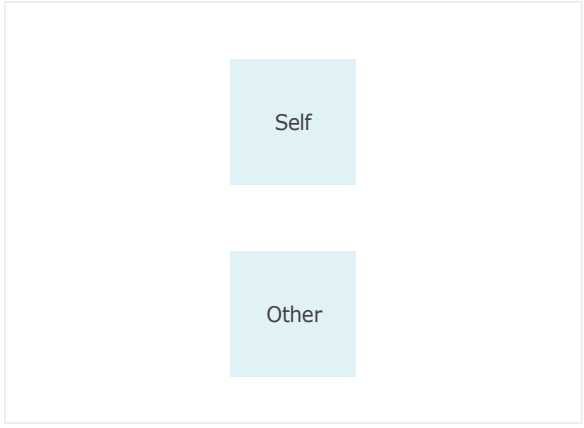

Figure 1. Cycle of Emotions

The next step is to move to the *Other* chair and engage in *role-reversal* (Dayton, 2005; Moreno, 2019; Z. Moreno, 2012); here they can "become" the other person and share their truth.[1] The goal is to access the suffering of the Other and to speak from their heart. "Difficult" patients and difficult people, in general, are often using coping modes excessively or in a manner that is highly problematic; getting to the pain at the heart of their being creates the possibility of empathy – which is the central goal of role-reversal. Embodying a patient, they might say such things as: "I know that I behave very poorly in the sessions. I just feel so ashamed being here with you." Or "Everyone hates me, and I think you are going to hate me too; I just don't want to let you get close." After hearing the *Other* speak, the therapist then moves back to the *Self* chair, and they take a moment to let in what the *Other* has said; they can then respond to what they heard. Often the patient or the difficult person seems more childlike and vulnerable after this experience. This experience of free and honest self-expression combined with an empathic experience of the *Other* can be both energizing and empowering. In many cases, one round is enough; but another round can be done if that seems like it will be fruitful. The therapist can then decide if they want to go forward in a new way or stay the course with what they are already doing.

Figure 2 is an example of a *four-chair* or *rhombic dialogue* structure. At the top of this rhombus-shaped figure is the *Self* chair. In the middle are two chairs – one for resentments or negative feelings and one for positive or compassionate feelings. At the bottom is *Other* chair – which is for the imagined patient or difficult person. At its heart, this dialogue structure is rooted in Perls' emphasis on ambivalence or the idea that we often have feelings of both *appreciation* and *resentment* for the people in our lives (Perls, 1969). This dialogue can not only facilitate the clinician's ability to remain centered in problematic relationships, but also it can empower them to take steps to end or radically alter a connection with someone else.

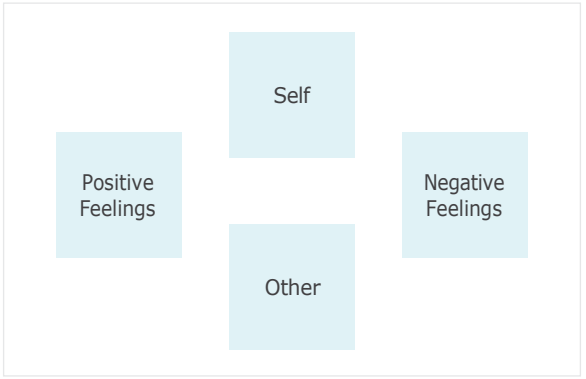

Figure 2. Vector Dialogue

The therapist starts in the *Self* chair and begins by imagining or envisioning the challenging patient in the chair opposite; after taking a few moments for their reactive emotions to rise to the surface, they can then move to one of the two diagonal chairs and speak from their positive/compassionate part or their negative/frustrated/frightened part – whichever is more powerful at that moment; they would then move to the chair opposite and speak to the person in the *Other* chair – giving voice to the opposite set of emotions. This is known as a *Vector Dialogue* (Kellogg, 2014). Again, while the goal here is to speak openly and with emotion; *this is not a rehearsal for an actual conversation with a patient* – it is a private experience for the therapist.

Moving to the negative chair, the goal is for them to freely express what they are thinking and feeling. This could include things like: "I am so upset with you." "You do not cooperate in the session." "You frighten me." " This whole experience is just so frustrating." "I wish you were not my patient and that you would go away." "I do not feel like I know what I am doing when I am in session with you." "If other colleagues knew how badly this work is going, I would be ashamed."

The next step is to move to the diagonal chair on the other side and speak from positive feelings and compassion: "Even though you are behaving in difficult ways, I know that you are really just a very frightened child." "When I think about the incredible trauma that you have been through, I feel horrified; it is amazing to me that you lived through it." " The stories that you have told me about your family – I am enraged when I hear them. How could anyone do such a thing to a child." It is best if the clinician goes back and forth between these two perspectives at least three or four times – speaking with emotion, power, and intensity from each perspective. After this, they can come back to the *Self* chair and express to the patient in the *Other* chair, how they are now feeling toward them. Having experienced the complexity of their feelings toward the difficult person, it may be easier for them to go forward with more power and clarity in the relationship.

Internal Dialogues (Kellogg, 2004; Kellogg & Garcia Torres, 2021), in turn, involve the inner world of the therapist and the different parts that are contained there. Elliott and Elliott (2000) have written that "inside of each of us is a negative influence that is

[1] Role reversal should not be used with a person who is an abuser as this can block the effective expression of anger and other "negative" emotions and, therefore, interfere with the healing process.

responsible for 99% of our psychological problems. That negative influence is the Inner Critic" (p. 2). While the Inner Critic may be a central problem for patients; therapists are equally or perhaps even more susceptible to its attacks. This time, using the *Vector Dialogue* paradigm as an internal, rather than a relational, dialogue structure, therapists can work with and challenge their own negative self-messages or schemas (see Figure 3).

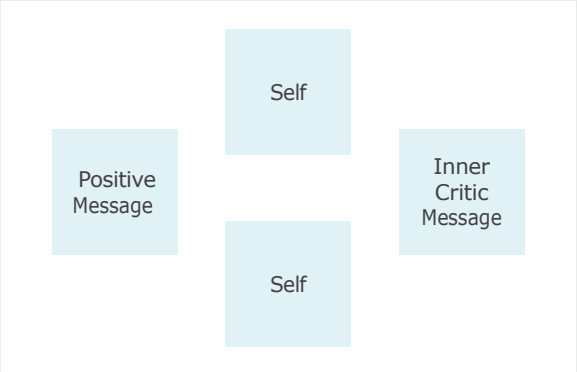

Figure 3. Vector Dialogue - Self

To begin, it may be useful for clinicians to write down four negative things that the Inner Critic says about them, and then, accessing the Inner Leader or the Healthy Adult Mode, they can write down four positive things that they know to be true about themselves – or that other people would say are true about them. The dialogue first begins with them imagining themselves in the *Other* chair. After getting a sense of their emotional response to seeing themselves in the chair opposite, they can again move to the chair that best reflects the dominant emotion. This could be the *Appreciations* chair – where they can speak to themselves in the *Other* chair from a positive perspective ("These are the things that I really admire about you, the things that I think are good."), or the *Resentments* chair – where they can give voice to the self-criticisms ("These are the things that really upset me about you."). They should go back and forth between these two middle chairs at least four or five times – speaking with as much intensity and emotion as they can muster. After this, they can return to the *Self* chair and process the experience – ascertaining what the balance is between the positive and the negative sense of self.

When analyzing the items on the YSQ-S3 (Young, 2005) and the SMI (Young, Arntz, Atkinson, Lobbestael, Weishaar, van Vreeswijk, & Klokman, 2009), four distinct patterns emerge: (1) perspectives on the self; (2) perspectives on the world; (3) rules or injunctions about living; and (4) the importance of expressing a particular part or mode. Therapists can discover these issues by taking the inventories, looking at patterns in their lives, connecting to the traumas that they have been through, identifying some of their problematic coping behaviors (e.g., anger, excessive shopping, etc.), and examining the beliefs and schemas that are elicited when a session does not go well.

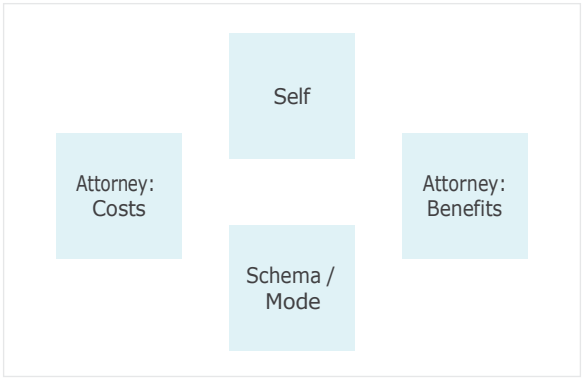

Figure 4. Utility Dialogue

Looking at Figure 4, the *Self* chair is at the top and the *Schema/Mode* chair is at the bottom. It is here, in the *Schema/Mode* chair, that the therapist can personify, embody, and give voice to a specific schema, mode, or behavior and propose that it might be true and/or good for the therapist. The two side chairs are there to facilitate a dialogue-based *cost-benefit analysis*, *an evidentiary dialogue*, or both, as appropriate. The therapist can either speak from the two sides themselves, or, building on the work of de Oliveira (2016) and Pugh (2020), they can embody two lawyers or attorneys – each of whom make the argument for their respective position. This can be a very powerful experience as the patient can get more distance from their schema or mode – which, in turn, helps to strengthen the Inner Leader or Healthy Adult Mode (Roediger, Stevens, & Brockman, 2018).

The first one is the Cost-Benefit exploration (Arntz & Jacob, 2013; Burns, 2006); here one lawyer will argue for the benefit of living by "truth" of a specific schema or allowing a particular mode to be active; the other lawyer will, in turn, lay out the costs of doing this. This is a dialogue that explores the *utility* of a schema, mode, or behavior.

An example from my own life. I started in the *Self* chair, and I thought about a belief I had that I wanted to explore. I went to the Schema/Mode Chair that was opposite, and, using a third person stance, I gave voice to a belief that I had held for a long time:

> "Schema therapy is an amazing psychotherapy. We have a framework and skills that other therapies do not have. We are the therapy of last resort, and we must never give up on a patient. No matter how difficult the case, Scott should persevere; if he does this, he will eventually succeed, and the patient will get better."

Next, I moved to the chair for the attorney that argued for the benefits of this belief. He said :

> "The benefits of this belief are that Scott will feel strong and empowered. It will inspire him to study and work hard, and it will give him the courage to take on difficult cases and to stay the course. As he has seen in the past, with enough determination, he can help people that had not been able to find help before."[2]

I then went to the chair of the attorney that argued for the costs of this approach:

> "This is too extreme of an approach. Therapy is based on a relationship between the therapist and the patient, and, for the work to be successful, the patient must, at some point, commit to the goal of getting better. Scott has gotten himself in trouble staying in the game with patients who refused to cooperate with the treatment; I think that it is very important that he gives himself the freedom to end the therapy if it is not working. It is just too stressful and imprisoning otherwise."

After going back and forth three or four times between the two attorneys, I moved to the *Self* chair and looked at the *Schema/Mode* chair across from myself. The question here is: Do I want to keep this schema or mode and stay the course, or do I want to make a change? In this case, I spoke to the schema about how deeply entrenched this belief has been in me, and how it is very difficult to let it go *and* how stressful it is to hold onto it. The conclusion was to begin to work with ideas from Safran (Safran & Kraus, 2015) and Roediger (Roediger et al., 2018) around "rising above" and stepping outside the therapy with the patient to get a better sense of where the difficulties lie between the two of us. Again, this was a dialogue that explored the *utility* of a schema or a belief.

The second one is the evidentiary dialogue (Young, 1993; Young et al., 2003). Here, the therapist (or lawyer) will look at evidence from the past and the present and make the case that the schema is true; in turn, the person (or lawyer) in the opposite chair will look at evidence from the past and present that disputes the schema and will argue against it. This dialogue explores the *validity* of the schema.

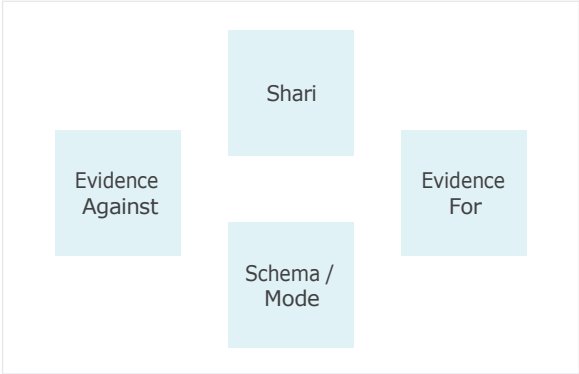

Figure 5. Validity Dialogue

Adapting an example from the classic *Schema Therapy: A Practitioner's Guide* book (Young, Klosko, and Weishaar, 2003), the case of Shari can serve as a model for an *evidentiary* dialogue (see Figure 5). Shari, a psychiatric nurse, can begin by sitting in the Self chair, and then move to the *Schema/Mode* chair that is opposite. Here she can give voice to her *defectiveness/unlovability* schema in the third person. "I believe that Shari is so fundamentally flawed that she will never really be loved by others, nor will she ever be successful. It would be best for her to realize that this is true and for her to accept herself as someone who is less than others."

Moving to the middle chairs, she can do an *evidentiary dialogue*. In one chair, she will give voice to the evidence from both her current life and her past that support the schema; she will then move to the opposite middle chair and dispute the schema by giving voice to the evidence from the past and the present that does not support the schema. She can do this in the first person, or she can use the prosecutor and defense attorney form. The goal of this form of Chairwork is to challenge the *validity* of the schema.

Making the case for the schema she would say things like: "No one ever loved me or cared for me when I was a child"; "I'm awkward, stilted, obsessive, afraid, and self-conscious with other people"; and "I get too angry inside" (Young et al, 2003, p. 95) Moving to the chair opposite and disputing the schema, she might say things like: "My husband and children love me"; My patients like and respect me"; "I'm sensitive to other people's feelings"; "I try to be good and do the right thing. When I get angry, it's for good reason" (Young et al., 2003, p. 96). After going back and forth several times – giving voice to each perspective with as much energy and emotion as she can muster, she would return to the *Self* chair and weigh out the strength of the arguments. Among the different conclusions that she might come to are:

1. The schema was true for her in the past, but it is no longer true.

[2] When I did this work, the attorney was a male; therapists may find that these figures are of different genders than themselves.

2. The schema was never true; she misperceived things based on what other people had said to her. When she looked at the evidence, it just did not stand up.
3. The schema is true. Working with the understanding that all people have weaknesses, she can do some grief work and then accept her awkwardness with compassion and look at further developing her strengths.
4. She could acknowledge that there might be some truth to the schema, and then decide to make a conscious and concerted effort to: (a) challenge the childhood origins of the schema; and (b) learn new and more effective ways of working with the schema.

A final technical point: it is a wonderful thing to have an office with lots of space and four chairs in it; I realize that this is often not the case. One strategy is to put four markers on the floor in a rhombic shape and move among the different stances while standing up. Standing up can help to release energy and emotion and make the whole process more intense. Another way is draw four-box-rhombic shape on a piece of paper; point to each box with a pen and, in turn, give voice to that part. Working to give clarity to the parts and finding ways to create space – either physical or psychic – is crucial to the effective use of Chairwork in both psychotherapy and self-work.

I have been using Chairwork as a self-practice for many years, and I have found the *Four Dialogues – Giving Voice, Internal Dialogues, Telling the Story,* and *Relationships and Encounters* to be a powerful framework for doing this work (Kellogg & Garcia Torres, 2021). In this article, I have provided the blueprint for doing self-healing work within the *Relationships and Encounters* and *Internal Dialogues* structures. I think this is a very good place to start.

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